

Nepal Health Sector Support Programme

Quarterly Report



Reporting Period: January – March 2015

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Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
AWPB	annual work plan and budget
BNMT	Britain-Nepal Medical Trust
CA	Constituent Assembly
CAPP	consolidated annual procurement plan
CBIMCI	community based integrated management of childhood illness
CBNCP	community based newborn care package
CEONC	comprehensive emergency obstetric and neonatal care
cGMP	current good manufacturing practices
CHD	Child Health Division
CIAA	Commission for the Investigation of the Abuse of Authority
CMAM	community based management of acute malnutrition
CMS	contract management information system
CPN (Maoists)	Communist Party of Nepal (Maoists)
CPN (UML)	Communist Party of Nepal (United Marxist Leninists)
C/S	caesarian section
DDC	district development committee
D(P)HO	district (public) health office(r)
DfID	UK Department for International Development
DG	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
ENAP	Every Newborn Action Plan
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
HF	health facility
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
IHME	Institute of Health Metrics and Evaluation (University of Washington)
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
NHRC	Nepal Health Research Council
NHSP-2	Second Nepal Health Sector Programme
NHSP-3	Third Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPAS	Nepal Public Sector Accounting System
NPC	National Planning Commission
NSI	Nick Simons Institute
O&M	Organisation and Management
OAG	Office of the Auditor General
OB/GYN	obstetrics/gynaecology
OCCMC	one-stop crisis management centre
OPM	Oxford Policy Management
OPMCM	Office of the Prime Minister and Council of Ministers
PAF	Poverty Alleviation Fund
PBGA	performance based grant agreement

PD	Population Division
PDT	Project Development Team
PEER	peer ethnographic evaluation and research
PFM	public financial management
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
PIP	Procurement Improvement Plan
PNC	postnatal care
PO	procurement office(r)
PPICD	Policy, Planning, and International Cooperation Division
PS	procurement specialist
PSI	Population Services International
QA	quality assurance
QA&ITWG	quality assurance and improvement technical working group
QI	quality improvement
QITAC	quality improvement technical advisory committee
QoC	quality of care
RA	rapid assessment
RH	reproductive health
SARA	Service Availability and Readiness Survey
SBA	skilled birth attendant
SAVE/SCI	Save the Children International
SM	safe motherhood
SMNSC	Safe Motherhood and Neonatal Steering Committee
SNP	state non-state partnership
SPA	Service Provision Assessment
SSU	social service unit
STS	Service Tracking Survey
TA	technical assistance
TABUCS	Transaction Accounting and Budget Control System
TAG	technical advisory group
TARF	Technical Assistance Resource Fund
TB	tuberculosis
ToR	terms of reference
ToT	training of trainers
TWG	technical working group
UML	United Marxist Leninists
UNDB	United Nations Development Business
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	village development committee
WB	World Bank
WB-PQ	World Bank procurement quality
WDO	Women's Development Office
WHO	World Health Organization

1. Introduction

NHSSP is a programme of Technical Assistance (TA) to the Government of Nepal's (GoN's) Ministry of Health and Population (MoHP) and its 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).

This quarterly report covers the period January to March 2015. It was drafted in April and May 2015 during which Nepal suffered a 7.9 magnitude earthquake followed two weeks later by a 7.3 magnitude aftershock. Together, these quakes have killed more than 8500 people, making the disaster the deadliest to hit Nepal on record. More than half a million homes have been destroyed, most of them in remote areas cut off from emergency medical care.

The scale of this national disaster changed MoHP's operational context overnight with all available staff being immediately directed to support emergency services. The deployment and coordination of medical teams and supply of medicines to hard hit areas has become the overriding priority and resources are now severely stretched. Hospitals in Kathmandu and other affected areas are overloaded with staff chronically overworked.

Throughout this crisis, NHSSP's TA team has sought to provide rapid and highly responsive support to MoHP. These activities will be described in detail in our next quarterly report. This report, in accordance with contractual requirements, focuses on the period January – March.

Phase 1 of NHSSP ended in August 2013. Under phase 2, Options leads a consortium of partners comprised 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 created under MoHP's Policy Planning and International Cooperation Division (PPICD) to support new initiatives proposed by MoHP and its external development partners (EDPs). The phase 2 log frame was further revised during the DfID Annual Review in January 2014 and progress against each of its outputs for this quarter is described in detail in Section 3.

The work of NHSSP's advisors is based on:

- the requirements of NHSP-2;
- the on-going activities and plans of the various MoHP departments, divisions and centres;
- the NHSSP phase 2 inception report, and

- the individual year 2 work plans of advisors that were revisited and updated with GoN counterparts and DfID and finalised on 1st September, 2014 .

All work plans have been agreed with advisors' counterparts who are mostly the heads of divisions and centres including Family Health Division (FHD), PPICD, Logistics Management Division (LMD) and others. All NHSSP activities are designed to enhance the capacity of MoHP/DoHS to deliver NHSP-2 and, most recently, to 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 (January – March 2015)

Between 23rd – 25th February, 2015, MoHP hosted its fifth Joint Annual Review (JAR) under NHSP-2. The JAR assessed performance against NHSP-2 objectives and JAR 2014 action points, and set some key activities and targets for 2015. A joint Aide Memoire with fourteen key action points was signed with EDPs and, while the aftermath of the recent natural disasters will inevitably requires changes to some of these, each is listed below to provide a snapshot of sector priorities at this strategically important juncture:

1. MoHP will form a task force with representations from the NHSP-3 Programme Development Team (PDT) and other nominated representatives from GoN and EDPs to:
 - Develop, by May 2015, an implementation plan for the 5 years of NHSP-3 that reflects the key priorities in the NHSP-3 strategy
 - Prepare a budget for the annual work plan and budget implementation plan AWPB (IP) 2015/16 and hold a meeting between MoHP and EDPs to discuss the budget scenario by March 31, 2015
 - Jointly define the scope and develop the Joint Financing Agreement (JFA) by the end of April 2015
 - Until the JFA for NHSP-3 comes into effect, Joint Consultative Meetings (JCMs) for AWPB 2015/16 will be organised as per current practice stipulated under the JFA for NHSP-2
2. MoHP and the EDPs will begin discussions on Disbursement Linked Indicator (DLI) based financing modalities by the week of 23rd March 2015.
3. A draft bill of the National Public Health Act will be prepared by mid-July, 2015
4. The State Non-State Partnership Policy will be revised in line with the National Health Policy 2014 and endorsed by the end of September 2015.
5. EDPs to indicate budget support and TA commitments for FY 2015/16 not later than end of March 2015.
6. Identify the required number of human resource (HR) positions to be furnished through local contracts for implementing different programs and specify in NHSP-3 document.
7. Update the Financial Management Improvement Plan (FMIP) jointly with MoHP, the Ministry of Finance (MoF), National Planning Commission (NPC), Financial Comptroller General's Office (FCGO), Office of the Auditor General (OAG) and EDPs to identify systemic issues and actions to be taken over NHSP 3 by the end of June, 2015.
8. Submission of OAG external audit report for FY 2013/14 by June 15, 2015.
9. The practice of redistribution of drugs and commodities will be initiated in three districts from each region (15 districts) to minimise stock-outs and overstock situations.

10. Adjust the timeline and provide adequate funding for the first year implementation of the procurement and supply chain management plan by the end of March 2015.
11. Staffing of Physical Asset Management Section under Management Division ensured – temporary recruitment by July, 2015 and permanent staffing by December, 2015.
12. Roll out new National Healthcare Waste Management Guidelines in 1000 public and selected private health facilities by the end of September 2015.
13. Increase the budget and enhance the capacity of Regional Health Directorates for implementation and monitoring of public health activities and hold them responsible and accountable against delegated authority for programmes in their regions effectively. Progress to be discussed in next JAR.
14. Comprehensive assessment initiated and short-term plan prepared to manage overcrowding of maternity wards in referral hospitals to ensure quality of care for safe and respectful delivery by June 2015.

NHSSP TA provided support for the planning, implementation and facilitation of the JAR which was widely regarded as an important and successful sector event.

Concurrently with the JAR, DFID carried out its annual review of NHSP-2 including an assessment of NHSSP TA effectiveness. Following a half day of presentations and discussions with the TA team, DFID's follow up queries were addressed in writing. A DFID-Options contract management meeting was also held immediately following the review.

Progress made between January and March 2015 against the programme's log frame outputs is summarised as follows:

In Strengthening Core Health System Functions

A **value for money (VfM) case study on LMD's Technical Specification Bank** was prepared. This compared investment costs with the present value (PV) of net savings using three different investment analysis techniques, namely: (i) net present value; (ii) benefit to cost ratio; and (iii) discounted payback period. The VfM results were calculated over a 10 year period and showed that the investment produced a positive net present value (NPV) under all scenarios with a latest payback period of than 3.3 years and with a minimum return of £2.6 to every £1.0 invested.

A **procurement training plan for the regions/districts** was prepared and approved by LMD and a first workshop held at Kathmandu for 35 participants from Central Region.

The **supply chain review programme** was completed with all regions having now been visited. However, it was noted that some supplied equipment could not be used since an appropriate operation and maintenance budget had not been created.

Important evidence of progress in **public financial management (PFM)** was MoHP's timely submission of its first Financial Monitoring Report (FMR) for 2014/15 within 30 days of the quarter's end. This showed a zero balance for DFID in the pooled fund. The clearance of audit queries was improved as a result of directly requesting responses to queries from cost centres. TA also worked with MoHP and the World Bank to examine concepts related to performance based financing.

Progress in **Health infrastructure** included supporting MD and DUDBC to identify priority secondary and tertiary level hospitals for construction or upgrading in the coming year. A list of recommended projects was forwarded to the health minister for approval. The collection of data on existing health infrastructure was completed by DUDBC using mobile phone technology, thereby updating Management Division's health infrastructure information system (HIIS). Technical assessments for the rehabilitation of Seti and Bheri Zonal Hospitals and Surkhet Regional Hospital were completed.

In Strengthening Information and Monitoring Systems

Monitoring and evaluation. Management Division's customized DHIS2 Nepal database was uploaded to <https://hmisnepal.org> and scheduled for roll out to districts from April 2015 onwards. NHSSP, WHO and GiZ are currently supporting MoHP to institutionalise DHIS2 use at various levels. Five HMIS coordinators continued to provide support to staff at selected health facilities at regional and district levels in order to improve the quality of HMIS data entered.

More broadly, TA supported the development of a programme monitoring framework to help divisions and centres track progress under NHSP-3 and began the preparation of a detailed compendium of results framework indicators. Advisers also supported the pre-testing of tools and training of supervisors for the planned 2015 Nepal Health Facility Survey. These tools were subsequently endorsed by the NHFS working group.

