NHSSP Nepal Health Sector Support Programme

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Nepal Health Sector Support Programme

Quarterly Report with Annual Summary

Photo: DFID

PD M10 Quarterly Reporting Period: July – September 2015 with Annual Summary

Contents

Acronyms and Abbreviations

AA	anaesthetic assistant
ADRA	Adventist Development and Relief Agency
ANM	auxiliary nurse midwife
ASBA	advanced skilled birth attendant
AWPB	annual work plan and budget
CA	Constituent Assembly
CAPP	consolidated annual procurement plan
CBIMCI	community based integrated management of childhood illness
CBNCP	community based newborn care package
CEONC	comprehensive emergency obstetric and neonatal care
CHD	Child Health Division
CMS	contract management information system
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
EWARS	early warning and reporting system
FCHV	female community health volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FMR	Financial Monitoring Report
FP	family planning
FY	fiscal year
GBP	Great British Pound
GBV	gender-based violence
GESI	gender equality and social inclusion
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
HMIS	Health Management Information System
HQIP	hospital quality improvement process
HR	human resources
HuRIS	Human Resource Information System

IP	infection prevention
IT	information technology
IUCD	intrauterine contraceptive device
JAR	Joint Annual Review
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
KFW	Kreditanstalt für Wiederaufbau (German Development Bank)
KOICA	Korean International Cooperation Agency
LARC	long acting reversible contraception
LMD	Logistics Management Division
LMIS	Logistic Management Information System
M&E	monitoring and evaluation
MD	Management Division
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
MWCSW	Ministry of Women, Children and Social Welfare
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
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPC	National Planning Commission
O&M	Organisation and Management
OAG	Office of the Auditor General
OB/GYN	obstetrics/gynaecology
OCMC	one-stop crisis management centre
OPM	Oxford Policy Management
OPMCM	Office of the Prime Minister and Council of Ministers
PBGA	performance based grant agreement
PD	Population Division
PDT	Project Development Team
PFM	public financial management
PHAMED	Public Health Administration, Monitoring and Evaluation Division
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
PNC	postnatal care
PPICD	Policy, Planning, and International Cooperation Division
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

RAMP	remote area maternal and newborn health pilot
RH	reproductive health
RHCC	reproductive health coordination committee
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
VP	visiting provider
VSC	voluntary surgical contraception
WB	World Bank
WB-PQ	World Bank procurement quality
WDO	Women's Development Office
WHO	World Health Organization

1. Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit its combined quarterly report for the period July-September 2015 and summary annual report for 2014/2015, the fifth and final year of the programme which closes in December 2015.

The reporting quarter began nine weeks after the 7.9 magnitude earthquake that hit Nepal in April 2015 killing around 10,000 people and seriously affecting over half a million people. Given the disruption caused by the earthquakes, this report inevitably references aspects of the TA programme's earthquake response but generally aims to limit its reporting to contracted NHSSP activities. The first quarterly report on DfID funded, and NHSSP implemented, Health Sector Transition and Recovery Programme (HSTRP) which addresses earthquake response issues follows in November 2015.

Background to NHSSP

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).
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.

Section 2 of this report provides a brief narrative summary of the main activities and results delivered by NHSSP in the programme year October 2014 - September 2015 but falls well short of reporting programme results at outcome and output levels. This will be done at programme end in December through a final report. Section 3 provides a detailed account of the last quarter's TA activities and results.

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;
- the individual work plans of advisors;
- requests from MoHP for technical support.

All adviser work plans have been agreed with respective ministry 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, prepare the ground for NHSP-3 and respond to urgent needs. 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 (2014-15)

Following seven years of, at times, fractious deliberations, Nepal's Constituent Assembly finally passed the country's new federal constitution which came into effect on 20th September 2015. This completes Nepal's long awaited transition from a Himalayan monarchy to a secular multi-party democracy.

The constituent assembly has now transformed into a full-fledged parliament with K.P. Oli (United Marxist Leninist party) replacing Sushil Koirala as prime minister of a new coalition government that will lead the country until new elections are held at an, as yet, unspecified time.

Government financing for health in Nepal saw MoHP's budget in 2014/15 rise to NPR 33.5 billion (GBP 0.2 billion), or 5.4% of total national budget, an increase in real terms over the preceding year though less than the 6% sought. The 2015/16 budget for services and health systems development was significantly disrupted by funds needed for emergency response measures.

