NHSSP Nepal Health Sector Support Programme

Nepal Health Sector Support Programme

Quarterly Report

Reporting Period: Oct - Dec 2013

Contents

Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
AWPB	annual work plan and budget
CA	constituent assembly
CAPP	consolidated annual procurement plan
CBNCP	community based newborn care package
CEONC	comprehensive emergency obstetric and neonatal care
CHD	Child Health Division
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	Director General
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
EOC	emergency obstetric care

FCGO	Financial Comptroller General's Office
FCHV	female community health volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FMT	Fund Management Team
FP	family planning
FY	fiscal year
GAAP	Governance and Accountability Action Plan
GBP	Great British Pound
GBV	Gender-based Violence
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
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
NSI	Nick Simons Institute
OB/GYN	obstetrics/gynaecology
OCMC	one-stop crisis management centre
OPM	Oxford Policy Management
OPMCM	Office of the Prime Minister and Council Minister
PD	Population Division
PEER	peer ethnographic evaluation and research
PFM	public financial management
PHCRD	Primary Health Care Revitalisation Division
PIP	Procurement Improvement Plan
PO	procurement office(r)
PPICD	Policy, Planning, and International Cooperation Division
PS	procurement specialist

PSI	Population Services International
QA	quality assurance
QI	quality improvement
RA	rapid assessment
RH	reproductive health
SCF	Save the Children Fund
SM	safe motherhood
SNP	state non-state partnership
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
VDC	village development committee
WB	World Bank
WDO	Women's Development Office
WHO	World Health Organisation

1. Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit this quarterly report for the period of October to December 2013, the twelfth quarter of the programme and the first under its second phase.

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).

Phase one of NHSSP ended in August 2013. Under phase two, Options leads a consortium of partners including 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 Policy Planning and International Cooperation Division (PPICD) to fund new initiatives put forward by MoHP and external development partners (EDPs). Progress made against the outputs in the new logframe is described in Section 2.

The purpose of this report is to document the activities and results delivered by NHSSP between October and December 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 NHSSP phase 2 inception report and the individual work plans of advisors. All work plans have been agreed with advisors' counterparts who are commonly the heads or directors of divisions and centres, such as the Family Health Division (FHD), PPICD, Logistics Management Division (LMD), and so on. All NHSSP activities are designed to enhance the capacity of MoHP/DoHS to deliver the second Nepal Health Sector Programme (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

Despite attempts by several political parties to disrupt national elections, a generally 'free and credible' poll took place on November 19th 2013 in the presence of international observers. Voter turnout was a record 78%. Of the 240 first-past-the-post seats available, the Nepali Congress party won a plurality with 105 seats while the Communist Party of Nepal (United Marxist Leninists) won 91 seats. The Communist Party of Nepal (Maoists) won just 26 seats and other parties 18 seats. A total of 335 constituent assembly (CA) posts were allocated for proportional representation but several remain to be filled as a result of internal party disputes. This has delayed the formation of a new government and a first meeting of the new constituent assembly. A Nepali Congress and UML-led coalition government seems probable. It will have 12 months to finalise Nepal's new federal constitution.

Delays in the political process are seen, ironically, to have improved staffing stability in MoHP, as a result of the embargo placed on staff transfers in the run up to the election. This is likely to be a temporary respite which will change once a new government and health minister are installed.

Summary of Key Events in this Quarter

This quarterly report marks the effective transition between phase and one and two of NHSSP. Under phase two a smaller, more focused and embedded TA team is working on a reduced number of thematic areas under new in-country leadership. As noted, following the preparation of a phase two inception report in September 2013, a new draft NHSSP TA logframe was developed and this provides the structure for this report. In a departure from phase 1 reporting, this document focuses on outputs and progress against key health system strengthening indicators rather than technical inputs in orthodox thematic areas.

The heading levels of each section in the report relate to 1) the NHSSP TA output; 2) the related NHSP-2 output; 3) the NHSSP indicator and 4) the NHSSP work plan number which is derived directly from the indicator.

A key objective of NHSSP phase 2 is to support the design of NHSP-3 for 2015-20. For this reason, this report both describes progress made in NHSP-3 planning and also provides recommendations on key issues that NHSSP TA and government counterparts believe should be addressed within the new sector plan.

In the reporting period, significant progress was made in the thematic areas as follows:

In Strengthening Core Health System Functions

A feasibility study on building linkages to enable the CMS (Contract Management Information System) to improve Logistic Management Division's (LMD's) procurement, forecasting and delivery of goods procedures advanced. Supply chain management meetings were arranged and quality assurance of procurement documentation began with the arrival of quality assurance advisers. A study with suggested formulae for accurate budget price estimating of procurement tenders was completed as was a second study on the supplier market. To date, 840 technical specifications of medical equipment have been uploaded in the technical specifications bank.

Piloting of the Transaction Accounting and Budget Control System (TABUCS) was completed with findings used to modify the operating software. System, user and training manuals were updated, a training of trainers (ToT) course run and an external service provider contracted to train users at cost centres across the country. Internal Financial Control Guidelines and Audit Clearance Guidelines were prepared to improve fund flows, absorptive capacity and levels of accountability at MoHP cost centres. In addition, web connectivity with the office of the Financial Comptroller General's Office (FCGO) was achieved, so allowing MoHP to directly access to FCGO data. A Public Financial Management (PFM) working committee was formed and a draft revision of the Financial Management Improvement Plan (FMIP) prepared. A Draft Procurement Improvement Plan (PIP) was also developed and discussed with MoHP management.

In infrastructure, Standard Land Selection Guidelines to enable the Department of Urban Development and Building Construction (DUDBC) to ensure that new health facilities are built on suitable sites were approved. The web-based Health Infrastructure Information System (HIIS) was endorsed and used for the first time by Management Division (MD) to select new construction projects for the current financial year. Staff from 35 districts were trained to use the HIIS and standard infrastructure bidding documents and guidelines for construction companies were published.