Following the preparation of a schema for a uniform data coding system to assign unique identification codes to health facilities, MoHP's records of health infrastructure was codified and updated. This now clears the way for functional linkages to be established between various management information systems and the improved analysis of available data.

Under **essential health care services** the piloting of the hospital quality improvement process (HQIP) advanced with the QI committee in Taplejung carrying out a fourth planning and review cycle without central level support. Performance against the 3rd round action points proved to be extremely good and suggests that the QI process can be effective in improving service quality with only modest financial investments. Advisers also supported the preparation of QI Implementation Guidelines which have been forwarded to the QAI TWG for review.

Activities to address overcrowding in tertiary facilities included follow up visits to six referral hospitals during which encouraging progress against plans was noted despite delayed budget release from MoHP. Implementation of strategic birthing centre strengthening was delayed due to staff recruitment difficulties in Banke. These difficulties have subsequently been overcome and staff are now in place.

The CEONC mentor together with NHSSP team continued their support visits to district and referral hospitals in order to improve the functionality and quality of CEONC services. Visits were made in nine district hospitals and two referral hospitals. The number of districts offering CEONC services has increased from 55 in December 2014 to 58 by end of March 2015.

MoHP's efforts to improve MNH programming in underserved remote areas advanced in Taplejung with both planned hospital and community level activities implemented. The mid-term review of RAMP was carried out in February with the participation of district and VDC/HF level stakeholders and the report was finalised in March.

Activities to strengthen selected health facilities included posting two ANM to the district hospital to enhance skills, reviewing health facility operation and management committee (HFOMC) strengthening processes in all VDCs and carrying out quality of care self-assessments in six birthing centres. The RAMP project management committee met once in the quarter and a district reproductive health coordination committee (RHCC) meeting was held in March.

Programmatic support to FHD to meet family planning demand included a revision of the concept note for the FP/EPI pilot and the orientation of 156 health service providers running EPI clinics in Sindhupalchowk district. 664 HFOMC members and 695 FCHVs in all 79 VDCs in the district were oriented on the launch of the integrated FP and immunisation services.

For the visiting provider pilot, a revised concept note was shared with HERD/MM and DFID and implant training provided to 12 government health workers from Ramechhap district. Regarding the VSC+ pilot, initial consultation meetings were held in Baitadi and Darchula districts. The VSC+ concept note will now be revised based on these visits.

Under **health policy and planning**, the draft outcomes and outputs of NHSP-3 were shared at the JAR and comments made reflected in the strategy document and results framework. A first draft of the NHSP-3 Implementation Plan was prepared in consultation with departments and divisions. The PDT is now preparing a final draft of the strategic document and results framework to be forwarded to the Steering Committee for endorsement and to MoHP for approval prior to submitting to Cabinet.

Gender equality and social inclusion. Despite early progress on plans to integrate health social mobilisation within MoFALD's Local Governance and Community Development Programme (LGCDP), a decision was taken in the quarter to put further work on hold until NHSP-3 objectives are finalised.

The Social Service Unit (SSU) Operational Guidelines were formally approved by the Minister and backstopping support continued at facility level including guidance on preparing case studies for presentation at forthcoming annual review workshops. ToR for the evaluation of SSUs were finalised and consultants contracted to carry out the assessment which is now underway.

The write up of the one stop crisis management centre (OCMC) annual national review workshop held in late 2014 was completed and shared with concerned stakeholders. TA support was also provided for the UNFPA supported development of GBV Clinical Protocols for front line health workers. Draft protocols have now been completed, shared with MoHP for finalisation and sent for translation.

Progress in **public financial management** included dissemination of the eighth demand side financing (DSF) Rapid Assessment (RA) report in February 2015. Chaired by FHD's director, the meeting was attended by stakeholders from NHSSP, UNICEF, WHO and Save the Children. The consultants incorporated comments made in the final draft submission which was subsequently endorsed by

FHD.

Data collection, entry, cleaning and analysis for the unit cost analysis of Aama were completed and a scope of work for a consultant to provide data quality assurance was prepared. An analysis plan was developed and discussed and the OPM team in Oxford analyzed and assured data quality. Preliminary descriptive tables were sent to the lead consultant and the Nepal team is now addressing comments made and preparing the report.

Technical Assistance Response Fund (TARF) Funding

TARF funded activities in the quarter were as follows:

1. Support for the finalisation and dissemination of the operation and management (O&M) study at the request of MoHP.
2. 6 months' consultant support for NHSP-3 IP development at the request of DoHS's Director General.
3. Initiatives for improvements in public financial management (PFM) and capacity building of MoHP officials on PFM.
4. Continued financial support for three procurement specialists as requested by LMD.
5. Continued financial support for the CEONC mentor as requested by FHD.
6. Continued financial support for three PDT consultants for NHSP-3 development.
7. Continued financial support for remedial design work for health infrastructure in Bheri, Seti and Surkhet Hospitals.
8. Continued financial support for the skilled birth attendant (SBA) mentor at the request of NHTC/FHD.
9. On-going support for the development of a new Health Act as requested by MoHP.

Summary details of actual and planned TARF expenditure to date are as follows:

Descriptions	Amount	Remarks
Total Fund Value	£500,000	
Spent to end February 2015	£200,894	
Additional committed to date	£249,582	
Value of applications under consideration	£21,526	
Projected remaining balance	£27,998	

Additional support

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

a) In Monitoring and Evaluation (M&E)

Support to MoHP from NHSSP and ICF Macro on the Nepal Health Facility Survey continued throughout the quarter. Under a local research agency contract awarded to New ERA to customise various modules and data collection tools, work also proceeded on pre-testing the tools. Training of survey supervisors commenced during January and was completed in February following which the final tools were shared with stakeholders and endorsed by the NHFS technical working group.

Residential training of 90 enumerators by master trainers was completed in March and included the supervised use of the tools in the field and receiving feedback from supervisors. Once completed, plans were made for enumerators to move to the field and begin work. These plans were subsequently interrupted by the 25th April earthquake (see 2.1.4).

b) In Financial Management

The training and the roll out of the transaction accounting and budget control system (TABUCS) at all cost centres across the country was completed in the previous quarter. In this period, a monitoring framework was prepared and forty finance officers trained using NHTC funds (see 1.2.1).

c) In Essential Health Care

SAVE continued their efforts to strengthen new born care in Nepal, completing the training of over 750 SBAs on the community based integrated management of neonatal and childhood illness (CB-IMNCI) at health facilities. SAVE's quarterly report is included as Annex 2 and the remote areas study got underway.

The following NHSSP and sub-contract payment deliverables were submitted during the period:

Mgmt.	M6	Quarterly report
CB-IMNCI	5	TOT and HF staff training for district technical staff (evidence = curriculum, session plan and attendance list)
DHIS2		Saipal - Completion of preparatory work for Nepal DHIS version 1 and DHIS2 application developed including dashboards for all programme
NFPP	FP1	Orientation and training of health facility in charge and service providers on FP/EPI integration completed in Sindupalachowk district
NFPP	FP3.1	District consultation and planning meeting completed in 2 districts
M&E	19.1	NHFS 2015 tools designed, pretested and customized in CAPI system in conjunction with ICF International with technical support from ICF International
Proc	7.2	50% Quality assured ICB's and NCB's documents achieved and report on procurement submitted
NHFS	2	Questionnaire pre testing completion report (15% of total costs)

RAMP	RA2	Mid-term review of programme completed and disseminated
M&E	20	Strategic survey plan developed as part of the NHSP-3 M+E framework with NHRC ensuring clarity on the survey needs and timing
TABUCS	T5	MOHP capacity to carry forward TABUCS built
CB-IMNCI	6	Mid-term report with confirmation that FCHV training completed

All final, non-sensitive documents were uploaded to the NHSSP website (www.nhssp.org.np). NHSSP's website has had 17,500 hits since Jan 2012). NHSSP's Facebook page 'likes' at the end of the quarter totalled 6000 and 200 people currently follow the programme on Twitter.

3. Detailed Quarterly Updates



TA Output 1: Core Health System Functions Strengthened



NHSP-2 Outputs: **Improved physical assets and logistics management (7)**
 Improved health 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)

Following approval of the CAPP for 2014/15 in the last quarter, procurement activities began although implementation progress to date has been slow. The procurement monitoring report is now proving useful in highlighting procurement trends while the contract management system (CMS) pipeline report is seen as a useful resource for forecasting procurement demand and is now operational in all divisions.

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)

As previously noted, the frequent by-passing of agreed procedures for both international competitive bids (ICBS) and national competitive bids (NCBs) has effectively compromised the QA system. For this reason, TA efforts are focusing on a review of LMD procurement since 2010 and identifying ways to improve procurement under NHSP-3.

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

The development of LMD's electronic Contract Management Information System (CMS) continued with several additional reporting formats developed. Others are still needed in order to meet MoHP financial reporting requirements.

A procurement training plan for the regions/districts was prepared and accepted and a first workshop held in Kathmandu for 35 participants from Central Region. Two further workshops for participants from Eastern and Far Western Regions are scheduled for April. Initial feedback has been positive with many participants reporting that this is the first time they have received in-depth procurement training.

Visits to regional and district centres to review supply chain processes (including procurement and contract management) continued with four trips undertaken. The supply chain review programme has now been completed across the country with all regions visited. A key finding is that much of the equipment supplied cannot be used due to the absence of operation and maintenance budgets.

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

Good progress was made in demand forecasting and delivery information with the rollout plan approved in the last quarter now being implemented in central/regional warehouses and all divisions. A trial of the CMS linkage system in the Finance Section began in December and the results are currently being assessed.

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

A VFM case study on LMD's technical specification bank was prepared. This quantitative assessment compared the investment cost with the present value (PV) of net savings using three different investment analysis techniques, namely: (i) net present value; (ii) benefit to cost ratio; and (iii) discounted payback period. The VFM results were calculated over a period of 10 years and the investment produced a positive net present value (NPV) under all scenarios with a latest payback period of than 3.3 years and with a minimum return of £2.6 to every £1.0 invested.

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

LMD's web-based technical specification bank for medical equipment, drugs and other materials reached 1237 entries (209 pharmaceuticals and 1028 equipment) against combined phase 1 and 2 targets of 400 and 1100 respectively. A consultant was engaged to write advanced pharmaceutical specifications and these will be added in the coming quarter. The databank is hosted on LMD's website (www.dohslmd.gov.np). To date, the bank has received 3789 hits and 5482 specifications have been downloaded by various interested parties. These numbers are marked increases on last quarter's figures.

LMD's and NHSSP's biomedical engineers continued promoting use of the bank and have now visited nineteen hospitals in thirteen districts during which they also coached LMD's bio-medical engineers on post-shipment inspections and the rejection of sub-standard items.

