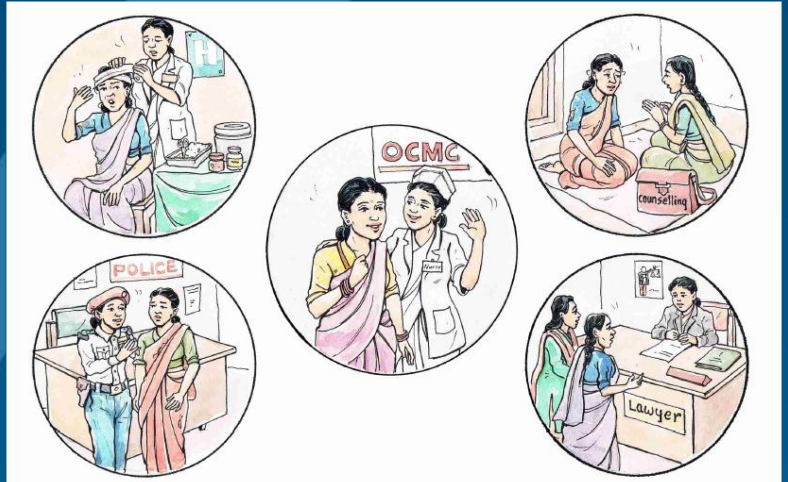
NHSSP Nepal Health Sector Support Programme

Nepal Health Sector Support Programme

Quarterly Report



Reporting Period: January - March 2014

Contents

ACRONYMS AND ABBREVIATIONS 3

1. INTRODUCTION 8

2. SUMMARY OF PROGRESS 9

3. DETAILED THEMATIC UPDATES 14

Output 1: Core Health System Functions Strengthened..14

Logistic Management Division's Capacity for Transparent and Timely Procurement....................14

Timeliness of Budgeting and Financial Reporting..16

Availability of Standards and Criteria for Expansion of Health Infrastructure..............................18

Output 2: Information and Monitoring System Strengthened..21

M&E Framework for Strategic Plan Developed and Evaluation Tools Institutionalise in MoHP...21

Quality of Care (QoC) in Maternal Health Services..22

Output 3: Institutional Reform Processes Supported..26

Draft NHSP-3 Document..26

Refocused and Sustainable Equity and Access Programme..27

Aama Unit Delivery Costs Identified..30

4. PAYMENT DELIVERABLES..32

ANNEX 1 – PUBLICATIONS PRODUCED 33

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
CIAA	Commission for the Investigation of the Abuse of Authority
CMAM	community based management of acute malnutrition
CMS	contract management information system
CPN (Maoists)	Communist Party of Nepal (Maoists)
CPN (UML)	Communist Party of Nepal (United Marxist Leninists)
C/S	caesarian section
DDC	district development committee
D(P)HO	district (public) health office(r)
DFID	UK Department for International Development
DG	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
EPI	Expanded Programme on Immunisation
FCGO	Financial Comptroller General's Office
FCHV	female community health volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FMR	Financial Monitoring Report
FMT	Fund Management Team
FP	family planning
FY	fiscal year
GAAP	Governance and Accountability Action Plan
GBP	Great British Pound
GBV	gender-based violence
GESI	gender equality and social inclusion
GIS	geographic information system
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoN	Government of Nepal
H4L	Health for Life
HFOMC	health facility operation and management committee
HIIS	Health Infrastructure Information System
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HR	human resources
HuRIS	Human Resource Information System
ICB	international competitive bidding
INGO	international non-governmental organisation
IT	information technology
JAR	Joint Annual Review
KFW	Kreditanstalt für Wiederaufbau (German Development Bank)

LGCDP	Local Governance Community Development Programme
LMD	Logistics Management Division
LMIS	Logistic Management Information System
M&E	monitoring and evaluation
MD	Management Division
MDG	millennium development goal
MIS	management information system
MNCH	maternal, neonatal and child health
MNH	maternal and newborn health
MoF	Ministry of Finance
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MoU	memorandum of understanding
MS	medical superintendent
NC	Nepali Congress
NCB	national competitive bidding
NGO	non-governmental organisation
NHSP-2	Second Nepal Health Sector Programme
NHSP-3	Third Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPC	National Planning Commission
NSI	Nick Simons Institute
O&M	Organisation and Management
OAG	Office of the Auditor General
OB/GYN	obstetrics/gynaecology
OCMC	one-stop crisis management centre
OPM	Oxford Policy Management
OPMCM	Office of the Prime Minister and Council of Ministers

PD	Population Division
PDT	Project Development Team
PEER	peer ethnographic evaluation and research
PFM	public financial management
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
PIP	Procurement Improvement Plan
PNC	postnatal care
PO	procurement office(r)
PPICD	Policy, Planning, and International Cooperation Division
PS	procurement specialist
PSI	Population Services International
QA	quality assurance
QA&ITWG	quality assurance and improvement technical working group
QI	quality improvement
QITAC	quality improvement technical advisory committee
QoC	quality of care
RA	rapid assessment
RH	reproductive health
SARA	Service Availability and Readiness Survey
SBA	skilled birth attendant
SAVE	Save the Children
SM	safe motherhood
SNP	state non-state partnership
SPA	Service Provision Assessment
SSU	social service unit
STS	Service Tracking Survey
TA	technical assistance

TABUCS	Transaction Accounting and Budget Control System
TAG	technical advisory group
TARF	Technical Assistance Resource Fund
TB	tuberculosis
ToR	terms of reference
ToT	training of trainers
TWG	technical working group
UML	United Marxist Leninists
UNDB	United Nations Development Business
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	village development committee
WB	World Bank
WDO	Women's Development Office
WHO	World Health Organization

1. Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit this quarterly report for the period January to March 2014, the thirteenth quarter of the programme and the second of its second phase.

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

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

The purpose of this report is to document the activities and results delivered by NHSSP between January and March 2014. 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 mostly the heads or directors of divisions and centres including the Family Health Division (FHD), PPICD, the Logistics Management Division (LMD) and so on. All NHSSP activities are designed to enhance the capacity of MoHP/DoHS to deliver NHSP-2 and prepare the ground for NHSP-3. Enhancing capacity, for NHSSP purposes, is defined as:

> *the changes in organisational behaviour, skills and relationships that lead to the improved abilities of organisations and groups to carry out functions and achieve desired outcomes.*

2. Summary of Progress

Overall Context

Following on from November 2013's general election, Nepal's second Constituent Assembly (CA) held its first session on 20th January 2014. The Assembly has been tasked with producing a new constitution within 12 months. After extended negotiations, on 10 February, Sushil Koirala was appointed prime minister, heading a new Nepali Congress (NC), United Marxist Leninists (UML) - led coalition government. A new health minister, Mr. Khagraj Adhikari, was appointed, replacing Mr. Vidyadhar Mallik.