In Strengthening Service Quality, Equity and Access

By December 2013, social service units (SSUs) were operational in seven hospitals including two new units in Maternity and Kanti Hospitals. MoHP prepared an SSU capacity development plan and monitoring and evaluation framework. Five days training on psychosocial counselling were organised for 106 staff from one stop crisis management centres (OCMCs), safe homes, rehabilitation centres, women development offices and the Nepal police's women and children units. Three OCMC staff nurses participated in an intensive 6-month psychosocial counselling training course.

At the request of Family Health Division, a senior comprehensive emergency obstetric and neonatal care (CEONC) consultant was appointed to support selected referral hospitals to address facility overcrowding and improve the quality of care available. Further, TA worked with the Nick Simons Institute (NSI) to help FHD prepare a draft concept note for a CEONC Coordination Group to support all CEONC hospitals. NHSSP TA provided additional support to FHD for an analysis of safe motherhood (SM) and family planning (FP) programming gaps. These were discussed during the national RH review and in FHD's planning meeting and appropriate strategies and activities formulated for inclusion in the 2014/15 annual workplan and budget (AWPB).

MoHP's 2013 study on access to maternal, neonatal and child health (MNCH) services in remote areas recommended the piloting of a core service delivery and demand side package of interventions to help communities access health services. Based on these recommendations, FHD and PHCRD prepared a draft concept note on interventions in one remote district to be taken forward in 2014. With a view to institutionalising service quality assurance systems for MNCH in health facilities, MD and FHD supported by several external development partners (EDPs) to prepare terms of reference for a National Quality Improvement Technical Assistance Group.

In Supporting Institutional Reform Processes

Progress was made in developing a unified coding system for Nepal's health management information systems (MIS) with MoHP confirming that all ministry MIS will now use the district and VDC codes prepared by the Central Bureau of Statistics, the health facility codes prepared for the Health Infrastructure Information System (HIIS) and the unified codes for basic health services being developed under the revised HMIS. Work on the District Health Information software DHIS-2 required to operate the revised HMIS advanced and MD prepared a detailed road map for its development and institutionalisation.

Strategic planning for the design of the third National Health Sector Support Programme (NHSP-3) began with preparations made for a process design workshop in early 2014. This will identify priorities, framing questions, structures, processes to be followed, and the resources required. NHSSP TA also worked closely with government and development partners to compile evidence of recent health sector progress and prepare eight technical papers for the 2014 Joint Annual Review (JAR). The JAR is expected to have a strong bearing on the aspirations, targets, structure and content of the next five year strategic plan.

In research, the 2012 Service Tracking Survey and Household Survey reports were disseminated and the draft STS 2013 report was shared with MoHP for comment. In addition, TA supported the preparation of a generic survey tool-kit containing templates, guidance notes and examples of quality survey designs, questionnaires, manuals, data analysis, planning and budgeting formats in order to enhance ministry capacity to design and manage surveys in the future. On demand side financing, a draft concept note for a review of the Aama programme was prepared alongside a draft concept note for an analysis of the unit costs of implementing Aama. Both reviews will be taken forward in early 2014.

Technical Assistance Response Fund (TARF) Funding

In the reporting period, PPICD was supported to develop and finalise TARF guidelines which were circulated to all divisions and centres. A small fund management team (FMT) was agreed with representatives from PPICD, DFID and NHSSP, with NHSSP acting as the secretariat. The MoHP nominated the PPICD official who also chaired the meeting. The FMT met during November and approval was given for TARF funds to support the following activities:

(i) **In Health Policy.** At the request of PPICD, two senior national consultants were contracted to support the MoHP in developing a draft health policy. Additional funding was allocated for a health policy dissemination workshop.

(ii) **In Safe Motherhood and Neonatal Health.** At the request of FHD, two consultants - a comprehensive emergency obstetric and neonatal care (CEONC) mentor and senior consultant - were contracted to provide guidance on improving CEONC service quality and reducing overcrowding. The FMT requested that FHD provide a work plan and make provision for taking forward these initiatives within next year's annual work plan and budget. In addition, a family planning coordinator was contracted for 5 months in advance of Population Services International (PSI) taking over funding of the post from February 2014.

(iii) **The National Health Training Centre (NHTC).** NHTC was supported to develop an integrated curriculum to help carry out orientation and induction training for over 1,200 new MoHP staff members (200 offices; 1000 non-officers) including doctors, nurses, paramedics and others.

(iv) **In Procurement.** At the request of LMD, funds were allocated to contract two procurement specialists to support and help build the capacity of LMD's procurement officers. A proviso was applied that these two be matched by an equivalent number from DoHS.

Additional support

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

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 the Transaction Accounting and Budget Control System (TABUCS) at all cost centres across the country (see 1.2.1).

c) In Essential Health Care

Funds have been set aside by DFID to support key aspects of new born care by Save the Children and, following further review. a revised ToR has subsequently been issued to SCF and a fresh proposal is expected by middle of February 2014.

Provision has also been made to implement the recommendations of the phase 1 remote areas study in one district.

Eighteen publications were produced in this quarter and all non-sensitive documents uploaded to the NHSSP website. Visitors to the website reached over 11,000 (since Jan 2012) and Facebook 'likes' exceeded 300. By the end of December NHSSP had 65 followers on Twitter and had tweeted 90 times since March 2013.

3. Detailed Thematic Updates

TA Output 1:
Core Health System Functions 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) capacity for transparent and timely procurement

1.1.1. Increase 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).

In the reporting period, TARF funds were used to hire a procurement specialist (PS) to 'match' the procurement officer (PO) recruited by DoHS. The process of hiring a second TARF-funded PS, who will support a second PO supplied by DoHS, is now underway. LMD is critically short of POs with which to conduct routine procurement and there is still much know-how to transfer. The two POs currently posted in to LMD are currently untrained as POs. TA provided continuing and continuous on-the-job training for the POs currently in place, updated the CAPP and oriented the new quality assurance (QA) advisers who are providing a further check on procurement documentation as a part of the overall QA process.

In the coming quarter, a second TARF-funded PS will be contracted and on-the-job training of LMD staff will continue. TA will liaise with FHD, World Bank (WB) and DFID to start the process for CAPP and annual work plan and budget (AWPB) 2014-15 preparations. This will include assisting with the delivery of a forecasting workshop. The TA team will continue to press for transparency by insisting that all relevant information is uploaded on to LMD's web site and dgMarket/United Nations Development Business (UNDB) Online as appropriate.