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**

As noted last quarter TABUCS has enabled the ministry to produce summary budget and expenditure data by programme and item in a single page printout. This has led to significant benefits in financial management and timeliness of reporting. MoHP's financial monitoring report (FMR) is now incorporated within TABUCS and DfID is able to access this report with its own username and password. MoHP has made significant strides in submitting FMRs within the stipulated 45 days following the completion of each trimester with both FMR-1 and FMR-2 for FY 2014/15 submitted within 30 days.

A monitoring framework has also been prepared, endorsed and uploaded into the system. This generates a national consolidated monitoring report which helps officials receive feedback from site visitors, respond to problems reported and track monitoring visits of support staff. It should be noted that in first 8 months of 2014/15 TABUCS captured 80% of all expenditures.

In the reporting period, NHSSP supported NHTC to train forty finance officers on TABUCS using a budget funds included in NHTC's AWBP. Training will help sustain the effectiveness of TABUCS which appears to be growing in popularity as evidenced by its 1550 Facebook friends around the country.

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

MoHP, supported by NHSSP TA, compiled a central record book of audit queries containing item-wise entries with amounts and descriptions from the 2012/13 audit (http://www.nhssp.org.np/health_financing/Audit%20Status%20Report.pdf). In further prepared notes on audit queries that were distributed at the JAR.

TA also supported DoHS to make an application to the TARF to fund consultants to prepare a draft training curriculum on improving audit responses and reducing queries. A six member committee was formed under DoHS' Director General to implement the training. This body appointed a national consultant and other staff needed to develop the curriculum which will be implemented in April 2015.

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)

The rationalisation of MoHP's Financial Monitoring Report (FMR) templates (from 33 to 6) reported in the last quarter has led to improvements in the timeliness of reporting with the 3rd FMR Report for FY 2013/14 and 1st FMR Report for FY 2014/15 and 2nd FMR for FY 2014/15 submitted within 30 days of the end of their respective trimesters. The latter ensured a zero balance for DFID in the pooled fund. It

should also be noted that NHSSP is also providing inputs to ensure the proper monitoring AusAID funds in the pooled fund.

At the time of writing, the Office of the Auditor General (OAG) was finalising MoHP's audit for FY 2013/14. Historically, the ministry has maintained a central record of audit queries only but this year it has requesting responses to queries from individual cost centres. This is seen as a significant development. The OAG also conducted performance-based audits in Siraha, Dhankuta, Ilam, Kalikot, and Banke districts and carried out an assessment of the effects of service delivery in Bir Hospital.

Also in the quarter, TA supported MoHP and the World Bank to examine concepts related to performance based financing and prepared a short note on public financial management practices in MoHP. This helped identify key indicators in procurement and financial management that can be linked to disbursement.

MoHP initiated discussions to update its Financial Management Improvement Plan (FMIP). NHSSP is supporting MoHP to review its existing FMIP and identify additional issues to be addressed. The findings from different FRAs and studies will be considered during the review process.

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)

Following MoHP's approval of the consolidated infrastructure procurement plan in 2014, TA inputs have focused on helping MD and DUDBC to implement it. This included identifying priority secondary and tertiary level hospitals and presenting a list of recommended projects to the health minister, secretary and director general. Next steps include further discussions on how to use evidence to set MoHP's infrastructure policy and planning priorities and securing endorsement for such policies from MoHP, NPC and other agencies.

At a more practical level, the collection of data on existing sites and infrastructure for all sub health posts upgraded to HPs and higher level facilities since 2061/62 was completed using photos and data collected on mobile phones. This has enhanced MoHP's inventory of health infrastructure. In the coming quarter, an analysis of the status of all health facilities across the country will be undertaken in collaboration with DHOs, DUDBC district divisional offices, MD and regional health directorates.

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

Training was completed on the GIS based referencing of health facilities in HIIS for DUDBC computer operators and DHO statistical officers from Mid and Far Western Regions. This training is seen as important for institutionalising the use of HIIS within government and enabling policy formulation for the repair and maintenance of existing infrastructure and planning of new facilities. Next steps include training MoHP officials to use the infrastructure planning system.

Rehabilitation of Zonal and Regional Hospitals:

Assessments for the rehabilitation of Seti and Bheri Zonal Hospitals and Surkhet Regional Hospital were completed following a multidisciplinary approach to prepare rationale designs for renovation, expansion, or reconstruction. The approach is systematic with new designs informed by prevailing disease patterns, morbidity, catchment areas and other indicators. Next steps include preparing conceptual, architectural, structural, plumbing/sanitary and electrical designs following which cost estimates and tender document will be prepared and forwarded to DUDBC for procurement.



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

Following the development in late 2014 of a schema for a unified coding system to assign unique identification codes to health facilities, MoHP's record of health infrastructure was updated. Management Division/DoHS is now in the process of submitting the unified coding system for endorsement to PHAMED which is the institutional home for its implementation. By introducing unique reference codes for health facilities, functional linkages between various management information systems will be improved leading to better analysis of data.

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)

Management Division's customized DHIS2 Nepal database is now hosted at <https://hmisnepal.org> and is planned for roll out to districts in April 2015. The HMIS data being entered into the current database at district level will then be transferred to the Nepal DHIS and output reports generated. NHSSP, WHO and GiZ are currently supporting MoHP to institutionalize the use of DHIS2 at various levels.

Five HMIS coordinators are supporting regional, district and health facility staff to improve the quality and use of HMIS data. The coordinators, in collaboration with programme focal persons in the respective regional health directorates, provided focused support to the selected districts and health facilities for this purpose.

2.1.3 Support the generation of primary information for NHSP-2

Over the last six months, NHSSP's advisors have supported MoHP to prepare its new NHSP-3 strategy document, results framework and implementation plan based on NHSP-2 evidence and learning. After a series of consultations with stakeholders the strategy document and results framework will be finalized in the next quarter. The results framework includes details of goal, outcomes and output level indicators

with appropriate disaggregation, baseline, milestones and targets with sources for measurement specified. A programme monitoring framework (effectively a sub set of the results framework (PMF)) has been developed to help programme divisions and centers monitor their various programmes. The details of these PMFs are currently being finalized. A detailed compendium of indicators is also being developed and contains details on the rationale/significance of each indicator, its technical definition, the rationale for the proposed target, sources of measurement and the use of each indicator in the results framework. This will help build a common understanding of the indicators among stakeholders and promote their proper use in programme monitoring and evaluation.

During the reporting period NHSSP advisors, along with EDP colleagues, supported MoHP to prepare its AWPB for the next fiscal year (2072/73), the first fiscal year of NHSP-3 implementation. This five day intensive workshop helped identify five year and one year priorities for the ministry based on available evidence and the draft five year sectoral strategy.

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

Pre-testing of tools and the training of supervisors for the 2015 Nepal Health Facility Survey (NHFS) was carried out in January and February 2015 and the final tools shared and endorsed by the NHFS technical working group. The selection and training of enumerators began in March and data collection will take place between April and July, 2015 with the preliminary report due in October 2015 and the final report in December 2015.

During the quarter, TA also worked closely with MoHP, NHRC and EDPs (esp. USAID and WHO) to review the Institute for Health Metrics and Evaluation (IHME)/University of Washington's recommendations on the Burden of Disease (BoD) scoping study. The working group also conducted a mapping exercise to assess the current status, next steps, priorities and feasibility of the studies recommended to help: refine Nepal's BoD estimates; collaborate with in-country partners to ensure quality in country level estimates, and determine the feasibility of estimating burden of disease at the sub-national level in the near future.

Further, NHSSP advisors worked closely with NHRC and MoHP to prepare an action plan to take forward recommendations from the scoping exercise. As a follow on action, NHSSP advisors met with Nepal Police officials to discuss developing their database to better support BoD estimates, particularly in relation to suicide and road traffic accidents and to help inform policy development and programming.

NHSSP's research advisor also worked closely with PHAMED, NHRC and DoHS divisions and centres to develop a survey plan that will help MoHP gather the information needed to develop evidence based policies, strategies, plans and programmes. This will improve value for money in research by avoiding the duplication of surveys and waste of scarce resources.

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

see 2.1.4.

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.

Hospital Quality Improvement Process: As a part of the hospital QI process, Taplejung hospital carried out its 4th self-assessment on March 29th. Almost all indicators scored 'green' (achieved) with the exception of patient dignity (privacy) and electricity supply. In response, the hospital decided to provide plastic bags in toilets to help preserve patient privacy. Hetauda hospital plans to conduct its 5th round of assessments in mid-April. Encouragingly, both hospitals are undertaking these self-assessments without central support.

QAI TWG activities: Two meetings of QAI TWG were held (January 13th and March 2nd) despite the post of QA Section Chief in Management Division remaining vacant. The chiefs of M&E and Planning Sections have stepped in to assume responsibility for the QA Section's program. Vacant posts on the QAI TWG (QA focal persons from FHD, CHD, NHTC, PHCRD, NCASC, and NHEICC) following recent transfers were filled by Management Division with new members briefed on TWG roles and activities.

During the QAI TWG meetings, the following were discussed:

- progress (scores obtained in each quality domain, signal functions and number of actions taken by both hospitals, and support required from central level); the possibility of expanding QI provisions based on experiences to date; comparisons of progress from both hospitals; HQIP challenges; actions required by the TWG including data gathering, analysis and on-site support, and
- issues related to FP training sites that need to be addressed based on assessments carried out in Nepalgunj, Pokhara and Kathmandu e.g. no enabling environment for classroom clinical training; no ownership of training; the need for joint supervision
- monitoring (via NHTC and FHD) and the development of standard criteria for selecting training sites.

In addition to the above, support was given to the drafting of a QI Implementation Guideline and feedback is now awaited from the QAI TWG

NHSSP TA also coordinated with Nick Simons Institute (NSI) to link hospital QI processes with the wider hospital management strengthening programme. This involved participating in planning workshops in four districts (Bara, Rautahat, Mohattari and Sarlaya districts). Some duplication was found in the two systems which strengthens the argument to integrate the hospital QI process with broader hospital management strengthening processes. Actions will now be taken to further integrate and align both systems.

Based on learning from the Hetauda and Taplejung pilots, it is recommended that the hospital QI process be scaled up in a phase-wise manner to cover all district hospitals in the country. The development of tools and mechanisms for QI processes at referral hospitals should also be taken forward.