In January 2014, MoHP and external development partners hosted the 2014 Joint Annual Review (JAR). Progress made in the sector in 2013 was discussed and provisional priorities identified for 2014. These were reflected in the 2014 Aide Memoire which was prepared and signed in record time.

Coinciding with the JAR, DFID conducted its annual performance review of NHSP-2. The two programme outputs assessed during the review both scored 'A' meaning they had met expectations. These were:

Output 1: Reduced cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors.

Output 2: Improved and equitable health systems to achieve universal coverage of essential health care services.

Following the review, NHSSP's log frame was revised to better reflect the reduced scope and changed priorities of the TA team under phase 2. This document reports against these new outputs as follows:

Output 1: Core Health System Functions Strengthened
Output 2: Information and Monitoring System Strengthened
Output 3: Institutional Reform Processes Supported

In March 2014, the Commission for the Investigation of the Abuse of Authority (CIAA) suspended the former Director General (DG) of DoHS, the former Director of LMD, the former Director of FHD and the Chief Financial Controller of DoHS over their alleged involvement in drug procurement irregularities and the loss of the file documenting the related decision making.

Summary of Key Events in this Quarter

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

In Strengthening Core Health System Functions

The amended consolidated annual procurement plan (CAPP) for fiscal year (FY) 2013/14 received a no objection agreement from the World Bank with minor comments. Work will begin in the next reporting period on the 2014/15 CAPP. Quality assurance (QA) procedures for annual procurement plans and bid documents were agreed by LMD and DFID and have now been incorporated within LMD's standard procurement process. LMD's Contract Management System (CMS) (electronic database) was upgraded to include reports, a contract management register, pipeline reports, suppliers' performance records and delivery-to-warehouse reports. A feasibility study was also carried out on linking the Contract Management System to the forecasting and delivery of equipment and pharmaceutical requirements. LMD's Technical Specifications Bank neared its 1000th specification (and indeed reached it on 5th April 2014).

Prospects for improved budgetary control following the roll out of the Transaction Accounting and Budget Control System (TABUCS) advanced with each of MoHP's 278 cost centres now connected to the system. On line data entry and report generation is now possible at each centre and over 200 finance and planning officers have been trained to use the system.

In January, MoHP formally endorsed its Internal Financial Control Guidelines and Audit Clearance Guidelines. These have now been printed and distributed to all cost centres and district comptroller offices. High level officials were also oriented on the guidelines at a national workshop.

MoHP's Public Financial Management (PFM) Committee and working committee finalised the Financial Management Improvement Plan (FMIP) (2012/13 – 2015/16) and the first Financial Monitoring Report (FMR) for 2013/14 was prepared using information drawn exclusively from the Financial Comptroller General's Office's (FCGO's) website.

Health infrastructure planning improved with the cabinet's approval of the list of facilities to be upgraded in 2013/14. For the first time, this selection was made based solely on the Health Infrastructure Information System's (HIIS's) revised criteria for health facility upgrading – thereby avoiding the possibility of political, or other, interference. The guidelines for selecting land for the construction of health facilities endorsed in late 2013 were printed and distributed to all Department of Urban Development and Building Construction (DUDBC) district offices. An important corollary to this achievement is MoHP's recent agreement that land can now be purchased for the construction of new health facilities. Monitoring of construction projects improved with DUDBC's third trimester report which included both progress on building projects and reasons for delays.

In Strengthening Information and Monitoring Systems

The roll out of the Ministry's revised HMIS advanced through the training of 200 HMIS trainers and subsequent training of hospital and local health facility staff and female community health volunteers. A total of 75,000 health personnel will be trained on the new HMIS by the end of July 2014. The quality of training is being safeguarded by a contracted external consultancy – New Era.

Meeting the information needs for the design of NHSP-3 was assisted through the compilation of evidence of sector progress as reported in various research studies, surveys and improved information systems and a comprehensive report was presented at the 2014 JAR. Further, the 2013 Service Tracking Survey (STS) was circulated to stakeholders for final review and comments, and work continued to identify ways to harmonise the STSs, Service Provision Assessments (SPAs) and Service Availability and Readiness Surveys (SARAs) through a single 'Nepal Health Facility Survey' to be conducted in early 2015.

The development of a system to monitor and manage the quality of maternal, neonatal and child health (MNCH) in health facilities advanced though Management Division's (MD's) approval of terms of reference (ToR) for a Quality Improvement Technical Advisory Committee (QITAC), Quality Assurance and Improvement Technical Working Group (QA&ITWG) and hospital quality improvement (QI) committees. FHD developed a hospital QI toolkit on maternal and newborn health (MNH) including a self-assessment tool, score sheet and action plan. It also formed a hospital QI committee in Hetauda Hospital chaired by the medical superintendent, which then carried out an assessment identifying problems and preparing an action plan to address them.

The senior consultant appointed in late 2013 to help address overcrowding in referral hospitals visited 10 such facilities to assess use of the FHD-allocated 'Fund for Referral Hospitals to Address Overcrowding Issues' and compliance with its implementation guidelines. Levels of awareness on the fund's availability however proved to be very low and so the consultant facilitated rapid access to the fund which subsequently led, in a very short timeframe, to improvements in the number of beds and human resources (HR) available and the repair of labour rooms and operation theatres in several sites. Seti Zonal Hospital was also provided with consultant support to prepare short and long term plans to address overcrowding.

Support for remote area planning continued with the finalisation of FHD's Remote Areas Study Report and the design of a pilot programme to improve service provision in one remote area (Taplejung). Rapid assessments of five sites were carried out with local health officials in this pilot district. These assessed current levels of performance and challenges related to both service delivery and demand creation. Approval of the design of the remote areas work is expected in April 2014 following which a formal baseline study will be carried out.

In Supporting Institutional Reform Processes

A high level workshop to support strategic planning for NHSP-3 took place in the reporting period during which agreement was reached on the development process, timeline, management structure, thematic areas and approaches to be followed. Cross-sectoral Steering and High Level Advisory Committees were formed - both having Ministry of Finance (MoF) and National Planning Commission (NPC) representation. Team leaders for each of the 9 thematic groups were nominated and the formation of

individual groups is now underway. Agreement was also reached on the formation of an MoHP-EDP Project Development Team (PDT) to be supported by national and international TA. The PDT will help coordinate activities and support the work of individual thematic groups.