The potential risks affecting these activities are: 1) Further changes of staff members in the PO and Contract Management (CM) sections; 2) the possibility of EDPs reverting to project style approaches and existing procurement workload being reduced significantly within LMD under NHSP-3 in which case the capacity building inputs over the past three years may prove redundant, and 3) a reluctance of DoHS to begin the CAPP process timeously.

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

The feasibility study on providing linkages to enable the CMS (Contract Management Information System) to improve LMD procurement, forecasting and delivery of goods procedures is well advanced (see below).

Supply chain management meetings were arranged to bring together various projects, programs, consultancy firms, international non-governmental organisations (INGOs), non-governmental organisations (NGOs) and donor partners etc. involved with LMD operations so as to avoid duplication of efforts and enable possible synergy of activities.

Funding for visits to regional warehouses was arranged to enable LMD to conduct knowledge transfer activities with regional warehouse staff. Training of staff, in particular LMD contract management staff, commenced on various core and non-core procurement and contract management activities.

As noted, additional quality assurance activities relating to procurement documentation commenced with the appointment of the QA advisers.

A study with suggested formulae for accurate budget price estimating for procurement tenders was completed. A further study, including recommended actions to increase supplier participation in LMD tenders, was also completed (see below).

The main risk associated with these activities appears to be the lack of LMD institutional support to ensure they are owned, institutionalised and likely to be sustained.

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

As noted, the feasibility study on linkages to enable the CMS to improve LMD procurement forecasting and delivery of goods procedures is well advanced. The feasibility study for CMS and finance linkages is scheduled to commence in January 2014. Focus work areas in the first quarter of 2014 include proceeding to detailed software programming for the CMS linkage with demand forecasting, finance and delivery procedures incorporated on the assumption that they are shown to be feasible.

The main risks to this activity are the lack of cooperation witnessed among LMD counterparts to implement improved systems (e.g. data entry, and the possible duplication of these activities by other programs) in spite of the fact that the introduction of such a system will make their work simpler and more efficient.

1.1.4. Enhance value for money in procurement practices by improving LMD knowledge of the supplier market for selected procured goods

In order to increase supplier participation (particularly that of local suppliers) in LMD tenders, and thereby increase competition and transparency, a study was completed on the supplier market including why some suppliers are not submitting bids to LMD. Findings, including recommendations on how to address the non-participation issue, were presented in a stakeholder workshop. Recommendations will be followed up in the next quarter in conjunction with the WB, as required.

1.1.5. Expand capacity of LMD to effectively ensure quality of goods procured through use of the technical specification bank and appropriate use of biomedical engineers

To date, 840 technical specifications of medical equipment have been uploaded in the technical specifications bank. These are generic in nature to ensure appropriate technical standards are adopted and to increase the quality of products purchased from various sources and at different levels of the health system. LMD used these specifications in 2012/13 for the procurement of medical equipment including international competitive bids (ICBs) 29, 30, 31, 32 and KfW used them in ICB1 and will apply them again in the current fiscal year.

Dissemination of the technical specifications to government hospitals and health facilities is in progress. To date LMD's and NHSSP's biomedical engineers have visited and conducted meetings with Bir Hospital, Maternity Hospital and the Civil Service Hospital. Capacity building of LMD's biomedical engineers for the further development of the technical specifications bank and technical evaluation of bids is ongoing.

Under NHSSP phase 2 the target is to include 700 new technical specifications (300 for medical equipment and 400 for drugs, medicines, vaccines, consumables and other health sector commodities) in the bank by the end of August 2015. New technical specifications will be uploaded as soon as they are developed and approved. TA will continue to increase the capacity of LMD's biomedical engineers for development of the technical specifications bank and technical evaluation of bids.

The principal risk associated with this initiative is a delay in hiring a pharmacist to develop the technical specifications for drugs medicines, vaccines and consumables. There is also a risk that LMD biomedical engineers may leave their jobs to seek other employment, or that their contracts are not extended, given that they are only contracted for twelve months on a year on a year-by-year basis.

Indicator 1.2 Timeliness of Budgeting and Financial Reporting

1.2.1. Improve budgetary control by supporting roll out of TABUCS nationally, and building capacity of MoHP to effectively manage and use TABUCS

The transaction accounting and budget control system (TABUCS) was developed to improve the timeliness and quality of MoHP's financial reporting through improved data collection, including local revenue collection and payroll payments, and the introduction of effective financial controls. Timely reporting and the generation of quality financial monitoring will help MoHP meet its reporting requirements to Government of Nepal (GoN)/Ministry of Finance (MoF) and external funding partners.

In the reporting period, piloting of TABUCS was completed and findings used to modify the programme's software. The system, user and training manuals were updated and MoHP issued letters to 278 cost centres to prepare the infrastructure required to operate TABUCS and to nominate participants for TABUCs user training. A training of trainers (ToT) course was run and an external service provider contracted to train users.

In the next quarter, users from all cost centres will be trained and the system further strengthened as required. MoHP will engage national health training centres, regional health directorates and regional health training centres to support training and the roll out of TABUCS across the country.

The principal risks affecting this initiative are limited power supplies, back-up systems and web connectivity at cost centres and the functionality of the central level TABUCS server. The potential for transfer of trained staff also represents a potential threat.

NHSP-3: Under NHSP-3 a key objective should be to link TABUCS with other management information systems (MIS) including HMIS, Human Resource Information System (HuRIS), Health Information Information System (HIIS), Logistic Management Information System (LMIS) and CMS.

1.2.2. Capacity of MoHP cost centres to deal with audit queries and provide financial reports built

In the reporting period, Internal Financial Control Guidelines and Audit Clearance Guidelines were prepared to improve fund flows, absorptive capacity and levels of accountability in MoHP cost centres. These guidelines promise to ease internal auditing processes, reduce audit irregularities and facilitate timely responses to audit queries. In early 2014, a national workshop to introduce the guidelines will be held and training programmes to support implementation run.

The main risks to this initiative are that the guidelines may not be fully implemented and high level support may not be forthcoming. There is limited availability of funds to train staff from the 278 cost centres required and the potential for staff, once trained, to be transferred to positions where their newly learned skills cannot be used.