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

Follow up (through visits and telephone calls) was carried out in 6 referral hospitals and the following actions taken in response to initial plans made:

Hospital	Progress made against action plan
1. Seti Zonal Hospital, Kailali	<ul style="list-style-type: none"> Recruited 5 nurses, 6 ANMs, 1 anaesthetist/doctor, 1 lab assistant, 5 ward attendants/helper in labour room Processed bidding documents for tendering equipment completed constructed of bio-gas facility
2. Narayeni Sub-regional Hospital, Birgunj	<ul style="list-style-type: none"> Recruited 2 obs/gynae doctors; 6 ANMs, 6 SNs; 4 guards; placed 1 cleaner for post-operative from another department Put mattresses on two bed frames that can now be used; managed 2 mobile screens to improve privacy in labour room; Set up the OT, which is now equipped and supplied with surgical instruments. Installed new Autoclave in CSSD room Installed 8 benches for visitors in waiting areas
3. Western Regional Hospital, Pokhara	<ul style="list-style-type: none"> Added 8 extra maternity beds Processed bidding documents for supplies Repaired broken toilets Installed a baby warmer Recruited 10 nurses/ANMs using the current budget
4. Bharatpur Hospital, Chitwan	<ul style="list-style-type: none"> Recruited 2 medical officers, 2 lab technicians Painted all rusted beds/trolley with enamel Repaired toilets in waiting area, cashier area, PNC and gynae wards
5. Janakpur Zonal Hospital	<ul style="list-style-type: none"> Recruited 2 Ob/Gyn doctors, 5 staff nurses, 9 ANMs, 1 anaesthesia assistant, and 1 lab technician Made available a cautery machine Renovated doctor's room and assigned a security guard Processed open tender bidding for equipment and instruments Initiated rotation of duties of staff from each department to enable each to perform a wide range of duties in each department Installed and launched an electronic attendance system for staff Provided 20 dressing sets for quality care in the dressing section
6. Koshi Zonal Hospital, Biratnagar	<ul style="list-style-type: none"> Recruited 1 gynae, 4 medical officers, 3 SNs, 4 ANMs, 2 anaesthetic assistants Processed for open bidding to purchase equipment/supplies for maternity; provided 10 delivery sets

It should be noted that delayed budget release from MoHP to hospitals during the first two quarters of the current fiscal year slowed the pace of implementation of planned activities.

Support to strengthen the strategic birthing centre at Banke which complements the initiative was delayed due to staff recruitment difficulties at Banke DHO. Staff were eventually deployed to birthing

centres by early March 2015. Five ANMs (SBAs) from selected birthing centre were posted to Banke hospital for skills enhancement. The DHO also allocated funds for free referrals from these five birthing centres which are expected to begin from mid April. An evaluation of the approach taken to support the three referral hospitals and strategically located birthing centres is planned for Sept/Oct 2015.

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

The CEONC mentor together with NHSSP team continued their support to district and referral hospitals in order to improve the functionality and quality of CEONC services. Support visits were made in nine district and two referral hospitals. It was noted that the number of districts offering CEONC services has increased from 55 in December 2014 to 58 by end of March 2015. Two district hospitals (Taplejung & Bajura) re-started services and one new hospital (Rolpa) provided CEONC services for the first time. All three hospitals were able to function with staff employed by government and others contracted using the CEONC fund.

In the reporting period, CEONC mentoring was carried out in Khotang, Hetauda, Rautahat, Bara, Parsa, Bhaktapur, Sindhuli, Sarlahi and Dhading district hospitals and at Seti Zonal Hospital, Dhagadhi and Bheri Zonal Hospital in Nepalgunj. The recruitment and retention of staff remain the key obstacles to providing uninterrupted 24/7 CEONC services. The CEONC mentor guided staff on the effective recruitment and management of health staff including doctors, anaesthetic assistants, lab technicians, and nurses.

In order to establish CEONC services in Sindhuli hospital, FHD staff and NHSSP TA participated in a one day on-site planning workshop on 13th March. Approximately 65 participants, including the hospital team and officials from the CDO, DDC, UNFPA, Plan International, Nepal Red Cross Association, FCHVs, political representatives, journalists, took part. Following this meeting, DoHS issued a letter to transfer an anaesthesia assistant from Janakpur Hospital to Sindhuli Hospital such that the latter is now able to provide C/S services.

A similar exercise took place in Sarlahi on 14th March to better understand why CEONC services were not being provided. Hospital staff were guided in service provision and internal communications including decision making and running effective meetings. In addition, support staff and nurses were mobilized to clean the labour and sterilisation rooms. FHD's and MD's AWPB implementation guidelines were also shared with the medical superintendent and a decision taken to form a committee to utilize the hospital strengthening budget allocated in MD's AWPB 2071/72. The recruitment of a CEONC team (including a doctor, nurse, anesthesia assistant, and lab technician) was identified as the main priority.

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

During the reporting period, support was provided to FHD to develop the NHSP-3 results and monitoring framework, prepare the NHSP-3 implementation plan, finalize the costed implementation plan for family planning (2015-20) and prepare the Nepal Every Newborn Action Plan (2015-35).

NHSSP TA also supported FHD to carry out a RH review and planning workshop with partners.

Based on the study carried out in Banke district, the PNC job-aid was revised, printed and distributed to several hospitals and health facilities. These will help improve the quality of pre-discharge PNC following institutional delivery. More generally, TA supported the family planning section to revise its FP training packages.

TARF funds were used by NHTC to support staff visits to 9 SBA training sites (Amda hospital/Damak; Koshi zonal hospital/Biratnagar; Janakpur hospital/Dhanusha; Narayani sub-regional hospital/Birgunj; Bharatpur hospital/Chitwan; Western Regional Hospital/Pokhara; Mid-western regional hospital/Surkhet; Dhaulagari zonal hospital/Baglung; and Bheri zonal hospital/Nepalgunj) to support on QoC service delivery. The SBA Mentor funded by TARF helped support on onsite coaching of SBA trainers and to form QI committees..



Figure 1: NHSSP TARF funded staff discussing partographs with trainees.

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

(see 2.2.7)

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

NHSSP TA continued to support the DHO in Taplejung to implement the remote areas MNH pilot (RAMP). A mid-term review of RAMP was carried out in February with the participation of district and VDC/HF level stakeholders. The report “Remote Areas Maternal and Newborn Health (MNH) Pilot (RAMP) Mid-term Review of Progress: Preliminary Lessons Learned” was finalised in March.

Activities to strengthen selected health facilities included placing two ANM at the district hospital to enhance skills, reviewing HFOMC strengthening processes in all VDCs and carrying out quality of care self-assessments in six birthing centres. The RAMP project management committee met once and a district RHCC meeting was also conducted in March.

Taplejung staff also carried out a review of HMIS records and reports at health facilities for the last financial year. The need to do this was identified during the mid-term review as a result of mismatches found. Areas to improve were identified and action plans formulated to improve recording and reporting. This process is also seen to have enhanced the capacity of health facility staff to manage HMIS recording and reporting.

During the next quarter, the DHO will organise a district coordination meeting for the distribution of drugs and will continue to provide oversight and monitoring of the programme at VDC level. The project staff will focus on supporting and monitoring EAP activities and the establishment of a referral fund at health facility and community levels.

Two compelling case studies of a life saved and a life lost were prepared and are appended to this report as Annex 3.

2.2.7. Support to design and implementation of interventions to reach un-reached population in family planning

In the reporting period, the concept note for the FP/EPI pilot was revised and shared with HERD/MM and DFID. In Sindhupalchowk district a total of 156 health service providers running EPI clinics were oriented in 6 batches, each lasting two days. These orientation sessions focused primarily on the process for integrating FP/EPI services including the use of decision making flip charts, the WHO medical eligibility criteria wheel job aid, the counselling of postpartum mothers and the roles and responsibilities of various stakeholders and recording/reporting processes.

Further, implant training was provided to 8 government health workers in the district in 2 batches at the SPN/MSI training centre in coordination with NHTC. An experienced visiting provider (VP) also visited 11 birthing centres to assess the quality of FP services being provided. Based on this assessment, existing IUCD providers will now be coached to improve their technical skills.

A total of 664 HFOMC members and 695 FCHVs in all 79 VDCs in the district were oriented on the launch of the integrated FP and immunisation services and their support to mobilise communities requested. Following completion of the orientation programme, supervision visits were made by DHO staff and NHSSP to 17 facilities to assess progress made in integrating EPI/FP services and to strengthen the abilities of staff to provide these services.

For the visiting provider pilot, the revised concept note was shared with HERD/MM and DFID. Implant training was provided to 12 government health workers from Ramechhap district in 3 batches at Chhetrapati Family Welfare Centre (CFWC) in coordination with NHTC. The VPs also visited health facilities in their clusters to assess the readiness of health facilities to provide FP services and especially implant and IUCD services. Nearly 80% of all health facilities in the district were visited and the status of human resources, infrastructure, and service quality assessed. A contracted 'super coach' and mentor then provided 2 days of training on coaching skills for 3 VPs to boost their abilities to coach skilled birth attendants on IUCD service delivery.

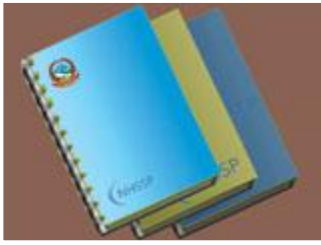
HFOMCs and FCHVs of all 55 VDCs of Ramechhap are currently being oriented on VP interventions and their support for community mobilisation requested.

For the VSC+ pilot, initial district consultation meetings were completed in both Baitadi and Darchula districts during which support for the pilot was sought. The VSC+ concept note will be revised based on the findings of these visits. The development, printing and distribution of IEC materials advanced with 6 types of IEC materials prepared. A flex containing a message on immunisation, HTSP and FP, an EPI/FP integrated service flow chart, and job aids were updated and printed while 2 job aids were reprinted. These materials were distributed to Sindhupalchowk and Ramechhap districts. In the coming quarter, some will be distributed to Baitadi and Darchula.

In the coming quarter, a district implementation planning workshop will be held in Darchula and Baitadi, the VSC+ concept note will be revised and shared and an implementation guide for the VSC+ pilot prepared. HFOMC/FCHV orientation in Ramechhap will be completed and the integration of FP/EPI services in Sindhupalchowk and VP services in Ramechhap advanced. The VSC+ intervention will also be introduced to Baitadi and Darchula districts and technical support visits made to all pilot districts.

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

SCI's quarterly progress report is included as Annex 2.



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

The draft outcome and outputs of NHSP-3 were shared during the JAR 2015 and comments received from the EDPs and other stakeholders incorporated. The Programme Development Team (PDT) organised a series of meetings to further refine and streamline the strategic document and the results framework. A first draft of the NHSP-3 Implementation Plan has been prepared in consultation with all departments and divisions.

The PDT is now preparing a final draft of the strategic document and results framework. These will be forwarded to the Steering Committee for endorsement following which they will be submitted to MoHP for approval and forwarding to the Cabinet. After the submission of these final drafts to MoHP, the PDT will finalize the Implementation Plan.