The integration of MoHP's Equity and Access Programme (EAP) within the Ministry of Federal Affairs and Local Development's (MoFALD's) Local Governance and Community Development Programme (LGCDP) (social mobilisation component) advanced with the development of a concept note and ToR for an assessment of its viability in four village development committees (VDCs) of two districts. A biannual review of progress made by MoHP's seven social service units (SSUs) identified issues to be incorporated within the SSU guidelines and the monitoring and evaluation (M&E) framework for SSUs, developed by Population Division (PD), was also agreed.

The scaling up of social audits based on lessons learned during piloting was taken forward through orientation programmes for 31 participants from 17 new districts and 82 district health office/district public health office (DHO/DPHO) personnel, focal persons and non-governmental organisation (NGO) representatives from 22 districts. Importantly, the Primary Health Care Revitalisation Division (PHCRD) and seven development partners signed a memorandum of understanding (MoU) establishing a collaborative framework for social auditing of health service provision.

An M & E framework for one stop crisis management centres (OCMCs) was developed and will be tested in Hetauda in April 2014. Further, a high level joint monitoring visit was made to Saptari and Sunsari OCMCs with the delegation led by the secretary of the Office of the Prime Minister and Council of Ministers (OPMCM) and included the DG of the Women and Children Department, the Deputy Attorney General, a Home Ministry representative, the director of the police headquarters' Women and Children Directorate, the chief of the Population Division, and the Gender Equality and Social Inclusion (GESI) Section Chief.

The planned review of the Aama programme began with a central level workshop on private sector involvement followed by a review of 10 private sector institutions to identify implementation bottlenecks. A draft concept note and ToR for a study on the unit cost of implementing Aama were prepared. The study will commence in April 2014.

Technical Assistance Response Fund (TARF) Funding

Summary details of the status of the TARF are presented below. Further details can be found in the relevant section of the report.

Descriptions	Amount	Remarks
Total Fund Value	£500,000.00	

Spent to date	£49,991.31	Salaries for FHD consultants (Dr. Ganga, Dr Prajapati, comprehensive emergency obstetric and neonatal care (CEONC) mentor); PHCRD for social audit training; LMD for two procurement specialists; PPICD for two senior consultants for health policy development, and PD for a GESI consultant for GESI training of trainers (ToT) in the regions. This amount also includes daily subsistence allowance, accommodation and associated meeting/workshop expenses.
Committed to date	£30,850.00	Commitment made for PHCRD for social audit monitoring, MOHP-HR for organisation and management survey
Remaining Balance	**£419,158.69**	

Pending Applications

- National Health Training Centre (NHTC): skilled birth attendant (SBA) training
- PPICD: NHSP-3 development processes
- FHD for CEONC: Safe motherhood mentor and consultant MoHP: Finance for audit query clearance workshop

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 TABUCS at all cost centres across the country (see 1.2.1).

c) In Essential Health Care

A contract was issued to SAVE to provide technical support for the strengthening of new born care in Nepal, including the development and implementation of context-specific new-born care plans in high-need areas; the strengthening of government programme quality, and government monitoring and supervisory systems. At the time of writing, the SAVE team had mobilised, preliminary discussions with CHD had been held and draft work-plans and monitoring indicators were being finalised.

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

Seven payment deliverables and 10 publications were produced in this quarter and all non-sensitive documents were uploaded to the NHSSP website. Visitors to the website reached over 12,250 (since Jan 2012) and Facebook 'likes' exceeded 350. Approval was received from MoHP to upload NHSSP documents onto its website. Uploading will begin once the MoHP site has been upgraded.

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

In this reporting period, the amended CAPP for FY 2013/14 was presented to the World Bank and subsequently received a no objection agreement with minor comments. This up-to-date document serves as a useful planning tool for the systematic procurement of pharmaceuticals and medical equipment. Work will begin in the next three months on preparing next year's (2014/15) CAPP. It is planned to involve all DoHS's divisions in preparing this plan so that it is comprehensive and consolidated. The main risk of this not happening properly is if LMD does not institute the procedure in time to complete the production of the 2014/15 CAPP by the end of FY 2013-2014 (15 July 2014).

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

QA procedures for annual procurement plans and bid documents were agreed by LMD on 21 January 2014 and DFID on 4 February 2014. These procedures have subsequently been incorporated within LMD's standard procurement process. They are needed to improve the quality of bidding documents, evaluation reports and draft contracts for international competitive bidding (ICB) (under World Bank Guidelines) and national competitive bidding (NCB) procedures (under Nepal Procurement Act and Regulations). The procedures' checks are to be carried out by independent adjudicators.

The next step is to ensure that the new QA system is used and applied to bids identified as agreed for inspection (80% of the total). Note that the list has been slightly amended due to the changes made to the 2013/14 CAPP.

The main risks for QA not being properly implemented is that, as already experienced, QA recommendations may not be accepted by the World Bank. Further, the constant changing of the content of procurement documents is confusing to LMD staff, who had already agreed procurement documents from last year's (2012/13) procurement processes.

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

In this reporting period, reports and features were added to the CMS (electronic database) including a contract management register, pipeline reports, suppliers' performance records and delivery-to-warehouse reports. These reports and features will be useful for contract management, procurement planning and financial reporting by improving the efficiency of LMD logistical arrangements and improving government supply chain procedures.

The next steps to support system improvements are to continue system development activities, train and make LMD contract and warehouse personnel aware of the newly developed systems and the benefits of using them and make known the information available from the new systems to a wider audience in government. The potential of the CMS is more likely to be realised if other DoHS organisations use the information provided by the CMS for their demand forecasting of drugs and equipment.

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

A feasibility study was carried out on linking the CMS to the forecasting and delivery of equipment and pharmaceutical requirements. The study found that this linking up was workable and should improve the efficiency of MoHP demand forecasting and LMD logistic systems. At the beginning of the next quarter an implementation trial will be completed to design and install the software tools in one DoHS division and one regional medical store. Following on from this, a pilot project will be carried out to improve forecasting and delivery processes. This will involve divisional forecasting staff and central/regional and district warehouse staff working with the pilot team taskforce to scale up this initiative. This work is going ahead in collaboration with other MoHP divisions (including the Child Health Division (CHD)) on demand forecasting to ensure that the divisions are aware of the potential of the CMS.

Initial contact was made with DoHS's Finance Office to explain the electronic CMS and to see where cooperation was feasible and worthwhile. The aim here is to provide wider and more useful information to the Finance Office on LMD health contracts and their implementation status. The next step is to undertake a feasibility study on whether the CMS can provide useful information to DoHS's Finance Office.