NHSP-3: Provision should be made for the internal financial control guidelines and audit clearance guidelines to be updated in the light of implementation experience.

1.2.3. Support wider Public Financial Management (PFM) programmes by providing inputs on issues including fiduciary risk review, supporting governance structures of the Financial Management Improvement Plan (FMIP)

In the final quarter of 2013 web connectivity with the office of the Financial Comptroller General's Office (FCGO) was achieved, thereby allowing MoHP direct access to FCGO data. A PFM working committee was formed and a draft revision of the FMIP prepared and shared with EDPs. In addition, a Draft Procurement Improvement Plan (PIP) was prepared and discussed with MoHP management. Each of these initiatives has the potential to improve MoHP financial management practices including safeguarding the quality and timely submission of financial reports. TA efforts in the coming quarter will focus on finalising the revised FMIP and PIP**.**

The greatest potential threat to the PFM and FMIP initiatives is the transfer of audit and PFM staff and working committee members to posts where learned skills cannot be applied.

NHSP-3: There is a need to develop a comprehensive PFM framework covering the Governance and Accountability Action Plan (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)

NHSSP TA supported the development of Standard Land Selection Guidelines in the reporting period to enable the Department of Urban Development and Building Construction (DUDBC) to ensure that new health facilities are built on suitable sites. Easily accessible and construction-ready land that is easy to supply with basic services including water, power and road connectivity will yield major cost savings. This contrasts with current practices whereby major investments in land development (cut and fill, terracing and the construction of retaining walls and road access) are needed before construction can start.

Having developed the guidelines, efforts are now needed to institutionalise their use and raise local awareness of the pitfalls of building on unsuitable land. In the coming quarter TA will work with DUDBC to identify planned facilities that have been inappropriately located and work with health facility operation and management committees (HFOMCs) to identify alternative sites.

The major risk associated with this activity is the potential for non-compliance with the guidelines by district authorities as a result of pressure from the communities or local government authorities.

Another notable achievement in the reporting period was the selection by the MD of health facility construction projects for 2013/14 using the web-based HIIS and in accordance with standard criteria on accessibility, population and other key factors. Adherence to transparent systems and procedures will improve the abilities of MD and DUDBC to target un-served populations for health facility investments, limit political interference and stop expenditure on unproductive sites. In the coming quarter TA will work with MD to ensure the HIIS selection process is endorsed by MoHP and to further institutionalise use of the system.

In addition to improved planning processes being adhered to, standard infrastructure bidding documents and guidelines for construction companies were published and disseminated to DUDBC district offices. Consistency in bidding documents allows any contractual and legal disputes to be addressed more easily. In the coming quarter district level orientation on the use of standard bidding documents for infrastructure will take place.

NHSP-3: Capacity building of central and district level officials in HIIS use should be considered as a sound investment to improve the quality of health infrastructure planning, construction and monitoring. Climate change and other geographic and demographic factors should also be considered in health infrastructure planning including building in seismic zones, flood plain areas and landslide prone areas. Access to sustainable water sources and the migration of rural, hill and mountain populations also need to be considered.

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

The web-based HIIS described above was completed, officially approved and taken into use by MD and DUDBC in December 2013 following which technical staff from DUDBC and D(P)HO offices in 35 districts were trained in its use. In addition to supporting infrastructure planning HIIS allows the construction and maintenance status of health facilities to be monitored and locally updated over the internet

The main risks to the HIIS are seen to be limited financial resources available and the extended time needed to fully institutionalise its use. It is anticipated that two or three planning, construction and monitoring cycles will be needed in order to demonstrate its utility. Annual budget allocations also need to ensure that facility data can be kept up to date.

NHSP-3: Resources for HIIS capacity building in MoHP and DUDBC and the regular updating of facility data should be included in next year's AWPB. Further provision will be needed to link HIIS with other MIS.

TA Output 2:
Service Quality, Equity and Access Strengthened

NHSP-2 Output: Reduced Cultural and Economic Barriers to Accessing Health Care Services (1) Improved Service Delivery (4)

Indicator 2.1: Availability and Distribution of Quality Maternal Health Services

2.1.1 Social Service Units (SSUs) piloted across 8 zonal and referral hospitals and an institutional home for SSUs established

By December 2013, SSUs were operational in seven hospitals including two new units established in Maternity and Kanti Hospitals. Preparations for an additional pilot SSU in Bir Hospital are underway with an expected opening date in early 2014. Acting on the recommendations of the 2013 SSU review, MoHP prepared an SSU capacity development plan and monitoring and evaluation framework. These are seen as essential components for institutionalising SSU related activities in MoHP programming.

In order to learn from experiences to date, an SSU review and planning workshop - partly funded by UNFPA, and chaired by the health secretary - will take place in January 2014. A key output from the workshop will be an updated set of SSU Operational Guidelines.

2.1.2. Scale up of social audits based on lessons learned from piloting

MoHP updated its Social Auditing Guidelines in June 2013. In the current FY, Primary Health Care Revitalisation Division (PHCRD) will apply the guidelines in 552 (including 296 new) facilities in 40 districts. To this end, staff from 17 districts were oriented. In-depth orientation is seen to be essential if social auditing is not to become 'empty ritual'.

In the next quarter PHCRD will organise a meeting of Health for Life (H4L), GiZ, CARE Nepal, Unicef, NHSSP and others to finalise support for the implementation and monitoring of social audits including tracking implementation of facility action plans.

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

In collaboration with UNFPA, a performance assessment of hospital based OCMCs was carried out in mid-2013. This examined facility functionality and service quality including how OCMC hospitals coordinate with district line agencies to provide legal, rehabilitation and livelihoods support to gender based violence (GBV) survivors. A Pulse Report summarising major OCMC achievements, areas for improvement and next steps was prepared.

In August 2013 a national GBV workshop recommended the creation of a GBV working committee of joint secretaries from MoHP, the Ministry of Home Affairs (police), the Ministry of Women, Children and Social Welfare, the Office of the Attorney General and the Ministry of Federal Affairs and Local Development. Discussions with the Prime Minister's Office and the Department of Women and Children on inter-sectoral coordination at district level are now underway.