Health sector coordination and planning made important strides, principally through January 2015's Joint Annual Review (JAR) which helped build strong alignment around Nepal's new Nepal Health Sector Strategy (2015-20) (NHSS (2015-20), formerly known as the Nepal Health Sector Programme – 3 (NHSP-3). NHSS (2015-20) officially started in July 2015 but the operational and budgetary demands of post-disaster recovery efforts and uncertainties over EDP financial commitments and tools in the coming years have effectively delayed implementation.

As reported in NHSSP's 2nd quarterly report for 2015, the earthquakes of Spring 2015 seriously disrupted Nepal's public health services and, overnight, changed the Ministry's focus to the provision of emergency services, medical evacuations and the supply of essential medicines and goods, including temporary health facilities, to the hardest hit areas. Within weeks, emergency relief efforts gave way to MoHP-led district needs assessments and coordinated action with development partners to restore essential health care services in the 14 worst affected districts. NHSSP's advisers joined ministry counterparts in these efforts, putting existing work plans aside to provide support to the MoHP to help address the humanitarian needs and influx of humanitarian support.

Despite this disruption and the responsiveness and flexibility of the team, significant progress was made against NHSSP's three programme outputs in the programme year October 2014 – September 2015 as summarised below.

Output 1: Strengthening Core Health System Functions

Progress in ***procurement*** through the Logistics Management Division (LMD) included the further expansion of its ***web-based technical specification bank*** for medical equipment, drugs and other

materials. This reached 1532 entries (472 pharmaceuticals and 1060 equipment) against combined phase 1 and 2 targets of 400 and 1100 respectively. The databank is available on LMD's website (www.dohslmd.gov.np) and widely used in Nepal and regionally. A value for money (VFM) case study carried out in the year showed that a minimum return of £2.6 for every £1.0 invested is being achieved by the bank.

Progress made on other quality assurance (QA) mechanisms included finalisation and national roll out, in collaboration with Health for Life (H4L), of LMD's electronic ***Contract Management System*** (CMS) to help evaluate bids and track procurement progress.

An important achievement in the year was the preparation by LMD of the ***2014/15 consolidated annual procurement plan (CAPP)*** for DoHS. This is the third successive year that a CAPP has been prepared and, while procurement progress has been slow for a number of procedural and governance related reasons, the consolidated plan promises to improve overall procurement and cost efficiencies due to the potential for bulk purchasing and distribution.

Important discussions on ***procurement reforms,*** including the role and authority of LMD took place in the year with agreement reached to take this forward under NHSS (2015-20) beginning with the commissioning of an organizational and management study linked to the earlier agreed procurement reform concept note and action plan.

Evidence of important progress made in ***public financial management*** (PFM) in the year was MoHP's timely submission of its 3rd ***Financial Monitoring Report*** (FMR) for 2014/15 and the preparation of a central book of audit queries. The latter was a result of implementing MoHP's new ***Internal Financial Control Guidelines and Audit Clearance Guidelines***. The value of total audit queries against audited expenditure in 2013/14 was NPR 2.39 billion (11.5% of total expenditure), down from 13.8% in the previous year.

MoHP's innovative ***Transaction Accounting and Budget Control System*** (TABUCS) was further developed to include a budget authorisation facility and, following extensive training and IT investments, was successfully rolled out across MoHP's 280 cost centres. To date, TABUCS has captured 59% of MoHP's FY 2015/16's financial data[1]. To support tracking of the system's effectiveness, a TABUCS monitoring framework was also developed.

Health infrastructure design, planning and construction management advanced with ***technical standards for health facilities upgraded*** to include electrical, water and sanitation services and ***land selection guidelines*** for new and upgraded facilities endorsed and taken into use across the country. Costed architectural designs were also prepared for the retrofitting of outdated zonal and regional hospitals and for public health laboratories.

Improved management of Management Division's (MD's) ***Health Infrastructure Information System*** (HIIS) facilitated the preparation of a ***Consolidated Annual Procurement Plan (CAPP) for infrastructure***. This was seen to reduce political interference in project selection and simplify tendering processes. The tracking of construction progress through HIIS provided the evidence needed to fine delinquent contractors for time overruns and, accordingly, construction progress rates were seen to improve.