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

In December 2013, a workshop was held to disseminate the findings and discuss the recommendations of a study on the supplier market, including why some major suppliers are not submitting bids to LMD. In the current quarter, LMD accepted a number of recommendations from the study including the need to improve local manufacturers' understanding of international competitive bidding, to reduce manufacturers' experience requirements for bidding and increasing manufacturers' awareness of joint ventures and price adjustment clauses in multi-year contracts.

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

As of 5 April 2014, 1,000 technical specifications had been designed, drafted and uploaded into LMD's Technical Specifications Bank. The bank, which is housed on LMD's website (www.dohslmd.gov.np), provides standard specifications of equipment and pharmaceuticals that are open to anyone to view and download. The specifications are designed to encourage the procurement of higher quality goods.

A hits and download counter was added to the bank at the beginning of March 2014. Up to 5 April 2014, there had been 798 hits and 895 downloads of specifications, thus illustrating the popularity of this resource. It is known that the bank is being used by organisations in Bangladesh and by an increasing number of medical establishments in Nepal. In the first three months of 2014, LMD's biomedical engineers visited eight hospitals in Kathmandu, Bara and Makawanpur districts to promote the use of the bank.

The work will continue by designing, drafting and uploading more specifications, including extra ones requested by other medical establishments and by visiting Nepal's other four regions to promote the bank's use. LMD is collaborating with regional directorates on this work.

The bank will eventually be handed over to LMD. The main risk that could undermine the usefulness of the bank is if LMD does not keep it up-to-date. At the same time, there is a risk that future LMD heads could decide to lower the quality of requirements, which would require changed specifications.

Indicator 1.2 Timeliness of Budgeting and Financial Reporting

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

The use of TABUCS by all MoHP cost centres will 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. A major benefit of the system is that expenditure can only be entered (and thus happen) against standard NPC sub-activities and within approved budget limits. Improved timeliness of timely reporting and the generation of quality financial monitoring reports will help MoHP meet its reporting requirements to the Government of Nepal (GoN), MoF and external funding partners.

This reporting period saw the fully-fledged introduction of TABUCS and the building of capacity to use it. The design of the software was completed and the system was rolled out across the country. All of MoHP's 278 costs centres are now linked to TABUCS, which is housed on MoHP's server in Kathmandu. Online data entry and report generation is now available in all of these centres. Between January and March 2014, 224 finance and planning officers from DHOs, DPHOs and other cost centres in 66 districts were trained on using the system. These personnel are now entering 2013/14 expenditure data and 'learning-by-doing'.

The next step is to train personnel in the remaining 9 districts towards the target of training at least one person from each cost centre by mid-July 2014. This should enable all of these centres to enter the current year's (2013/14) expenditure data into the system. Alongside this work, it is planned to set up offline TABUCS in cost centres that lack adequate internet access. The frequent failures of the central server that hosts TABUCS, the limited availability of electricity and internet connectivity in some costs centres and the transfer of trained staff to other positions or sectors are the main risks to TABUCS being properly implemented and used.

NHSP-3 follow on: A key objective of NHSP-3 should be to link TABUCS with other relevant management information systems (MISs) including the Health Management Information System (HMIS), the Human Resources Management Information System (HuRIS), HIIS and the Logistics Management Information System (LMIS). This is desirable to improve the integration of planning and implementation of programmes.

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

In January 2014, MoHP endorsed its Internal Financial Control Guidelines and the Audit Clearance Guidelines which were prepared in the previous quarter. Leading on from this, in February 2014, high level officials were orientated on the guidelines at a national workshop. The guidelines were subsequently printed and distributed to all cost centres and district treasury comptroller offices.

Compliance with these guidelines should improve fund flows, budget absorption capacity and levels of accountability at MoHP cost centres. Compliance with recommended procedures by cost centres will help reduce audit irregularities and facilitate timely responses to audit queries. It will also build the capacity building of MoHP and cost centre staff in financial matters. The next step is to brief financial personnel from all cost centres on the guidelines.

The main risks that could limit the impact of this initiative are the limited funds available in the current Annual Work Plan and Budget (AWPB) to train staff from all 278 cost centres on the guidelines and the transfer out of trained and experienced staff.

NHSP-3 follow on: The two guidelines need to be updated and improved in line with experiences of implementing them.

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

Frequent meetings of the PFM Committee and Working Committee are being held. The last meeting of the Advisory Committee was held on 28 February 2014. The work of this committee has included facilitating the rollout of TABUCS and the introduction of the internal control guidelines.

The major achievements in the current reporting period were:

- finalising the first revision of FMIP (2012/13 to 2015/16) for improving MoHP's financial management practices, including by safeguarding the quality and timely submission of financial reports;
- for the first time, the third FMR of 2012/13 and the first FMR of 2013/14 were prepared using information obtained online from the website of the FCGO; and
- the introduction of performance based contracting in six hospitals with the disbursement of government grants being linked to the meeting of performance targets.

To meet the requirements of the Joint Financing Arrangement, in this quarter the unaudited financial statements of NHSP-2 (Project Account) for 2012/13 were submitted by MoHP to the Office of the Auditor General (OAG) and in January 2014 MoHP responded to the OAG's queries on the audited financial statements of NHSP-2 for 2011/12. The next step is to implement and monitor FMIP and make any necessary revisions.

The greatest potential threat to the PFM and FMIP initiatives is the transfer away of audit, PFM staff and working committee members. Inadequate monitoring of the implementation of FMIP by MoHP, departments and regional directorates is an additional risk.

NHSP-3 follow on: A comprehensive PFM framework covering the Governance and Accountability Action Plan (GAAP) and FMIP indicators needs to be developed.

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)

a. Health facility upgrading criteria

HIIS incorporates several components including a geographic information system (GIS) based planning system to inform the selection of health posts to be upgraded to primary health care centres (PHCCs) and 15 bed hospitals. This was developed using standard criteria on accessibility, population and other factors to assess whether certain facilities should be upgraded. The system prioritises health facilities and hospitals that serve large populations, helps avoid overlapping or shadowing by other higher level institutions and addresses geographical location, human development index and accessibility criteria. The aim is to increase the coverage of health services and enable policymakers and planners to plan the location of new health buildings rationally and avoid ad-hoc and vested interest-based decision making.

The list of health facilities for upgrading to a higher level for FY 2013/14 was agreed by the cabinet on 4 February 2014.

Also in the quarter, these upgrading criteria provided the basis for a ministry-level decision to upgrade 10 smaller facilities to 15 bed hospitals and 5 to PHCCs. This decision was taken following an analysis of all of Nepal's health facilities at PHCC level and below.

The next steps are to build the capacity of MoHP and DUDBC officials to use the GIS-based planning system in the next FY (2014/15) and to upgrade the system by adding more layers of information including roads, natural resources, natural hazards and updated settlement lists. The updating information will be sourced from the Roads Department, the Survey Department and the Central Bureau of Statistics.