As decided during the JAR 2015, the PDT is also working to ensure that the AWPB for 2015/16 is aligned with NHSP-3's priorities.

In the coming quarter, the final draft of the strategy document and results framework will be prepared and a Steering Committee meeting convened to endorse it. This will then be submitted to the MoHP for approval. The draft AWPB 2015/16, which will be aligned to NHSP-3 priorities, will be presented along with the draft Implementation Plan at the second JCM following which the final draft Implementation Plan will be prepared.

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

See 3.1.1

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

No new developments in the reporting period.

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 the last reporting period, MoFALD provided indications of its willingness to integrate MoHP's Equity and Access (EAP) Programme into its Local Governance and Community Development Programme (LGCDP). This followed completion of a rapid assessment of Health and Governance Social Mobilisation Programmes in two districts carried out under PHCRD from which a summary note was produced with key findings and recommendations on the way forward.

Following feedback received from DFID a rapid situation assessment in the two focus VDCs of Dang district was planned and a concept note submitted to DfID for approval. Following extensive discussions it has been agreed to cease work on this initiative at the present time and reconsider it under NHSP-3.

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

In the reporting quarter, MoHP's revised SSU operational guidelines were formally approved by the health minister.

Backstopping support visits were made to SSUs at Maternity, Bir Hospital and Bharatpur Hospitals and guidance provided on the preparation of case studies in selected SSUs (Bharatpur, Bheri and Seti) to document compelling cases and good practices for presentation at forthcoming annual review workshops.

The ToR for the evaluation of the performance of pilot SSUs were finalized and consultants contracted to carry out the assessment which has now begun.

In the next quarter, an annual review workshop of SSUs will be organised by Population Division. The SSU evaluation findings will be presented to triangulate the findings and validate the recommendations. The SSUs will also be visited to review progress and performance as a result of capacity building inputs made by Population Division and NHSSP. TA will also help develop a road map for SSUs under NHSP-3.

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

Preparations including several rounds of meetings were conducted to orientate district officials and social auditors on the SA process (outline for orientation, finalisation of date and participants, requesting support from partner organisations). The preparatory work with PHCRD and districts for social audit evaluation is also on-going.

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

An OCMC annual national review workshop was held in the last quarter of 2014 which reviewed achievements, good practices, lessons learned and recommendations for strengthening and scaling up

OCMCs. NHSSP provided technical support for the workshop and prepared the workshop report which has now been shared with the concerned stakeholders.

TA support was also provided for the UNFPA supported development of GBV Clinical Protocols for front line health workers. The draft protocols developed have now been shared with the MoHP for finalisation and in due course will also be sent for translation.

With support from the Asia Foundation, a five days basic training on GBV and psychosocial counselling was held in February for 24 female police staff to help them support the Nepal Police's women and children units in the Kathmandu valley. This will be followed by police officer training in the 17 OCMC districts, at regional training schools and the Police Academy.

Earlier in the year, the GBV National Coordination Committee of OPMCM decided to prepare some integrated national GBV guidelines. The Ministry of Women, Children and Social Welfare and MoHP led this work while NHSSP helped prepare consultant ToR. TA also helped Population Division prepare a TARF proposal to support this work.

Further support to OCMCs remains a priority for NHSSP and a 17th centre was established in Puythan in the quarter. Orientation to the DHO, DPHO staff and concerned stakeholders, and the formation of a district coordination committee, also took place.

Based on the recommendations of the 2014 OCMC annual review, several best practice case stories were prepared. These document three OCMCs having different working modalities and performance levels. Consultations with various stakeholders for these case studies took place in Dhulikhel and Dang. In the next quarter these case stories will be finalized and shared with stakeholders.

The main challenge facing OCMCs is to achieve greater integration of services and make them effective one-stop service centres through greater collaboration between district and central levels and various sectoral organisations at local level.

it is important to mobilize and increase the capacity of service providers, community based outreach staff and support services so that GBV survivors and vulnerable groups are better informed about the available services and support systems at OCMCs.

Indicator 3.3: Aama unit costs identified

3.3.1 Review the Aama Programme

The final dissemination of the eighth DSF Rapid Assessments (RA) was held at FHD on 5th February 2015. Chaired by FHD's director, the meeting was attended by key stakeholders from NHSSP, UNICEF, WHO and Save the Children. The consultants incorporated comments made in the final draft submission which was subsequently endorsed by FHD.

Under RA VIII, NHSSP helped prepare the ToR and bid documents and provided overall guidance to the RH research subcommittee. TA also made technical inputs to help finalize tools, select samples, conduct training, analyze data and write the assessment report. A key learning point from this process was the importance of preparing a brief summary report to inform policy makers and managers. This is now being prepared.

ToR for the ninth DSF RA were approved by the RH research subcommittee with a notice requesting letters of interest from consultancies being published on 14th February 2015. Six research agencies submitted expressions of interest and a decision will be made in April.

Also in the quarter, a management note was prepared and shared with FHD's director, DG and DFID. This note was prepared on the basis of several studies and field visits to help the director and DG better understand the implementation status of the Aama programme and identify the roles of various institutions in addressing the issues and concerns identified.

Further, the Aama programme implementation status was updated using data from both public and private facilities. Where noncompliance with Aama programme guidelines was found, FHD sent corrective instruction letters.

Also in the reporting period, NHSSP with the support from international consultant began a review of demand side financing schemes with a special focus on the Aama program. ToR were shared with FHD and EPDs and interviews with key stakeholders were completed. The findings of the review will be presented to key stakeholders with the report due for submission in May 2015.

3.3.2 Conduct Unit Cost Analysis of Aama

Data collection, entry, cleaning and analysis for the unit cost analysis of Aama were completed and the scope of work for a data quality assurance consultant prepared. An analysis plan was developed with OPM in Oxford that assured the quality of data and conducted the analysis. Preliminary descriptive tables were sent to the lead consultant and the Nepal team is now addressing comments received and preparing the analysis report.

A key recommendation is to run a one day workshop to share preliminary findings and policy implications. NHSSP's health financing TA led the study process and will now help translate analysis findings into policy recommendations.

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

As noted, NHSSP is providing FHD with support to assess the implementation status of its Aama programme in both public and private sectors. Findings from the Aama rapid assessment, unit cost analysis and DSF review are expected to provide evidence to both improve implementation and draw out policy level recommendations. Priority activities for the next quarter are preparing a draft action plan based on study findings including discussions with stakeholders on the further expansion of Aama in the private sector. An assessment of related budgetary implications, support to FHD to recruit consultants for the ninth rapid assessment (RA-IX), providing guidance on its implementation and helping FHD prepare its AWPB 2015/16 and business plan are also anticipated.

4. Payment Deliverables

12 payment deliverables were submitted in the reporting quarter:

Mgmt.	M6	Quarterly report
CB-IMNCI	5	TOT and HF staff training for district technical staff (evidence = curriculum, session plan and attendance list)
DHIS2		Saipal - Completion of preparatory work for Nepal DHIS version 1 and DHIS2 application developed including dashboards for all programme
NFPP	FP1	Orientation and training of health facility in charge and service providers on FP/EPI integration completed in Sindupalachowk district
NFPP	FP3.1	District consultation and planning meeting completed in 2 districts
M&E	19.1	NHFS 2015 tools designed, pretested and customized in CAPI system in conjunction with ICF International with technical support from ICF International
Proc	7.2	50% Quality assured ICB's and NCB's documents achieved and report on procurement submitted
NHFS	2	Questionnaire pre testing completion report (15% of total costs)
RAMP	RA2	Mid-term review of programme completed and disseminated
M&E	20	Strategic survey plan developed as part of the NHSP-3 M+E framework with NHRC ensuring clarity on the survey needs and timing
TABUCS	T5	MOHP capacity to carry forward TABUCS built
CB-IMNCI	6	Mid-term report with confirmation that FCHV training completed

Annex 1: Publications Produced

No publications were prepared in the reporting period:

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

Quarterly Report for the period January – March 2015

Save the Children

**Technical Assistance for the Strengthening the Newborn Care Programme in
Nepal**

Save the Children International/SNL-DfID Programme in Nepal

List of Abbreviations

ANM	auxiliary nurse midwives
BC	birthing centre
BPP	birth preparedness package
BEONC	basic emergency obstetric and neonatal care
CEONC	comprehensive emergency obstetric and neonatal care
CB-IMNCI	community based integrated management of neonatal and childhood illness
CB-NCP	community based newborn care program
CHD	Child Health Division
CHX	chlorhexidine
DFID	Department for International Development
DHO	district health office
DoHS	Department of Health Services
ENC	essential newborn care
GoN	Government of Nepal
FCHV	female community health volunteer
HF	health facility
HFOMC	health facility operation and management committee
HMIS	Health Management Information System
LMIS	Logistics Management Information System
MNH	maternal and newborn health
MNCH	maternal newborn and child health
MoHP	Ministry of Health and Population
NHSSP	Nepal Health Sector Support Programme
OPD	outpatient department
PHN	public health nurse
PSBI	possible severe bacterial infection
QA	quality assurance
RHD	regional health directorate
SBA	skilled birth attendant
SCUK	Save the Children UK
SCUS	Save the Children US
SNL	saving newborn lives
TA	technical assistance
TSV	technical support visit
VDC	village development committee

Background

The Department for International Development (DFID) and the Nepal Health Sector Support Program (NHSSP) in partnership with Save the Children is providing Technical Assistance (TA) to the Ministry of Health and Population (MoHP), Nepal to strengthen newborn care approaches through the implementation of the Integrated Management of Neonatal and Childhood Illness (IMNCI) program from April 2014. The project has now completed 12 months since the project launch. This quarterly report documents the activities carried out during the fourth quarter of this project, covering the period of 1st January to 30th March 2015, and will focus on the activities carried out in the training, mobilisation, and maintenance phases.

The key activities completed during the quarter and the lessons learned during this phase are detailed below:

Overview of Key Project Activities from January to March, 2015

1.0 Roll out of the CB-IMNCI Package

1.1 Health Facility (HF) Level Training on CB-IMNCI

The first objective of the project is to support the development and early implementation of the Community Based Integrated Management of Neonatal and Childhood Illness (CB-IMNCI) program based on the Government of Nepal (GoN) approved package. Under this objective, a series of training sessions were organised in tiers, starting with HF level training followed by Female Community Health Volunteer (FCHV) training and mother's group orientations.

As of the reporting period, the remaining batches of HF level training have been successfully completed and 212 health workers have been trained in Nawalparasi in 20 batches. In the previous reporting period, HF level training was completed in Rasuwa and Nuwakot. All the planned trainings for the HF level have been successfully completed within the stipulated timeframe and a total of 754 health workers including Skilled Birth Attendants (SBAs) have received training in the project implementation districts against the target of 733 (103% of target achieved). The actual number of health workers trained exceeded the target as new health workers joined the health service during the training period.