[1] The higher figure reported in our quarterly report for April-June 2015 was for cost centres out of the Kathmandu Valley only.

Essential post-earthquake activities in infrastructure included preparing a ***14 district health infrastructure master plan*** and the completion of detailed needs assessments of damaged health facilities in 13 districts with one district ongoing at the time of writing. Technical designs, specifications, bills of quantity and construction guidelines were also prepared for ***prefabricated health structures*** which are needed to provide health services in the hardest hit districts.

Output 2: Strengthening Information and Monitoring Systems

Under ***monitoring and evaluation***, NHSSP supported MoHP to develop a ***unified coding system*** to enable the greater integration of management information system (MIS) data sets in order to improve analysis service use and public health status. A ***registry of all health institutions*** with unique identification codes was subsequently prepared.

A major collaborative achievement with WHO, GiZ and others in the year was the development of the ***Nepal District Health Information System 2 (DHIS2)*** - an adaptable globally recognised IT platform suited to hosting MD's Health Management Information System (HMIS). DoHS is rolling out DHIS2 for HMIS at health facility level in the 14 earthquake affected districts and at DHO/DPHO level in the other 61 districts.

Management Division's ***revised HMIS*** was successfully rolled out in the year following extensive training and IT investments and support from five HMIS coordinators who aided districts and health facilities - particularly hospitals - requiring assistance. NHSSP coordinated with MD and EDPs for the printing and distribution of ***HMIS recording and reporting tools*** which were distributed to 38 districts.

The revised HMIS and other information management systems such as the Logistic Management Information System (LMIS), Health Infrastructure Information System (HIIS), annual Service Tracking Survey (STS) and Nepal Multiple Indicator Cluster Survey (NMICS) provided the information and insights needed to effectively monitor ***NHSP-2 outputs and outcomes*** and provide effective indicators and baselines for ***NHSS (2015-20)***. Here TA coordinated with EDPs (notably WHO, UNFPA, UNICEF and H4L) to help MoHP prepare the strategy document, a ***monitoring and evaluation strategy and results framework***. Baseline values and targets for most key indicators have been agreed together with disaggregation levels and measurement/data sources.

TA also worked with MoHP and EDPs (esp. USAID, WHO, UNFPA and ICF International) to develop tools and implement the first **Nepal Health Facility Survey (NHFS),** 2015. Data collection was outsourced to a local research organization New ERA and is expected to be completed by mid October 2015. MoHP is currently designing the structure of a 'Key Findings Report' to be disseminated ahead of the main report.

NHSSP's M&E advisers also began work with DfID's health advisers to further analyse Nepal's recent ***National Demographic Health Surveys*** (NDHS's 2001, 2006, 2011) and **NMICS 2014** to assess trends and gaps in health status, practices and service utilisation related to reproductive, maternal, newborn, fertility and mortality indicators. Further, advisers supported FHD to plan, design and implement a monitoring and evaluation plan for the ***'Remote Areas MNH Access Pilot Project'.***

Under **essential health care services** the piloting of FHD's ***hospital quality improvement process*** (HQIP) began to yield promising results. QI committees in Taplejung and Hetauda district hospitals conducted 4 and 3 assessments respectively using QI self-assessment tools, completing 48 out of the 65 (74%) activities planned. These actions related mostly to human resources, supplies/drugs, and use of the CEONC fund. Challenges identified included difficulties recruiting anesthetists, waste management and obtaining information and education communications (IEC) materials, equipment and supplies from the centre.

Based on the lessons learned from Hetauda and Taplejung hospitals, the high level QI technical advisory committee (TAC) has proposed that the HQIP approach be rolled out using FHD's ***QI implementation guidelines*** to cover all health facilities in each district and include provision for a feedback mechanism for health workers and regular support visits. FHD has made plans to scale up HQIP in 10 districts in the current financial year.