This process can only be full institutionalised once the upgrading guidelines have been endorsed by the cabinet/MoHP. The guidelines were finalised and submitted for approval in February 2014.

NHSP 3 follow on: NHSP-3 should promote the full institutionalisation of the evidence based decision making system described above for the upgrading of health facilities and hospitals.

b. Land selection guidelines

MoHP's 'Guidelines for Selecting Land for the Construction of Health Facilities' were finalised and endorsed and taken into use in the last quarter of 2013. Their application will save the large land development costs that have often been incurred when building on difficult sites. It is also expected that implementation of the guidelines will increase the number of appropriately located sites having water supplies and road connections. NHSSP is providing on going TA to MD and DUDBC for this initiative. It is recognised that that in some areas suitable land, as defined by the guidelines, may simply not be available in which case further efforts will be needed to identify acceptable sites.

In this reporting period, the guidelines were sent to all DUDBC district offices for use when selecting sites for construction in FY 2013/14. Adding to the criteria, the government agreed that, if justified, the Ministry can procure land for new buildings. This should enable MoHP to build on more suitable sites. Previously the government could only build on donated land which was often unsuitable. The institutionalisation of these guidelines into regular practice for health Infrastructure construction is awaiting government approval and will be assisted by their publication as formal MoHP guidelines.

NHSP 3 follow on: Once the guidelines are institutionalised, their implementation will need to be monitored regularly.

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

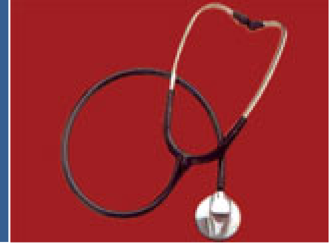
Progress reporting — In the reporting period, NHSSP supported DUDBC to prepare its third trimester progress report against approved procurement plans for submission to the World Bank. These reports cover the progress of building projects and identify reasons for delayed projects in order to identify rectifying measures. NHSSP's infrastructure advisor will continue working to build the capacity of DUDBC officials to prepare these reports. The main risk to a successful outcome here is the frequent transfer of DUDBC officials to other government agencies.

NHSP 3 follow on: Institutionalise the regular production of progress reports using HIIS, which should contain district level data.

Monitoring visits — NHSSP supported the pre-2014 JAR field visit and a visit to the Karnali region with senior DFID officials to inspect the progress of health facility building works. These visits can help external development partners to understand how their support is used. It also provides them with a chance to provide on-the-spot feedback on initiatives and to discuss critical issues. Such a discussion took place on the long pending issue of the completion of construction at Surkhet Hospital. This proved to be a good learning opportunity for government officials, local officials and the EDP representatives present. It is recommended that such visits happen often, although too frequent visits to the same places should be avoided.

NHSP 3 follow on: Regular field visits should be made by high level officials so that they see the realities on the ground.

TA Output 2: Information and Monitoring System Strengthened



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

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

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

No significant changes since last quarter.

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

In 2013, NHSSP TA supported MD to revise its HMIS indicators, recording and reporting tools and reporting processes. The development of a more complete and disaggregated monitoring system will ensure that quality data are available and are more likely to be used in planning.

During this quarter, NHSSP continued to provide TA to MD to assure the quality of training on the revised HMIS:

- Two hundred HMIS trainers completed the master ToT programme for central and regional staff and district level focal persons in January and February 2014. DHOs and DPHOs across the country then began to train health facility and hospital staff and female community health volunteers. It is expected that all 75,000 personnel will be trained on the new HMIS by the end of July 2014.
- Among the 200 trainers, 100 HMIS facilitators have been supporting the central HMIS, regional health directorates and all 75 DHOs/DPHOs to roll out the district level training programmes. The main risk that could hinder this work is low quality training programmes. A national service provider organisation (New ERA) was therefore appointed to monitor and oversee the quality of the district training programme.
- The District Health Information System-2 (DHIS-2) is the information technology (IT) platform for the revised HMIS. NHSSP, working in collaboration with other development partners, continued to support MD to roll out the revised HMIS using DHIS-2. Efforts continued to build the capacity of the national team with support from international experts on DHIS-2 for this purpose.

NHSP-2 and NHSP-3 follow-on: The revised HMIS will be implemented from the beginning of FY 2014/15. This will serve to monitor NHSP-2 performance using disaggregated data and provide evidence to inform the preparation of NHSP-3 and the development of accurate baselines against which appropriate NHSP-3 (2015–20) targets can be set.

2.1.3 Support the generation of primary information for NHSP-2

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

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

The following progress was made in of the three work areas described below, each of which is of high importance for the preparation of NHSP-3:

- **Data for strategic planning** — NHSSP advisors worked closely with government counterparts and development partners to compile evidence of recent health sector progress by supporting research studies, surveys and providing TA for developing information systems. A comprehensive report on this work was presented to the 2014 JAR in January 2014. This exercise proved to be useful preparation for identifying priority areas for inclusion in the next five year strategic plan (NHSP-3). This evidence will ensure that quality data informs policy design and NHSP-3 planning and the preparation of MoHP's FY 2014/15 AWPB. NHSSP advisors are currently supporting preparation of the NHSP-3 M&E framework.
- **Large surveys** — NHSSP TA is providing on-going support for large-scale surveys on health service provision and health status. In March 2014, the draft report of the STS 2013 was circulated to stakeholders for final review and comment. Dissemination of the final report is planned for May 2014. Also of note is the decision taken that: as the Multiple Indicator Cluster Survey 2014 is underway with the final report due in September 2014, the next Nepal Demographic and Health Survey will now take place in early 2016.
- **Harmonising surveys** — An important part of this work is to support MoHP to harmonise the population and health facility based national level surveys, considering the national requirements and international commitments of the government and its development partners. NHSSP and other development partners are looking at ways of harmonising the currently separate STSs, SPAs and SARAs. In this reporting period, stakeholders tentatively agreed that a harmonised 'Nepal Health Facility Survey' will be undertaken if possible in early 2015, meaning that an STS will not be carried out in 2014. Further, NHSSP's advisors are also working with the United Nations Family Planning Association (UNFPA) to determine whether the next series of UNFPA-supported 'Facility Based Assessment for Reproductive Health Commodities and Services' could inform the JAR 2015 with progress against the NHSP-2 log frame indicators for which the STS is cited as the main source of information.

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

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

Considerable progress was made in the reporting period on institutionalising QA for MNCH in health facilities and hospitals. The following work went ahead in collaboration with MD, FHD, Health for Life (H4L), Deutsche Gesellschaft für Internationale Zusammenarbeit (GiZ), and the Nick Simons Institute (NSI):

- MD finalized ToRs for the QITAC, QA&ITWG and hospital QI committees.