The training covered the management of sick neonates and under-five children, management of low birth weight and birth asphyxia, counselling for mothers on the Birth Preparedness Package (BPP), Essential Neonatal Care (ENC) and a recording/reporting system strengthening in line with the Health Management Information System (HMIS). Following the training, the health workers appeared to have been employing the treatment protocols to manage the under-five children and sick neonates in their respective HFs, as found during the initial Technical Support Visits (TSVs).

The details of the health workers who received the CB-IMNCI package training are summarised below:



Fig 2: Practical session during the health facility level training, Nuwakot

Table 1: Details of Health Workers Training

District	Dates of training	# of Batch	Target	Total participants trained	Category of participants				
					Male	Female	Doctors	HWs/DHO	SBA/Nurse
Rasuwa	22 Nov - 18 Dec 2014	4	86	86	44	42	3	50	33
Nuwakot	21 Nov - 30 Dec 2014	12	247	248	130	118	12	141	95
Nawalparasi	25 Nov 2014 - 25 Jan 2015	20	400	420	202	218	9	232	179
Total		36	733	754	376	378	24	423	307

One of the most significant challenges identified was the transfer of trained and untrained health workers across districts. Health workers who had received training on the CB-IMNCI package were often transferred to another district while untrained staff were simultaneously transferred to the project implementation districts. Realising this, the project has now planned to provide training to new/transferred HF staff in Nuwakot, Rasuwa, and Nawalparasi, possibly during May 2015, using identified project savings.

Moreover, health workers have demanded to increase the training and travel allowances in comparison to the government rate. To minimise this issue, a standard rate needs to be developed jointly with the GoN and partners when scaling up the program further.

1.1.1 Monitoring of CB-IMNCI Program:

In this reporting period, during the final batch of the HF level CB-IMNCI training in Nawalparasi district, Mr. Chudamani Bhandari, CB-IMCI Chief, Child Health Division (CHD) and Mr. Dilip Chandra Poudel, Project Manager, SNL/SCI, monitored the training and supervised the facilitators. During the training, Mr. Bhandari stressed the need to focus on the management of neonatal cases and the rationale of the package. Additionally, Mr. Bhandari provided feedback to facilitators on how to optimise the training opportunities in order to cascade information at community level.

Following the completion of the HF level training, Mr. Bhandari also accompanied the monitoring visits with the District Health Office (DHO) and key project staff to ensure the implementation of the CB-IMNCI program and monitor the Birthing Centres (BCs). In addition, case management was observed and IMNCI Out Patient Department (OPD) registers and reporting forms assessed during the visit. Mr. Bhandari also visited two of the HFs in Nawalparasi: Pitaungighat HP and Dumkauli PHC, during the third week of January 2015. During the visit, it was observed that the case management skills of workers post training had improved compared to previous case records from the months prior to training, and the use of treatment protocol was also found to have increased. However, there were still gaps, particularly in the recording and reporting of the case management of under-five children. More strikingly, the number of under-two case referrals from the FCHVs was very low which required immediate attention. Based on these observations, on-site coaching and written suggestions were provided to all health workers during the debriefing meeting.



Fig 3: CB-IMCI section chief providing guidance for improving under-five case management in Dumkauli PHC, Nawalparasi

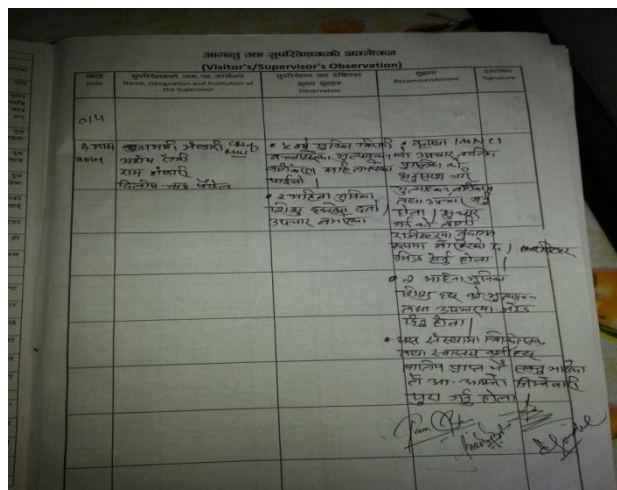


Fig 2: Written suggestions in the CB-IMNCI OPD register during visit, Nawalparasi

1.2 FCHV training on IMNCI Program

The HF level trainings were followed by community level training in the project districts, facilitated by consultants hired by the implementing partners together with HF level staff from DHO who had already received training.

The key objective of the training was to capacitate the FCHVs, who are the frontline workers at the community level, and upgrade their skills in managing and referring cases of neonatal and childhood illness. As of 30th March 2015, FCHV level training has been completed in Nuwakot and Rasuwa districts. Of the 1,368 FCHVs targeted in these two districts, 1,338 (98%) have received training. Training for FCHVs in Nawalparasi is ongoing and of the 54 batches planned, 36 batches of training have been completed as of 28th March 2015 with 442 FCHVs trained on the CB-IMNCI package. All FCHV level training is expected to be completed by 13th April 2015. The dates of the FCHV training, total batches, and district-wise details are provided below in **Table 2:**



Fig 4: FCHV Training, Nuwakot

Table 2: Details of the FCHV Training

District	Date of Training	Number of Batches	Target	Number of Participants
Nuwakot	2 Jan - 15 Feb 2015	64	1123	1106
Rasuwa	23 Dec 2014 - 24 Jan 2015	21	245	232
Nawalparasi	22 Feb 2015 - present (Ongoing)	36	713	442 (as of 28 March 2015)

Although the training mostly ran smoothly, most of the FCHVs were not satisfied with the allowance and demanded an increase. Moreover, lack of accommodation for the FCHVs was a barrier to effective learning, particularly for those travelling from far away areas.

Language and communication was another issue as the facilitators did not speak and understand the local language, while FCHVs who were illiterate and/or of an older age found the training more of a challenge. Therefore, it is necessary to take the language skills and learning abilities of the trainees into consideration at both the planning and implementation phases to ensure better training outcomes.

1.3 VDC/HFOMC Members' Orientation:

With the objective of raising awareness of the package at the community level and improving the uptake of the services by mothers, orientations for Village Development Committee (VDC)/Health Facility Management Committee (HFOMC) members were carried out in all three districts. The orientations further aimed to optimise the use of local resources from VDCs, foster support to FCHVs and increase the use of Maternal Newborn and Child Health (MNCH) services. The orientation sessions were jointly facilitated by staff from consulting firms and the DHO and emphasised the implementation modality of the CB-IMNCI package and their roles. The members were also oriented on the key interventions in CB-IMNCI, the use of chlorhexidine (CHX), the use of a foot length card to manage premature and low birth weight, and available MNCH services through HFVs or FCHVs. Altogether, 815 VDC/HFOMC members were oriented in Rasuwa and Nuwakot. The VDC/HFOMC member orientation is ongoing in Nawalparasi and as of 28th March 2015, 384 VDC members have attended the orientations.

1.4 Mothers' Group Orientation:

Orientation for mothers' groups was provided to raise awareness in the community and deliver the key MNCH messages to encourage the uptake and utilisation of services. This orientation was carried out in each ward the day following the FCHV training, running from 28th December 2014 to 24th January 2015 in Rasuwa with 2,548 mothers directly benefitting from the program. Similarly in Nuwakot, the training ran from 6th January to 15th February 2015 with 8,402 mothers attending. This activity is ongoing in the Nawalparasi district with around 36 batches of training completed as of 30th March 2015 and 18 batches still remaining to be held. A total of 7,737 mothers have already been oriented thus far. During the orientation, trained FCHVs delivered the MNCH messages using flip charts focusing on the importance of birth preparedness, the use of CHX gel, danger/referral signs during pregnancy, delivery, and post-natal periods. In addition, mothers were oriented on danger signs in newborns, ENC, and danger/referral signs in under-five children. Mothers from Rasuwa and Nuwakot districts, where the foot length intervention for management of premature and low birth weight at household level by trained FCHVs is being piloted, were also oriented in foot length measurement. Mothers from Nuwakot and Rasuwa were particularly interested in the foot length card as this was newly introduced to the district. A selection of quotes from the program has been presented below to reflect their impressions during the orientation.

"I quite like the concept of foot length card, it's easy to administer and helpful"

"...since we have phones at hand now, this foot length card program is very feasible and interesting and also supports the newborn"

"...unknowingly we have been following wrong practices in cord care so it's better to seek skilled care at birth"

A few FCHVs faced difficulties in facilitating the mothers' group orientation; in particular, those who were elderly and/or illiterate could not facilitate properly using the flip charts due to vision impairment and/or a lack of facilitation skills. In such instances, facilitators from consulting firms supported the FCHVs in delivering the sessions.

2.0 Strengthening Maternal and Newborn Care Services

2.1 MNH Update and Skill Standardisation

Maternal and Newborn Health (MNH) update and standardisation activities were carried out in Nawalparasi and Nuwakot districts. Two batches of training were organised in Nawalparasi district from 18th-20th February 2015 and 22nd-24th February 2015. A total of 44 nurses/SBAs were trained from different BCs including Comprehensive Emergency Obstetric and Neonatal Care (CEONC) and Basic Emergency Obstetric and Neonatal Care (BEONC) sites in Nawalparasi. Similarly, the same training package was conducted in Nuwakot district from 11th to 13th March 2015 with a second batch taking place from 15th to 17th March. A total of 52 service providers including nurses and auxiliary nurse midwives (ANMs) attended from different level BCs and BEONC and CEONC sites in both Nuwakot and Rasuwa districts. All the participants were involved in clinical simulations and practiced their techniques on models.



Fig 5: MNH update and standardisation

The post-training test results indicated that the participants were competent in conducting normal deliveries, third stage management and newborn resuscitation, and newborn care including cord care with CHX. In the first batch, the average pre-course assessment score was 70% whereas the post-course assessment score was 98%. Similarly, the average assessment score rose from 68% to 92% in the second batch. It is recommended that this program should not be limited to a one-time training program, but built in as a regular activity into the GoN healthcare system itself as it involves continuous learning and updates. The capacity of the MNH focal person should also be regularly enhanced to enable them to coach the SBAs at the BCs.