The main risk to successful OCMC operations is seen to be failures of district line agencies to coordinate support activities.

At the implementation level, 5 days training on psychosocial counselling were organised for 106 staff from OCMCs, Safe Homes, Rehabilitations Centres, Women Development Offices (WDOs) and Nepal Police Women and Children Units. In addition, three OCMC staff nurses participated in an intensive 6-month psychosocial counselling training course. Further, Population Division prepared and disseminated a OCMC resource book on legal provisions for GBV victims and district level health staff participated in a 16-days GBV national awareness campaign which included broadcasting radio jingles, holding review workshops, rallies, orientation programmes, interviews and meetings with journalists.

Ongoing work in the quarter included PHCRD's preparation of a Referral and Medical Treatment Protocol for GBV victims and a medico-legal training programme for 16 medical officers working at OCMCs. In early 2014, Population Division plans to meet with the Office of the Prime Minister and Council Minister (OPMCM) and other government and EDP officials to develop a OCMC road map based on the national review and OCMC assessment findings. An OCMC M&E framework and a clinical and referral protocol for GBV victims will also be developed.

It should be noted that one more OCMC has been planned in the current fiscal year - in Karnali National Health and Science Academy (Jumla district).

2.1.4 Support implementation of strategies to address overcrowding in tertiary facilities

At the request of FHD, a Sr. CEONC consultant was appointed to support selected referral hospitals for long- and short-term planning to address facility overcrowding and improve quality of care. Senior staff members from two referral hospitals (Koshi Zonal and Pokhara Western Regional) were oriented on the use of FHD budgets allocated to reduce overcrowding. To date, 10 referral hospitals have received such funds, but quality of utilisation of the funds has been poor in the absence of clear on-site guidance. FHD has sought the involvement a several agencies, including GiZ and Unicef, in supporting these hospitals.

In the coming quarter, rapid assessments of actions taken to reduce overcrowding will be carried out in Mechi and Lumbini referral hospitals and TA will continue to provide on-site orientation on the use of funds to the other 8 hospitals. TA will also provide local planning support to three referral hospitals for short and long term solution for overcrowding (Bheri, Koshi/Seti and Narayani/Lumbhini zonal hospitals [to be confirmed]). Further, a meeting with national and local stakeholders will be held to prepare a plan for the strategic locating of birthing centres in one of the three districts mentioned.

NHSP-3: It is essential that NHSP-3 continue to stress improving the quality of care in referral hospitals but this will not be feasible unless overcrowding in referral hospitals and under-utilisation of nearby birthing centres are addressed.

2.1.5 Support effective implementation of the CEONC Fund

As noted above a senior CEONC consultant and CEONC mentor were appointed to advise FHD on the effective use of the CEONC fund in reducing overcrowding and improving the continuity and quality of services provided. Examples of positive impacts from the CEONC mentoring process to date include:

(i) increased confidence of doctors to perform caesarean sections (C/S) (Hetauda and Bara District Hospitals)
(ii) improved communications between district health managers and service providers
(iii) direct use of the institutional incentive from the Aama programme in Udayapur hospital to improve maternity service provision
(iv) the establishment of a blood bank in Trishuli hospital
(v) preparation of a plan in Tanahun district hospital to upgrade to a CEONC facility including handing over and equipping a new building, and the recruitment of staff.

In addition, TA worked with Nick Simons Institute (NSI) to help FHD prepare a draft concept note for a CEONC Coordination Group to provide support to all CEONC hospitals. This initiative will be taken forward by FHD in the coming quarter. The CEONC Coordination Group will be created, with clear roles and responsibilities defined, and a review of CEONC fund utilisation in the 10 selected district hospitals (out of 36 districts with CEONC fund) will take place. Indicators and a monitoring mechanism to track fund use and CEONC service functionality are being developed.

Major risks identified include the absence of multi-year contracting for locally recruited service providers and problems with post grading and the career ladder for anaesthesia assistants which may drive a reluctance to train and work in CEONCs.

NHSP-3: Under NHSP-3 MoHP should continue its efforts to expand CEONC services to district hospitals while safeguarding the quality and continuity of services provided. To achieve this, sufficient numbers of adequately qualified human resources (HR) will be needed.

2.1.6 Support review, planning and budgeting of FHD/CHD/NHTC

In the reporting period, NHSSP TA supported FHD to carry out an analysis of safe motherhood (SM) and family planning (FP) programming gaps. These were discussed during the RH review and FHD's planning meeting and appropriate strategies and activities were formulated for further development and inclusion in the 2014/15 AWPB.

In order to increase the priority given to service delivery in remote areas, as reflected in divisional plans and budgets, NHSSP and the WB commissioned a situational analysis on access to maternal neonatal and child health (MNCH) services in remote areas. This was completed and based on the study's findings FHD and PHCRD have now planned a pilot intervention called "A Package of Community and Service Interventions and District Management Support, Tailored to the Local Context for Increasing Access to and Use of MNH Services in One Remote District". A draft outline of the pilot was presented at MoHP's reproductive health review and planning meeting. In the coming quarter the pilot intervention will be designed with participation from local, regional and central level stakeholders, financial support from DFID agreed and approval from DoHS's Director General gained. A broad-based technical working group (TWG) will be formed under FHD leadership including members from PHCRD, CHD, GiZ, Unicef, NSI and

NHSSP. The TWG will oversee implementation and monitoring of the pilot. NHSSP will also support FHD in finalising the materials needed to scale up the integration of FP in EPI clinics and obstetric first aid training.

NHSP-3: Under NHSP-3 a greater emphasis will be needed on practical strategies and programming to reach populations in remote districts.