- MD then formed the QITAC which is chaired by the DG of DoHS with membership drawn from directors of all divisions and centres. It is tasked with developing policy and strategies to guide the national QI system, reviewing progress on quality of care (QoC) and providing overall guidance and support for QI interventions.
- MD also formed the QA&ITWG of QI focal persons from divisions, centres and key agencies. It started work under the leadership of the chief of the QA Section of MD to support the QITAC to strengthen the national QI system.
- In March 2014, MD and FHD, with support from NHSSP, formed a hospital QI committee in Hetauda Hospital chaired by the medical superintendent with membership from 13 hospital personnel. This committee conducted its first assessment using a self-assessment tool (see below), identified problems and produced an action plan to address them.
- FHD, with support from NHSSP, drafted a hospital QI toolkit on MNH which includes a self-assessment tool, score sheet and action plan. The toolkit was presented at a meeting of the Safe Motherhood and Neonatal Health Sub-Committee and shared with MD and QA&ITWG members. It was then tested in Hetauda Hospital and finalised based on feedback.

The next steps are to support MD to conduct regular meetings of QITAC and QA&ITWG and to support MD, FHD and Hetauda Hospital to conduct their first QI meetings and to follow up on the action plan of the first Hetauda Hospital assessment. The recommended QI process will also be taken forward in Taplejung District Hospital. The main risks that could delay these initiatives are changes in the leadership of MD, FHD, and Makawanpur DHO and hospital.

NHSP-3 follow on: NHSP-3 should call for introducing the QI process in other hospitals. Also, QI indicators need developing for incorporation in NHSP-3 monitoring.

2.2.2 Support the implementation of strategies to address overcrowding in tertiary facilities

An NHSSP study from 2012/2013 documented the overcrowding of delivery services at referral hospitals noting that many facilities were unable to cope, thus leading to poorer quality of care. As these hospitals are training sites for SBAs, this impacts the QoC provided by SBA trainees. Progress made in this quarter to address this problem was as follows:

- A senior CEONC consultant and CEONC mentor (two persons) were appointed in the previous quarter (with TARF funding) to support FHD to address overcrowding. The senior consultant visited ten referral hospitals where FHD had provided a dedicated fund to address the overcrowding of delivery facilities. However, none of the hospitals were aware of the fund or its guidelines for use. These visits have, however, subsequently stimulated access to the fund and a number of changes including an increased number of beds, the recruitment of new HR, the repair of labour rooms and operation theatres and other hospital premises in several sites.
- FHD identified Seti Zonal Hospital as a referral hospital that would benefit from NHSSP planning support. Accordingly, the consultant worked with 68 hospital stakeholders to produce short and long term plans to address overcrowding. FHD has subsequently committed to increasing the budget for implementing the planned activities including HR, equipment and infection prevention activities.
- A meeting of national and local stakeholders in March 2014 prepared a plan for the strategic locating of birthing centres in Banke district.

In the next quarter, the consultant will support FHD to also facilitate the production of plans at Bheri Zonal Hospital and Narayani Sub-regional Hospital and continue supporting FHD to facilitate the central level response for hospitals' needs and monitoring and support hospitals to implement their action plans. NHSSP has also approached the NSI to consider supporting the strengthening of hospital development boards. Local collaboration and resource mobilisation will be done by hospital medical superintendents after the development of the plans.

The main risk that could undermine the impact of this work is the inability of the central level FHD to respond to requests on action plan implementation from the referral hospitals. In addition, weak monitoring and follow up of action plans could result in slippage at supported hospitals as they are very busy and just trying to cope with the current situation. Improving quality requires consistent efforts locally and support from other stakeholders including FHD and MoHP.

NHSP-3 follow on: Referral hospitals need continuous support for improving the quality of services and managing the quantity of demand, especially for maternity services.

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

The quality and provision of CEONC services at district hospitals varies. Hospitals have amounts allocated in their AWPBs (CEONC funds) for improving the provision of CEONC services but take up and use of the funds is inconsistent. To improve the provision of these services at hospitals, the TARF funded consultants supported the following work in this reporting period:

- A CEONC Working Group was established under the leadership of the FHD director with membership from NSI, GiZ and United Nations Children's Fund (UNICEF) and other interested partners. This group will support FHD to ensure the continuity and quality of CEONC services in district and referral hospitals and develop a framework for monitoring CEONC services.
- The CEONC mentor started to monitor the functionality of CEONC services by visiting Lahan, Sindhupalchowk and Baitadi Hospitals. The mentor supported service providers and hospital management boards to solve problems. Planning workshops were held at Terhathum, Bajura and Rolpa Hospitals to plan the rollout of CEONC services after which Bajura Hospital performed two caesarean sections.

The consultants will continue to support FHD to make the working group functional and promote the fulfilment of district hospitals' support needs for providing CEONC services. The support for CEONC in district hospitals is happening in collaboration with FHD's partners, which include UNICEF, Care Nepal, H4L and SAVE.

The main risk to this work is that the functionality of CEONC services in hospitals is affected by the government's financial rules, the lack of multi-year contracting and the limited availability of doctors who can perform caesarean sections (at district hospitals) and administer anaesthesia (at referral hospitals).

NHSP-3 follow on: NHSP-3 should direct efforts towards producing more quality HR, including by strengthening professional bodies and regulating academic training institutes. It should also support the continued expansion of CEONC sites to most of Nepal's districts.

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

NHSSP is supporting the development of strategies to improve the provision of MNH services to remote populations. The draft final report of the remote areas study (2013) was revised based on feedback from the WB. Leading on from the study's recommendations, the design of a pilot programme intended to improve MNH service provision in one remote area was completed. This programme will go ahead in the next reporting period in close collaboration with Taplejung DHO, FHD and PHCRD. The M & E plan for this pilot programme is being developed by the NGO HERD.

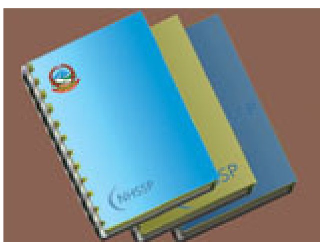
Also, in this reporting period, NHSSP advisors continued to:

- support FHD on evidence based planning for FY 2014/15;
- contribute to planning SAVE's newborn health project in coordination with CHD; and
- support the finalisation of materials for family planning(FP)/Expanded Programme on Immunisation (EPI) integration, obstetric first aid and postnatal care (PNC).