2.2 Joint Technical Support Supervision and Clinical Coaching

One of the key strategies to improve the knowledge and skill of the providers was through TSVs. A total of 46 TSVs were carried out at different BCs, including CEONC and BEONC sites, between January and March 2015 for providing technical/onsite coaching to the health workers/SBAs in all three districts. This included 17 BCs in Nawalparasi, 20 BCs in Nuwakot, and 9 BCs in Rasuwa. The activity was carried out jointly by the DHO focal person, SCI central/district based staff and experts from the consulting firms. During the TSV, it was observed that most of the HFs possessed the relevant treatment guidelines and protocols,



Fig 6: Onsite coaching to nursing staff, Nuwakot

and the case management was found to have improved compared with previous records. However, there were still a few areas that needed improvement such as general recording and reporting, temperature recordings, and some instances of variations in records and reports. The skills of the SBAs were further enhanced through onsite coaching during the TSV and feedback was provided to improve recording and reporting.

The regular monitoring and supervision from the DHO is vital to sustaining the quality of the services provided through BCs. This meant that the limited amount of actual supervision posed a problem in regular recording/reporting and ensuring service quality. After the TSV, the district-based SNL/DFID team along with the DHO staff have developed an action plan (summarising the issues, needs, and

suggestions for each site) to regularise the monitoring visits and ensure service quality. However, the implementation of the action plan with ownership from the government sector remains a challenge.

The district wise breakdown of the TSVs is summarised in **Table 4**.

Table 4: District wise breakdown of TSVs

District	Time period of the visits	Number of BCs visited	Number of BEONC sites visited	Number CEONC sites visited	Total TSVs
Rasuwa	1 Jan -1 Mar 2015	7	2	0	9
Nuwakot	23 Jan - 10 Feb 2015	16	3	1	20
Nawalparasi	30 Dec 2014 - 2 Feb 2015	11	5	1	17
Total		34	10	2	46

In addition, the project supported the establishment of a new BC in Ramche VDC in Rasuwa to improve access to birthing services in that particular locality. During this period, the technical team from Save the Children UK (SCUK) visited Nepal to support the Nepal country office team. Dr. Abdul Waheed, (Health Adviser, UK) and Ehtisham Ul Hassan (M&E Adviser, UK) visited Nuwakot BCs and Bhadrutar HF to monitor the BCs and oversee the FCHV training. During their visit, the team appreciated the newborn corner set ups and encouraged the SNL/DFID team to support to maintain the newborn corner as well as the labour rooms. Similarly, the HF staff were encouraged to regularly maintain the maternity registers and analyse the HMIS data. A DHO focal person was suggested to analyse the increasing number of deliveries, MNH related complications, case management of under-five children, and the current status of neonatal and childhood illness. The data analysis should then form an integral part of identifying the weaker performing indicators and help in further planning and monitoring.

2.3 Public Health Nurse (PHN) Exchange Visits

An exchange program was designed for PHNs to create cross-learning opportunities. The objective of the program was to enable the PHNs to learn about the situation of BCs at different districts and encourage them to maintain service quality in their respective districts through a competitive mindset. Additionally, the visit allowed PHNs to learn about the challenges faced by the BCs and possible ways to improve the quality service for MNH. This helped to motivate the PHNs to carry out frequent visits to BCs in order to keep the labour room and newborn corner well maintained and also helped to improve the readiness of BCs to provide quality MNH services through lessons learned from other districts. PHNs from Nuwakot visited Nawalparasi from 10th to 25th February 2015 and conducted TSVs at different BCs. Similarly, PHNs from Nawalparasi visited Nuwakot on March 10th to 14th 2015.

“The exchange visit is very productive; I can see now how the access to health facilities affects the service quality and utilisation. In contrary to the BCs in Nuwakot, the health facilities in Nawalparasi have good road access and the visit from the district level is also more frequent resulting in higher client flow and better service here in Nawalparasi than that of Nuwakot. When I go back, I plan to increase the visit to the BCs and further coach the SBAs.” - A PHN of Nuwakot

2.4. Supply of Commodities to HFs

During the reporting period, additional commodities were provided in the project districts, including 80 pieces of penguin suction supplied to each BC in all three districts, 270 CHX dolls (one in each HF and one per FCHV) in Rasuwa, and 6,690 CHX tubes (three to five tubes per FCHV) were provided during the training in Rasuwa and Nuwakot districts. Additionally, disposable syringes (10cc and 20cc) were provided for emergency pre-eclampsia and eclampsia cases and injection calcium gluconate was given to all BCs as emergency readiness to treat the side effects of magnesium sulphate. All HFs have an adequate stock of CHX tubes, so no additional supply of CHX was required this fiscal year.

2.5 Establishment of Newborn Corners

One creative approach applied by the project has been the setting up of newborn corners at BCs. These corners, made of local, low cost materials, seem to have had a very inspiring result in creating an enabling environment for institutional deliveries, particularly for BCs who were managing an increasing number of deliveries. For example, in Nuwakot BC, the number of deliveries rose from five during 15th July 2013 to 15th January 2014, to 16 deliveries during the same period in 2014/2015. The newborn corners improved the readiness of the HFs to receive newborns and also allowed for immediate



Fig 7: Setting up a newborn corner, Nawalparasi

management of asphyxia in newborns. The re-setup of the delivery room with newborn corners facilitated the easy handling of equipment and also promoted infection prevention. A total of 41 newborn corners have been established during this reporting period in Nuwakot, Nawalparasi, and Rasuwa districts. Altogether, 49 newborn corners have been established throughout the implementation period with minimal or no additional cost to the project.

3.0 Meetings and Workshops

3.1 CB-IMNCI Review, Reflection, and Planning Workshop

The CHD in coordination with MoHP and supporting partners organised a two day CB-IMNCI Review Reflection and Planning Workshop on 18th to 19th February 2015. The first day of the program was held at the National Health Training Centre in Kathmandu and the second day in Dhulikhel. The main objectives of the workshop were to review the lessons learned so far and also create a uniform understanding among the key stakeholders, as well as the harmonisation of the IMNCI activities across the country. Moreover, the workshop provided an opportunity to disseminate the newly developed IMNCI package and outline the implementation modality. In the workshop, SCI/SNL capitalised on the opportunity to share their experiences and lessons learned as initial CB-IMNCI implementers in the country. A total of 88 participants from the government sector (CHD, Regional Health Directorate (RHD), Department of Health Services (DoHS), DHOs, medical colleges, private hospitals, and other partner agencies participated in the meeting. Based on the lessons learned from SCI/SNL, the GoN decided to change the implementation module of the CB-IMNCI package and now the development of the new module by the CHD is underway. The project recommended developing context specific planning and prioritising the non-Community Based Newborn Care Program (CB-NCP) districts in the first phase of the scale up. In addition, a shorter training period was



Fig 8: IMCI Chief during the Review Reflection and Planning Workshop, Kathmandu

recommended for the CB-NCP implemented districts, and a new implementation module is being developed by CHD based on this feedback.

3.2 Meeting with Partners for Further Scaling up IMNCI Package

The IMCI section of the CHD held a meeting on 27th February 2015 under the chairmanship of Dr. Krishna Prasad Paudel, Director, CHD to follow up the CB-IMNCI reflection and planning workshop and to develop a consensus among the partners for further planning and rolling out of the CB-IMNCI package in all districts. The meeting was attended by representatives from the CHD, FWRHD, H4L, Care Nepal, Suaahara, USAID, One Heart Worldwide, CNCP, ADRA, UNICEF, GIZ, WHO, and SNL/SCI.

The main focus of the meeting was to develop consensus in selecting the project districts among the partner organisations for the scaling up of the IMNCI package. In addition, the meeting also revised the dose of amoxicillin for under-five children, focusing on the age and weight of the child based on the WHO Protocol.

The agreed scale up plan with the implementing partners is presented below:

Table 5: Scale up plan

Implementing Partner	Districts
Care Nepal	Dadeldhura
UNICEF	Kalikot, Mugu, Humla, Jumla, Saptari
Suaahara	Bhojpur, Sankhuwasabha, Dolakha, Lamjung, Myagdi
Save the Children	Nawalparasi, Nuwakot, Rasuwa
H4L	- Training site development and support during training in Surkhet and Rukum
ADRA	Jajarkot
Plan- Nepal	Makwanpur, Sindhuli, Rautahat, Sunsari, Banke, Morang
GoN	Okhaldhunga, Dhanusha, Sindhupalchok, Tanahun, Syangja, Kaski, Rukum, Surkhet, Dailekh, Achham, Doti. Gulmi and Ramechhap through USAID funding

3.3 Meeting with NHSSP/Options

A meeting with NHSSP/Options was held at the NHSSP office in Teku on 11th March 2015 in the presence of Dr. Maureen Dariang, Essential Health Care Service Advisor, NHSSP, Mr. Krishna Sharma, Head of Program Management, Option/NHSSP, Mr. Bharat Ban, National Program Manager, SCI/SNL, and Mr. Dilip Poudel, Program Manager, SCI/SNL. Key discussions from the meeting are presented below:

- The submission of payment deliverables has been revised because FCHV level training in Nawalparasi is expected to take place on 8th April 2015 and the compilation of the report may take time. Therefore, milestone seven, “Completion of IMNCI FCHV level training”, will be submitted on 30th April, and the payment milestone will be submitted on 22nd May 2015.
- The contract extension for two months up to September 2015 was brought up during the meeting where it was decided that the agenda will be further discussed. The SNL/DFID team will provide further updates on the additional activities for the no-cost extension period.
- Key updates on the ongoing program were presented.
- The context and development of the new program management module based on the experiences of SNL/DFID as early implementers was deliberated.
- With regards to the final evaluation of the project, it was decided that SCUK and Save the Children US (SCUS) will send the TOR to Options UK.

3.4 Visit from the SCUK Team for TA

With the overarching goal of supporting the SNL/DFID Nepal team, a team of experts from SCUK visited Nepal from 7th to 14th February 2015. The team was comprised of Dr. Abdul Haq Waheed, Senior Maternal and Newborn Health Advisor, and Ehtisham Ul Hassan, Monitoring and Evaluation Advisor. The main objectives of the visit were:

- to discuss and review the status of implementation of CB-IMNCI program in the districts
- to visit a sample of BC/BEONC sites and provide feedback and suggestions for improvement
- TA support to prepare the midterm progress report
- TA support for finalisation of modality to conduct the final project evaluation/end line survey
- TA support in preparation of TOR for external consultants to conduct the end line survey

After visiting the project districts and updating the overall project activities the team recommended the following key actions for further strengthening of the program:

- intensify efforts to enhance program quality during the remaining project period
- SCI/SNL project team to work more closely to learn from this experience and achieve expected outputs of the project in the remaining time
- carry out more frequent TSVs
- follow up on procurement of essential commodities to ensure improvement in quality of care at SC supported HFs
- analyse/use data collected from district focal points and promote use of data analysis in consultation with focal persons
- HF staff should be supported in carrying out a basic analysis of the collected data as well
- provide continuous support from the country team to improve the quality of CB-IMNCI project reports
- demonstrate and present creative actions (e.g. infrastructure improvement, clinic set up/cleaning, improvised newborn beds) that highlight part of the enabling environment to the DHOs and HFOMC members which will have a motivating and encouraging impact on both staff and local committee/communities for further support, utilisation, and maintenance

4. Other Activities Carried Out at District Level to Strengthen Health System Delivery

Some of the activities carried out at district level to strengthen the health service delivery are detailed below:

4.1 Support in Monthly and Quarterly Review Meeting at the District Level

SCI district based staff supported the quarterly review meetings through coordinating and communicating with the partner organisations. SNL/DFID district staff presented on the MNH activities carried out by the team and also reinforced the issues of maternal and newborn care at the district level. Moreover, project staff also provided support in the form of data analysis and developing templates for the presentation to be sent to the peripheral organisations with a special focus on MNH reporting. The template was designed to capture the key indicators of MNH. During the meeting, participants discussed poorly performing indicators and prepared an action plan for the next quarter. The project staff also facilitated HMIS data verification. SNL/DFID district staff assisted in compiling and cross verifying the reports with the HF level records together with the district HMIS focal person, and provided feedback and suggestions on improving the data quality. They further advised the HMIS focal person on timely report submission.