Indicator 2.2 Refocused and Sustainable Equity and Access Programme

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

MoHP's 2013 study on access to MNCH services in remote areas recommended the piloting of a core service delivery and demand side package of interventions to help communities to access health services. Based on these recommendations, FHD and PHCRD prepared a draft concept note on interventions at various levels in one remote district to increase access to maternal and neonatal services. Following cross ministry discussions facilitated by DFID's health adviser, PHCRD and the Ministry of Federal Affairs and Local Development (MoFALD) agreed to integrate EAP into the social mobilisation programme of MoFALD's Local Governance and Community Development Programme's (LGCDP). This represents an important breakthrough in cross-sectoral working for health that has the potential to strengthen local governance and accountability systems while promoting the empowerment of women and excluded groups. To date, preliminary meetings with the Ministry of Federal Affairs and Local Development (MoFALD) have taken place and agreement reached to review LGCDP's Social Mobilisation Guidelines and integrate selected elements of the EAP into the training curricula.

In the coming reporting period, MoHP and LGCDP will finalise the concept note and identify the pilot districts and VDCs. TA will support LGCDP to integrate health content into the social mobilisation guidelines and curricula based on EAP's 'reflect' process. A rapid assessment will be carried out and the approach to piloting decided. It should be noted that DFID has agreed to provide additional financial support for piloting and to provide inputs on the process.

Potential risks here include a lack of willingness among identified district development committees (DDCs) and village development committees (VDCs) to participate in the pilot, and the limited commitment and competence of NGOs contracted for social mobilisation.

Indicator 2.3: Quality of Care in Maternal Health Services

2.3.1 Support the development of a system and tools for monitoring and managing the quality of MNCH in health facilities.

With the goal of institutionalising QA systems for MNCH in health facilities MD and FHD, supported by H4L, GiZ, NSI and NHSSP, prepared draft ToR for a National Quality Improvement (QI) Technical Assistance Group (TAG). These include clear divisions of roles and responsibilities for both implementation and monitoring and discussions have now begun on developing a hospital quality improvement process and monitoring mechanism.

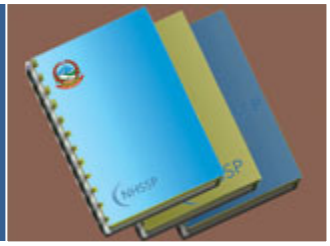
In the coming quarter the TOR for the national QI TAG will be finalised and its membership agreed.

The range of MNH services to be covered by the QI process will be finalised and ToR for QI Committees in district and referral hospitals drafted. A working group will be formed to identify key QI indicators and an appropriate monitoring mechanism developed. A central level QI workshop will then be held to finalise the QI components and dissemination and orientation workshops will then take place in the 2 hospitals selected for implementation in 2014.

Key risks to this initiative include any change of leadership in MD and FHD which will likely delay implementation or changes in key hospital staff involved in care management (medical superintendent , OB/GYN, nurse matron), and D(P)HO.

NHSP-3: Include the expansion of the QI approach to other hospitals and incorporate QI indicators in HMIS.

TA Output 3:
Institutional Reform Processes Supported



NHSP-2 Outputs: **Improved M&E and HMIS (6)**
Improved Sector Management (2)
Improved Sustainable Health Financing (9)

Indicator 3.1 Draft NHSP-3 Document

3.1.1 Support the integration of MoHP and DoHS management information systems by developing a unified coding system

Integration of the nine different MIS operated by MoHP and the DoHS will require standardised data coding on an information technology (IT) platform that supports data transfer between systems. Recent progress in developing the unified coding system is as follows:

- HMIS is now using the district and VDC codes prepared by the Central Bureau of Statistics. Continuing efforts are being made to build consensus on the use of the same codes for all MIS within MoHP.
- HMIS will adopt the health facility coding system prepared for the HIIS. Facility geospatial data will also be included in the revised HMIS.
- Unified codes for basic health services are currently being developed as a part of the revised HMIS.

3.1.2 Support the roll out of revised HMIS to ensure quality data and promote better use of data (including disaggregated)

In mid-2013, NHSSP TA supported MD to revise the HMIS indicators, recording and reporting tools, and reporting processes. The revised HMIS will now collect data on 35 indicators (up from 24) for which HMIS is the data source for NHSP-2 logical framework Indicators and allow data disaggregation by caste and ethnicity for 10 indicators and by gender age and cause for mortality and morbidity indicators. The revised HMIS also incorporates several vertical monitoring systems including those for Aama, EOC monitoring, TB, HIV/AIDS, nutrition and community based newborn care package (CBNCP).

Of growing significance is the revised HMIS's ability to capture data from all health facilities in Nepal including police, army, mission, teaching and non-public hospitals. The revised system will also generate sub-district level data.

The development of a more complete and disaggregated monitoring system will ensure that quality data are available and this is likely to increase data use in planning. Progress made on developing the HMIS IT platform and preparations for roll out in mid-2014 was as follows:

- Institutional support for the roll out of the revised HMIS was secured from all programme divisions and centres, district and health facility staff, and EDPs.
- Customisation began of the IT platform – the District Health Information System-2 (DHIS-2) – to operate the revised HMIS following discussions with EDPs, academics, medical colleges, private IT companies, experts and international DHIS2 consultant developers. An early DHIS-2 prototype was developed. The DHIS2 development and roll out process includes building local human and institutional capacity at central, regional and district level, the development and mainstreaming of a national health data warehouse and strengthening health information system governance.
- MoHP developed a set of health facility operating guidelines which make revised HMIS reporting a condition for annual registration renewal for all non-government health facilities.
- MoHP began procurement planning to upgrade its IT infrastructure.
- A detailed quality assurance plan for the training required for the roll out of the revised HMIS was developed in collaboration with government officials and external development partners.
- Following a request from MD additional DFID funds were secured to allow the QA function to be outsourced to the consultancy New ERA which will be responsible for ensuring the uniformity of high quality training across the country and supporting the roll out process.
- Accordingly, planning began for master trainer of trainers courses on the revised HMIS for central, regional, district and health facility levels. This training will expand the HMIS resource pool of over 200 people and train about 75,000 health workers and volunteers across the country.

3.1.3 Support the generation and analysis of primary information for NHSP-2 and to inform NHSP-3

NHSSP with other partners supported the Management Division to prepare a detailed road map for the development and eventual institutionalisation of the District Health Information System – 2 (DHIS-2) software, an open source programme developed by the University of Oslo and in use in more than 30 countries. During the quarter NHSSP and other partners supported Management Division to secure regional expertise from India to help contextualize the software for use in Nepal and plans are being made for a follow up visit and training.