In the next quarter, NHSSP will:

- disseminate the findings of the FP/EPI integration study;
- support FHD to implement FP/EPI integration once approved by CHD (also supported by UNFPA); (note that CHD's immunisation section is nervous about introducing the integrated approach due to the planned introduction of two new vaccines (polio and pneumococcal) in 2014/15 - further discussions are planned with CHD);
- support FHD to train health personnel on obstetric first aid with support for the production of a manual from UNICEF and World Health Organization (WHO) to support the scaling up of this training;
- print the PNC checklist to support its rollout in 2014/15 to all health facilities; and
- finalise the remote areas study report and begin implementing the remote areas MNH pilot in Taplejung.

NHSP-3 follow on: Use evidence generated by the forthcoming remote areas pilot initiative to develop and implement strategies to improve the reach of MNH services to remote populations.



TA Output 3:
Institutional Reform Processes Supported

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

Indicator 3.1 Draft NHSP-3 Document

3.1.1 Support to strategic planning for NHSP-3

A NHSP-3 process design workshop was held in Pokhara during which the development process, timeline, management structure, thematic areas and approaches to be followed were agreed. Cross-sectoral Steering and High Level Advisory Committees were formed - both having MoF and NPC representation. Team leaders for each of the 9 thematic groups were nominated and formation of the groups is now underway. Following the CIAA's recent action, a new leader for the procurement group is needed. The nine thematic groups are:

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

In addition, each thematic group will have a 'sounding board' of external stakeholders to include civil society representatives. These will provide feedback and advice to each thematic coordinator but will carry no decision making authority. Two additional entities will work across thematic groups to provide a) evidence support and b) M&E framework support.

In order to support the design process, agreement was also reached on the formation of a Project Development Team. This entity will have MoHP and EDP membership and be supported by national and international TA inputs. It will help coordinate activities and support the work of individual thematic groups. An application will be made to the TARF to cover the costs of national TA. H4L has indicated that it will support the costs of international TA.

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

In the reporting period, NHSSP TA worked closely with government counterparts and EDPs to compile evidence from various research studies, surveys and information systems to inform NHSP-3's design. This evidence was presented at the 2014 JAR and will be taken up by thematic groups to identify NHSP-3 priorities. A costed implementation plan will also be developed. This will draw on the planned review of NHSP-2's budget. NHSSP advisors began preparation of an NHSP-3 M&E framework.

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

Progress on strengthening state non-state partnerships (SNPs) remains static following delays at MoF in approving the 2013 Draft SNP Policy. This failure to approve policy means that the proposed SNP Unit under PPICD cannot be created, nor implementation modalities developed. The new chief of MoHP's Health Sector Reform Unit recently undertook to follow-up with MoF on this matter.

At the operational level, the financial framework for an MoU between MoHP and public sector medical colleges to supply medical staff to provide services in public health facilities is currently being discussed in MoHP with a view to signing an agreement within the current financial year.

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

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

In December 2013, MoFALD agreed to integrate MoHP's EAP into the social mobilisation component of its LGCDP. EAP works to extend access to health services by disadvantaged sections of the population.

In this reporting period, a concept note on carrying out an assessment of the value of integrating EAP into LGCDP's social mobilisation programme was developed, shared and agreed by PHCRD and LGCDP. A ToR was then developed and approved for the assessment in four VDCs of two districts (Dhading as a hill district and Rupandehi as a Tarai district). The procurement process is underway for the assessment which will run from mid-April to July 2014. NHSSP is providing TA for the assessment. The main risk that could undermine this work is if LGCDP is unwilling to agree to implement all the recommendations of the assessment.

NHSP-3 follow-on: If the proposed one year pilot initiative is successful then this approach should be widely implemented.

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

Several important pieces of work were carried out to help strengthen and institutionalise SSUs in hospitals in order to facilitate the access of disadvantaged people to free and subsidised health care:

- A biannual review workshop of the progress of SSUs was held in January 2014 and attended by medical superintendents, chiefs and account officers from the seven established SSUs. The workshop was chaired by the MoHP Secretary with the PPICD chief and the chief of PD present.

Participants reviewed progress and lessons learned and identified issues to be addressed. It also identified areas to be incorporated into the SSU guidelines and approved the M&E framework for SSUs which has been developed by PD. NHSSP provided TA to the workshop while UNFPA supported workshop costs.

- The revision of the SSU guidelines began in accordance with the recommendations of the SSU study (August 2013), inputs from the above review workshop and findings of follow-up visits. The revision will be completed in the second quarter of 2014 with technical support from NHSSP.
- NHSSP provided backstopping support to Bharatpur, Koshi and the central Maternity Hospital's SSUs and advised Bir Hospital on establishing its SSU.

In the next quarter, the other four SSUs will be visited and capacity building support will be provided to the SSUs by PD and NHSSP.

The main risk that could undermine government support for SSUs is if it generates too large a demand for subsidised and free health services that the government does not have the resources to meet.

NHSP-3 follow-on: This initiative is crucial for improving access to health services for disadvantaged people which is likely to be a core objective of NHSP-3. The current plan is to put SSUs in all referral hospitals from 2016/17.

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

The following events were run in this quarter to build knowledge and capacity on the social auditing of health service provision:

- In February 2014, an orientation on social auditing was provided to 31 participants from 17 new districts who are going to implement social auditing from this year (2013/14) with AWPB funding. NHSSP's advisor delivered some sessions.
- In March and April 2014, 82 DHO/DPHO personnel, focal persons, NGO representatives and EDP programme representatives from 22 districts (2 events) from all five regions were orientated on the social auditing of health facilities. The orientation covered the rational, objectives, steps, tools, analysis, organisation and facilitation of public meetings and reporting. NHSSP's TARF paid for this orientation with funding also allocated to pay for supportive supervision of the actual social auditing by participants which is planned for the April to July 2014 period. District officials from EDP-supported programmes participated in these programmes.

Also in this period:

- On 14 February 2014, PHCRD and seven external development partners signed an MoU establishing a collaborative framework for the social auditing of health service provision. The external development partners have since started to provide TA to PHCRD and the DHOs and DPHOs in their programme districts.
- PHCRD agreed for the United States Agency for International Development (USAID) supported H4L programme to support the social auditing of 50 health facilities in an additional five districts. NHSSP will help orientate implementing personnel in the five new districts in April 2014.

- A concept note was prepared and agreed to carry out an evaluation of the social auditing of health facilities in 2014 and 2015. It is planned for the baseline information to be collected for the evaluation in the next quarter with the end evaluation to be done through NHSSP TA support in 2015.

The main risk to all this work is that social audits are carried out as a mere formality. It also needs to be assured that the work plans resulting from social audits are properly implemented with good follow-up support from district and central authorities.