4.2 Organising and Regularising the Monthly Review Meeting

The SNL/DFID Project also provided technical support in organising and regularising the monthly review meeting. Project staff attended two monthly review meetings in different Illakas and encouraged monthly HMIS/Logistics Management Information System (LMIS) reporting from peripheral level to district level. District level health indicators (1st ANC visit, 4th ANC visit, institutional delivery, immunisation, nutrition, case management of neonatal and child health problems) were presented and analysed. Furthermore, issues surrounding newborn care services such as labour room set up, management of emergency drugs, sanitation of HFs and infection prevention measures for health workers were also discussed. In Nuwakot, district staff capitalised on the opportunity to discuss the newly piloted foot length intervention and use of CHX during the meeting.

4.3 Support in Organising the Reproductive Health Coordination Committee (RHCC) Meeting

SNL/DFID staff at field level attended the RHCC meetings and provided technical support in organising the meetings. Participants were made aware of the achievements against the planned activities of DHO and different supporting agencies working in the district, and all the participating stakeholders committed to work in coordination to improve the number of antenatal visits by mothers and institutional deliveries in the district among other MNH indicators. Since a number of different organisations are working in MNH in the district, the focus of the discussion was on developing clarity among the partners and identifying areas requiring tailored support by each organisation.

4.4 Regularising the Quality Assurance (QA) Meeting in Rasuwa District

A review of the reports from the first phase of technical supportive supervision was conducted by three consortiums at three focused districts. The 9-11 member QA committee was formed based on the QA guidelines of GoN and chaired by the DPHO. SCI/DFID supported the formation of the committee and coordinated with the committee members for regularising the meeting, documenting the meeting, and following up on decisions from previous meetings, along with providing financial support for refreshments. During the meeting, issues on maternal and neonatal health were discussed and areas of support identified. As of 31st March 2015, two meetings have been conducted based on the QA guidelines and the following issues have been discussed:

- review of CB-IMNCI training at HF level
- monitoring of the FCHV level training
- planning for BC/BEONC site setup and monitoring as per MOHP standards
- review of FCHV level training

QA meetings are documented and a system has been developed for regularising meetings. The QA committee has a plan for supervision and monitoring the program and followed activities as per the plan developed.

5.0 Future Activities

The following additional activities deemed to have added benefit to the project have been planned in the designated districts and will be funded by the savings from the previous project activities.

1. CB-IMNCI training to new/transferred HF staff

There are still sizable numbers of untrained health workers (25 staff in Rasuwa, 50 in Nuwakot, and 47 in Nawalparasi) who have been recently transferred during the project period, and additional CB-IMNCI training has been planned for these staff members in the coming month. The project will closely coordinate with CHD and DHO to conduct this activity.

2. IMNCI Review meeting with the HF In Charges

To improve and maintain the program quality, IMNCI review meetings will be carried out in all three districts. A two day meeting will be carried out in each district to review post-training performances.

3. Orientations for drug retailers/pharmacists

The CHD has decided to provide a one day orientation for drug retailers/pharmacists in the IMNCI implementation districts. Based on the revised implementation guidelines, the orientation will focus on the use of drugs for cases of diarrhoea and pneumonia in children aged under five, and Possible Severe Bacterial Infection (PSBI) for young infants aged under two months. This activity will be carried out in close coordination with each district's drug retailers' association and the DHO.

4. Development and printing of the MNCH handbook

A booklet to be used as a tool to promote the health of mothers, newborns, and children in the community has also been proposed to be produced with the unspent funds. SCI/DFID will be working on the MHN handbook development in partnership with VSO, FHD and CHD. This booklet is expected to address and record the continuum of care and will be piloted in five districts, one in each region.

Remaining activities as per the agreement:

1. FCHV Training report (deliverable #7)
2. TSV findings sharing at district level
3. Follow up after training of CB-IMNCI
4. End line Evaluation (deliverable #9)

Annex 3: Remote Area Case Studies

Case Study 1: Baby Limbu Survives Due to the Efforts of Lingkhim Health Post

Twenty-one year Kabila Limbu of Khejenim 3, Taplejung, eastern Nepal became pregnant for the first time in June 2014. She attended regular antenatal check-ups at her local health post at Lingkhim from the fourth month of her pregnancy after her interaction with the local social mobiliser. Her labour pains began at 5am on 19 March 2015 and her husband and in-laws took her to the birthing centre at Lingkhim Health Post.

She was admitted at midday complaining of the normal labour symptoms of lower abdominal pain, backache and vaginal discharges. I (the auxiliary nurse-midwife, ANM) found the condition of the mother and foetus to be normal. The foetal heart rate was regular at 140 beats per minute and the mother's cervix was open at 8cm wide. She had good regular and strong contractions. My only concern was that the baby's head was high. We closely monitored the mother and baby.

At 4:30pm, we found the mother's cervix to be fully dilated, but the foetus's meconium (the dark green faeces of the foetus) was staining the amniotic fluid in the womb indicating that the foetus could be having difficulties. So we closely observed the foetal heart sound and the mother's condition. We waited until 7 pm, but still the mother couldn't push the baby down. We then took the consent of her husband and tried vacuum delivery three times, but without any success. We strongly suspected shoulder obstruction of the foetus but were unable to do anything about it.

At 7.30 pm we phoned the district hospital, told them about the case and were advised to bring the mother as soon as possible (the hospital lies about four hours' drive away). It took about two frustrating hours to find a vehicle. A colleague and I accompanied the mother and husband and took along equipment to deliver the baby on the way.

At 1.40 am, after four hours drive from the health post, the mother had very strong contractions. We delivered the baby in the vehicle. He was in a bad condition looking very pale with no pulse, no reflexes and no breathing.

We wrapped him up and used a suction bulb to clear his breathing passages and an ambu bag to give him extra oxygen. The baby did not respond the first time we did suction on his mouth, resuscitation and stimulation. There was no sign of life and everybody thought he was lost. We tried a second time and eventually the baby came around and started to cry.

Everybody felt so happy as nobody had expected him to live. We gave the mother an oxytocin injection to reduce post-delivery bleeding and soon reached the district hospital and handed the mother and baby over to the care of the doctors and nurses.

A month after this difficult case and the mother and baby are healthy and we feel a strong sense of satisfaction at having saved the life of baby Limbu.

As told by Krishna Limbu, ANM, Lingkhim Health post

A large part of the credit for baby Limbu's survival can be attributed to Taplejung District Health Office (DHO) that has improved the awareness of local communities about maternal and newborn care and the strengthening of local health facilities to provide care. The Family Health Division and the Nepal Health Sector Support Programme (NHSSP) are supporting the DHO under an ongoing initiative (RAMP) to identify the most cost-effective strategies for improving access to MNH care across Nepal's many remote areas.

For the first few months of her pregnancy Kabila was not getting antenatal checkups nor was she taking the recommended iron-folic acid supplements. She started attending RAMP's MNH awareness sessions at her local mother's health group in October 2014. This convinced her to go for ANC checkups, take iron supplements and deliver at a health facility. She also took part in a husband-wife interaction that improved her husband's understanding about pregnancy danger signs and the support that Kabila needed. These awareness raising activities were run by the local NGO the Nepal Women's Entrepreneurs Association.

In 2014/15 the DHO has had considerable success in strengthening the MNH services provided at several health posts in remote areas of Taplejung (including Lingkhim Health Post). The ANM Krishna has recently attended an SBA refresher course, and the DHO provided intensive support for maintaining the necessary equipment and supplies to deal with complicated births. These improvements and the ANM's strengthened links with the district hospital for referring cases played a huge role in saving baby Limbu's life.



Father, mother and baby



Mother and baby

ANM Krishna standing outside Lingkhim Health Post holding the ambu bag and suction bulb that helped save the bay's life

Case Study 2: Basanti Died Soon after Giving Birth

The importance of improving access to MNH services was brought home to the project team by a woman dying in child birth in one of the project's VDCs in January 2015 (Box A). This was a tragic lesson for the project of a woman who was not reached.

Box A: She died soon after giving birth

A woman in the equity and access programme (EAP) area had married when she was only 14 years old. She had a difficult marriage as her husband often got drunk, her in-laws were not supportive and her first child died at four days old.

In 2014 the RAMP social mobiliser came to know that the now 18-year old woman was pregnant with her second child. She had not been participating in the RAMP MNH awareness raising meetings. The mobiliser went to her home in September 2014 and after a long discussion she admitted that she was six months pregnant. She was alone as her husband and in-laws were in Jhapa district on their personal work, a day's bus ride away.

The woman said she had never visited a health facility for an ANC check-up and had never taken iron supplements. The mobiliser invited her to participate in the next mothers' group meeting; but she did not come. She only attended after the mobiliser and local FCHV asked her again.

At her first meeting, the other members tried to convince her to go for an ANC check-up. She said she would, but did not. Neither did she go to the nearby primary health care outreach clinic for a check-up. The main reason for her not attending was the negligence of her husband and in-laws and the fact that the health facility was far away (2.5 hours walk away).

On 23 January 2015, nine months into her pregnancy, her labour pains started at 4 am. She delivered her baby at home the next day. She, however, had a retained placenta and due to heavy bleeding became unconscious. Even in that situation, her husband and mother-in-law did not try to take her to the health facility and instead called a traditional healer. After the woman had been unconscious for a long time, a neighbour went to the health post to call a health worker.

In the meantime the woman became conscious for a short while but soon after became unconscious again and died at 1 pm on 24 January 2015 leaving her baby daughter behind. *We cannot imagine the pain and feelings of despair she must have felt.*