A revised HMIS operating on a DHIS-2 platform will enhance data reporting, management and analysis. Once implemented, a significant volume of NHSP-2 end line data will be captured and progress against health strategy and MDG targets may be readily assessed.

The effective analysis, including trend analysis, of NHSP-2 performance using a fully institutionalised and revised HMIS is likely to inform the selection of performance indicators for NHSP-3 and the development of accurate baselines against which achievable NHSP-3 targets can be set.

3.1.4 Support to strategic planning for NHSP-3

Support to strategic planning for NHSP-3 design began with preparations for a process design workshop to be held immediately prior to the 2014 joint annual review (JAR). This will identify NHSP-3 priorities and framing questions, define structures to be formed (e.g. steering and working groups) and processes to be followed (e.g. strategy development plan etc.) and the resources required. Several EDPs have committed to provide technical inputs during the workshop; WHO, GiZ and NHSSP will provide logistical support.

30 MoHP and EDP officials will participate in the workshop which will be moderated by an international process management consultant contracted by NHSSP. As noted, workshop outputs will be shared at the JAR 2014 for feedback and endorsement following which the design process will begin.

Potential risks to progress include Nepal's politically fragile stage. MoHP's aspirations for effective sector management including a successful NHSP-3 design process may be undermined by high level political developments that lead to the transfer of senior MoHP officials and new appointments.

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

In addition to progress reported in 3.1.4 and 3.1.5, NHSSP TA worked closely with government counterparts and development partners to compile evidence of recent health sector progress for presentation at the 2014 JAR. The JAR is expected to have a strong bearing on the aspirations, targets, structure and content of the next five year strategic plan.

In this regard, a series of meetings took place with key stakeholders to prepare a comprehensive report on evidence from various research studies, surveys and information systems. NHSSP advisors began preparation of an NHSP-3 M&E framework. The availability of recent evidence will ensure that quality data inform policy design and NHSP-3 planning and the preparation of MoHP's 2014/15 annual work plan and budget of MoHP.

Specific progress made in research related activities in the reporting period is summarised as follows:

- the 2012 Service Tracking Survey (STS) and Household Survey reports were disseminated;

the draft STS 2013 report was shared with government for comments and is due to be finalised in February 2014.

3.1.6 Strengthen State Non-state Partnership (SNP) functions within PPICD

Progress on strengthening SNPs within PPICD has stalled primarily as a result of the MoF's failure to approve the 2013 draft SNP policy which it received for comment almost a year ago. Despite regular MoHP follow up, a clear lack of enthusiasm to endorse the draft policy is reported. The draft policy calls for a SNP unit to be established within PPICD but while the health secretary is empowered to create a temporary unit, this seems unlikely to happen in the absence of more senior endorsement. At the operational level performance based contracts for seven hospitals were issued and signed. Performance based contracts will improve financial management and efficiency.

Indicator 3.2: M&E framework for Strategic Plan Developed and Evaluation Tools Institutionalised in MoHP

3.2.1. Improve the availability and use of evidence /data for planning and policy design by strengthening information sources

At the request of MD, NHSSP TA began preparation of a generic survey tool-kit containing templates, guidance notes and examples for survey design, questionnaires, manuals, data analysis planning and budgeting. The objective here is to enhance ministry capacity to design and manage surveys in the future, so increasing efficiency and value for money of health monitoring and research.

Efforts were also made during the quarter to coordinate with government colleagues and EDPs to avoid the duplication of surveys and to reduce their frequency. In this regard an expert conducted a review of existing data needs and sources as well as plans by development partners to conduct surveys in 2014 and 2015. Following this agreement was made with DFID to eliminate both the planned Household Survey 2014 and STS 2015 as data will be provided by other surveys.

Indicator 3.3: Aama Unit Delivery Costs Identified

3.3.1. Review the Aama programme

A draft concept note for a review of the Aama programme, including details of rationale and proposed methodology was drafted following internal MoHP discussions. The review is seen as essential if MoHP, DoHS and FHD are to have the information needed to take clear policy and investment decisions on the future of the Aama programme and other demand side incentive schemes.

The review aims to identify bottlenecks in Aama programme implementation and operational concerns. It will also track progress made against key Aama indicators and identify reasons for both good and limited progress. In the coming quarter the draft concept note will be distributed for comment and developed into ToR to be shared with key sector stakeholders following which the assignment will be contracted out. The ToR will be built around the following three key activities:

a. Data collection: Secondary data will be collected and a literature review undertaken. Key informant interviews will be conducted to supplement secondary data and to identify bottlenecks.
b. Analysis of the collected data: The data will be collected and analysed for interpretation and write up. Data will be triangulated to ensure that routine, periodic, quantitative and qualitative information are all utilised appropriately.
c. Sharing of the findings and development of an action plan: Findings will be shared with key stakeholders and recommendations taken forward in an FHD plan of action.

Identified risks to progress include the limited interest and commitment of FHD leadership to implement any changes from current practices.

3.3.2. Conduct unit cost analysis of Aama

Since the launch of Aama in 2009, the unit costs of providing programme services have not been reviewed. Several recent studies have called for a review of unit costs amidst concern that reimbursement rates have fallen behind the real costs of providing the services and of users accessing them.

Against this backdrop, a draft concept note for an analysis of the unit cost of implementing Aama was developed. This describes the history of the Aama programme, the rationale for undertaking the analysis and methods used for similar assessments in the past. This note, developed in association with research agencies and the Nepal Health Economics Association, was shared with FHD's Aama technical director and supervisor. In the coming quarter the detailed study methodology will be developed and shared with stakeholders, a validation workshop will be conducted, an external research agency contracted and secondary data collected for analysis. Findings and recommendations from the analysis will then be shared with FHD and an action plan made to revise the guidelines and reimbursement rates as required.

The principal risk here relates to methodological challenges, namely that since unit costs vary by several factors including ecology, location and facility type (public vs. private), difficulties may arise with analysis and recommendations may point towards more nuanced implementation procedures and reimbursement rates than FHD may welcome. A further methodology challenge is the lack of a recent public health facility efficiency survey data which means that data from the 2004 survey of the same name will need to be adjusted and utilised.