NHSP-3 follow-on: The strategy for social auditing under NHSP-3 will be based on the recommendations of the process evaluation (2014–2015). One possibility to explore is harmonising local government and health social audits.

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

Substantial progress was made in this reporting period on developing OCMCs:

- NHSSP provided follow-up support to the OCMCs at Hetauda, Sarlahi and the Central Maternity Hospitals by reviewing progress and discussing the resolution of problems. This type of support will be provided to the other 13 OCMCs, probably by the GESI Section of PD with funding from its AWPB by mid-July 2014.
- NHSSP provided TA to PD to develop an M & E framework for OCMCs. The draft framework will be tested at Hetauda OCMC in April 2014.
- In February 2014, a high level joint monitoring visit to Saptari and Sunsari OCMCs was led by the responsible secretary at OPMCM. The DG of the Women and Children Department, the Deputy Attorney General, a Home Ministry representative, the director of the police headquarters' Women and Children Directorate, the chief of PD, the GESI Section Chief and NHSSP's GESI advisor took part. NHSSP produced a pulse report that articulated the main issues to do with strengthening OCMCs (see illustration from this report on front cover of this progress report). The report was distributed to all team members and district level stakeholders and helped to focus discussions. The team visited the OCMCs, district shelter homes and the police offices' women and children units and listened to a presentation by the OCMC district coordination committee. Orientation and policy instructions were provided by the secretary. Visit participants discussed how to resolve problems and improve the effectiveness and functioning of the OCMCs. The major issue is for OCMCs to provide integrated services that are the responsibility of different agencies. The visit team agreed to raise the issues observed and experienced at the next meeting of the central level OCMC coordination committee. The costs of the visit were borne by UNFPA and technical guidance provided by NHSSP. NHSSP is working closely with UNFPA to support the OCMCs.
- A 15-days long medico-legal training course was provided to 17 medical officers from 14 OCMCs. The training was organised by the Institute of Medicine and the quality of training was appreciated by participants. NHSSP provided advice and facilitation support for carrying out the training, which was paid out of PD's AWPB.

The main challenge is to make OCMCs real one-stop service centres through exemplary collaboration between district and central levels and the different sectoral organisations.

NHSP-3 follow-on: A key means of promoting integrated service provision is the production of umbrella guidelines for supporting gender-based violence (GBV) survivors, which should happen under NHSP-3 alongside establishing more OCMCs.

Other

A GESI ToT event was held from 6-9 April 2014 for NHTC, regional health directorate and regional health training centre trainers. These trainees will soon implement training in 14 districts on GESI mainstreaming in health service delivery. The government has allocated funds in its AWPB for GESI mainstreaming training for facility in charges and district supervisors to enable the roll out of GESI to the facility level. NHSSP provided technical support for the training while WHO paid for the accommodation costs.

Indicator 3.3: Aama delivery unit costs identified

3.3.1 Review the Aama Programme

Three areas of NHSSP work (3.3.1, 3.3.2 and 3.3.3) are carrying out important reviews of aspects of the nationwide Aama Programme.

- In February 2014, a central level workshop discussed private sector involvement in the Aama Programme. Most participants were from the private sector.
- Following this, in March 2014, FHD and NHSSP began an internal review of the implementation of the Aama Programme in the private sector. During the month of March 2014, information began to be collected from 10 of these institutions to identify bottlenecks in programme implementation and operational concerns. One aspect that is being investigated is the proportion of deliveries by caesarean section. An early finding (that needs confirming) is that a few private institutions that are *not* on the official list of institutions implementing Aama are being funded by DHOs/DPHOs for the programme. The review is working with DHOs and DPHOs in the districts where the institutions under review are based. Note that Aama Programme money is channelled through DHOs and DPHOs to private institutions. The review should be completed by May 2014. The findings will be used by MoHP/FHD to improve programme implementation in the private sector and gauge future financing needs. Its findings will be taken into account by the unit cost analysis (see activity 3.3.2 below).
- Also in this quarter, FHD called for proposals to carry out the regular rapid assessment of the Aama Programme.

NHSP-3 follow on: The modality for the implementation of the Aama Programme in the private health sector will need further developing beyond the current review exercises.

3.3.2 Conduct Unit Cost Analysis of Aama

The Aama Programme's unit costs of providing programme services have not been reviewed since the programme was launched in 2009. Several recent studies have called for a review of the unit costs in the light of concerns that reimbursement rates have fallen behind the real costs of providing the services and of users accessing them.

In this quarter, FHD with NHSSP support finalised a draft concept note for carrying out the Aama Programme unit cost analysis study. The note was shared with DFID and turned into the ToR for this work after incorporating comments. The ToR presents the scope and methodology of the costing study. The next steps are to finalise the ToR and appoint consultants to collect data. This work is planned to start in April/May 2014 with a final report due in September 2014.

If the study recommends that separate payment packages are provided to private institutions for Aama, then FHD may well be challenged to monitor the use of this money. It is also questionable if the level of funding is available if it is recommended that payments be increased.

NHSP-3 follow on: Support the FHD to develop an Aama Programme plan of action and capacitate FHD to scale-up the programme as a social security programme.

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

The above two pieces of work (the programme review and the unit cost analysis) are designed to feed into improved and updated Aama Programme guidelines. In the reporting period, preliminary work was undertaken for the third revision of the Aama Programme guidelines.

The review of the guidelines will be finalised after taking into account the findings of the unit cost review. At the same time, MoHP/FHD needs to allocate funds for the revision of the programme in the next FY (2014/15) as a separate budget line item.

NHSP-3 follow on: The continued development of the Aama Programme is likely to be an important areas under NHSP-3.

4. Payment Deliverables

Seven payment deliverables were submitted this quarter:

M2: Quarterly report (October – December 2013)

11.1: PFM: System for responding to audit queries established

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

7.1 QA procedures for CAPP ICBs and NCBs established, including QA template and disseminated with approval by DFID and LMD

8.1 Draft NHSP-3 design process document prepared

T1 Preparatory phase of TABUCS roll out finalised

HMIS1 HMIS sub-contract signed

Annex 1: Publications Produced

Core Health Systems	JAR 1: Progress in 2013 against target NHSP 2 M&E framework
	JAR 2: Progress in GAAP
	JAR 3: Progress report in Financial Management
	JAR 4: Progress report on Procurement
	JAR 5: Progress report on major health related research and studies
	JAR 6: Progress report on partnership, alignment and harmonisation
	JAR 7: Progress report on opportunities, challenges, lessons learned and strategic directions
	JAR 8: Progress report on GESI
	Response to Annual Review Queries
Pulse report	4th Quarterly Report 2013