3.3.3. Develop Aama FHD plan of action and/or review Aama guidelines

In order to move forward the unit cost assessment that will inform any revision of the Aama guidelines, an instructional letter was sent by the ministry to all district level and hospital cost centres highlighting the findings of the recent Aama rapid assessment. This will help prepare cost centres for the unit cost study. The letter instructed to health facilities to follow the revised Aama guidelines once developed.

As noted, the main risk identified to this activity is limited FHD commitment to following through on action plans to revise the current Aama Guidelines.

4. Payment Deliverables

Two payment deliverables were submitted this quarter:

The NHSSP-2 Inception report

7.1 QA Assurance procedures for CAPP ICBs and NCBs established, including QA template

The following deliverables will be submitted in the first quarter of 2014:

M2 Quarterly report October – December 2013 (this report)

4.1 Feasibility analysis completed on linking contract management and warehouse IT systems

8.1 Draft NHSP-3 design process document prepared

11.1 System for responding to audit queries established

Annexes

ANNEX 1: PUBLICATIONS PRODUCED

Core Health Systems	Infrastructure Procurement Review (Draft)
	Health Infrastructure Information System Journal Paper
Service Quality, Equity and Access	Review of Free Health Care Studies
	Remote Areas Study - Consolidated Report
	One Stop Crisis Centre Management Review
	PEER Briefing Notes 1-8
Institutional Reform Processes	Strengthening State/Non-state Service Delivery Partnerships
	Functional Assessment and Organisation Review of MoHP
	Pulse Report: Revised HMIS
Other	Phase 2 Inception Report
	Phase 1 Final Report

ANNEX 2 – TECHNICAL ASSISTANCE RESPONSE FUND GUIDELINES

Purpose of the Fund

The main purpose of the Technical Assistance Response Fund (TARF) is to provide Technical Assistance (TA) to Ministry of Health and Population (MoHP) quickly and responsively, as needs arise. Not all needs can be predicted well in advance and the Fund is designed to complement the more long term planned provisions of technical assistance that makes up the majority of support from NHSSP and other External Development Partners (EDPs). Work funded by the TARF must be aligned to the objectives of the Nepal Health Sector Programme 2010-2015 (NHSP-2) and the preparation of the Nepal Health Sector Programme 2015-2020 (NHSP-3). Subsequently, the experiences and lessons from implementing the TARF may also help the Policy, Planning, and International Cooperation Division (PPICD) of the MoHP to evaluate and assess the feasibility of establishing a similar TA fund under NHSP-3 with greater management exercised by MoHP in its operation.

Specifically, the TARF will enable the following priorities to be addressed:

- To provide increased flexibility to accommodate emergent MoHP priorities beyond those established through the Annual Work-plan and Budget (AWPB)
- To provide flexibility to MoHP to request support to address urgent priorities which are already reflected under the AWPB but the agreed outputs maybe compromised due to insufficient fund allocation or other unforeseen impediments
- To support MoHP to prepare for NHSP-3,

Other Support

- To supplement and support the delivery of the jointly agreed MoHP-NHSSP work plans, if skills and/or expertise required are beyond those available within NHSSP

Examples of support that could be provided through the TARF

Activities that could be funded	Examples of Activities not covered by the fund
Consultants/contracted technical support and associated expenses (travel, printing and workshop/meeting venues)	Scholarships. Isolated courses and conferences that are not part of the activities that are eligible for funding.
Supporting small scale pilots to inform planned scale up	Activities funded under NHSSP plans which have the required expertise already available; AWPB activities where funds are sufficient and the agreed outputs are likely to be achieved.
Analysis and Reviews	Purchasing physical assets (vehicles, equipment,

	construction)
Research and studies	Large scale printing
	Payment of government staff salaries

Management Arrangements

- Within the MoHP, the PPICD will be the institutional home for the TARF.
- A Fund Management Team (FMT) with representatives from PPICD, DFID and NHSSP will be formed to review and either agree or decline proposals.
- The FMT will develop the Guidelines for Proposal and criteria for proposal assessment and circulate to MoHP departments, divisions, centres and to the EDPs
- All requests will be channeled through a secretariat (provided by NHSSP.)
- All proposals must be endorsed and submitted to the FMT by the relevant Department/Division/Centre Director or Head of Division and must include a covering letter, rationale for the support requested (including Terms of Reference) agreed outputs, estimated budget, and proposed mechanism to assure the quality of the outputs.
- The FMT will review the proposals in line with the criteria and will decide each application on its technical merits and availability of funds
- The FMT will advise the proposers of the outcome of their proposal.
- The FMT will have the authority to refer more complex proposals to existing technical committees for further review and/or to seek further inputs from relevant expert(s) to support the team in its deliberations.
- In situations where urgent decisions are required the FMT may review and make decisions on proposals outside of face to face meetings and through exchange of emails.
- The FMT will monitor the operation of the fund and receive reports from the TARF secretariat on status of applications and fund utilization.
- The FMT will assess the effectiveness of the fund after four (4) months and thereafter at agreed intervals to continuously improve the fund's effectiveness. Based on the review, the FMT may adjust the modality of delivering TARF

Procurement and Contract Management

On approval of proposals, NHSSP will be delegated to manage the procurement and contracting process using their procedures which are aligned with DFID requirements.

NHSSP will be responsible for ensuring overall value for money under the procurement process including, where required, sourcing support from the open market through competitive tendering.

Quality Control and Acceptance of Work

- The FMT will take into consideration the proposed quality assurance mechanism when reviewing the proposals.
- The proposer may request the support of NHSSP advisers or other relevant experts to devise the quality assurance mechanism of the outputs.

- The proposer will report to the FMT on the achievements of the agreed outputs. The proposer may also be required to report progress periodically (as agreed in the proposal) to the FMT.
- The contractual obligation between the proposer and NHSSP is deemed to be completed only after the FMT approves the achievement of the agreed outputs

Collaboration with other EDPs

Under the direction of the FMT, NHSSP will share approved proposals with relevant EDPs.

Reporting

NHSSP will be responsible for reporting to the FMT on the status of applications, actual and projected expenditures (overall fund commitments).