Activities to address ***overcrowding*** in ten referral hospitals showed encouraging impact principally as a result of using a similar planning–action–review–planning cycle as that followed in HQIP supported by a dedicated ***'overcrowding' fund*** from FHD. The fund was used to hire 11 OBGYN/MOs, 5 anesthetist doctors, 2 anesthetist assistants, 93 SN/ANMs, 29 helpers/guards and a medical recorder and to purchase equipment such as cardiac monitors, autoclaves and surgical instruments. Major challenges faced were delayed budget release and insufficient funds to purchase essential anesthesia machines. Resulting improvements in the quality of care are suggested by stillbirth reductions in Bheri Zonal and Naraeni sub-regional, though not at Seti Zonal hospitals:

Hospitals	**FY (2070 – 2071)**		**FY (2071– 2072)**	
	Institutional Deliveries	**Total still births**	**Institutional deliveries**	**Total still births**
Seti Zonal Hospital	5912	78 (1.32%)	6177	100 (1.61%)
Bheri Zonal Hospital	5004	222 (4.43%)	4236	177 (4.18%)
Narayeni Sub Regional Hospital	7270	81 (1.11%)	7377	56 (0.76%)

The ***strategic birthing centre*** approach, including free referrals for obstetric complications, was piloted at five health facilities in Banke in the year. Delays in recruiting auxiliary nurse midwives (ANMs) delayed start up but the DPHO pushed ahead to orientate health facility operation and management committee (HFOMC) members and facility staff, and worked with the district ambulance committee to launch a ***free 24-hour ambulance service***. Further, the DPHO allocated funds to allow free referrals from the birthing centres. In 2071-72, 33 obstetric complications were referred from four strategic birthing centres to Bheri Zonal Hospital, 20 of these after launch of the programme. Institutional deliveries in the five SBCs rose from 587 in 2013/14 to 747 in 2014/2015 (+27%).

The number of districts set up to offer ***CEONC services*** increased from 54 in December 2014 to 61 by end of June 2015 but with slow budget release affected functionality in a number of facilities at various times in the year.

In support of FHD efforts to better understand how to strengthen maternal and neonatal health services in remote areas, TA continued its support Taplejung's DHO to implement the ***remote areas MNH pilot***. An internal mid-term review was conducted by the DHO and stakeholders in

February 2015 which showed that, with the exception of the supply of some equipment, all planned demand and supply activities had been completed including obstetric training for paramedics.

Following inputs to strengthen HFOMCs, a review was also carried out in the 10 health facilities in the pilot. This showed improvements in management capacities and the quality of MNH service provision. Further, seven birthing centres had established or strengthened ***referral funds*** for obstetric complications while, at community level, 65 mothers' groups had started emergency referral funds, holding an average of NPR 6,000.

In f***amily planning (FP)***, in Sindhupalchowk 4,378 postpartum mothers attended group health education sessions in expanded programme of immunisation (***EPI) clinics*** of whom 1,168 (27%) went on to receive FP services from these clinics between February and mid August, 2015. ***Visiting providers*** in Ramechhap provided 782 implants and 61 intra uterine contraceptive devices (IUCDs) in the same period. In the voluntary surgical contraceptive (***VSC)+ pilot*** in Baitadi, 37 women accepted minilaps, 13 men underwent non-surgical vasectomies (NSV), and 3 women implants services from 4 VSC+ outreach sites.

Output 3: Supporting Institutional Reform

Under **health policy and planning**, the NHSS (2015-20) design process was completed and the strategy endorsed at cabinet level and officially launched. This year's ***joint annual review*** (***JAR, 2015) and joint financing agreement (JFA)*** meetings were viewed as constructive, providing strong backing for the launch of NHSS (2015-20). Extensive efforts TA were also made in designing the post disaster needs assessment (PDNA) process including preparation of survey tools and supporting data collection across the earthquake affected districts.

Under *Gender Equality and Social Inclusion* (GESI) MoHP's minister approved the revised ***Social Service Unit*** (SSU) guidelines incorporating recommendations from the 2014 SSU annual review. TA provided orientation to staff in six hospitals on the guidelines and SSU monitoring indicators. Advisers further scoped out the establishment of an additional three SSUs in hospitals in the current financial year. ***An independent evaluation of SSUs*** was recently completed with the report due in the fourth quarter of 2015.

In 2012, NHSSP supported DoHS' Primary Health Care Revitalisation Division (PHCRD) to develop and pilot updated S***ocial Audit*** G**uidelines** drawing on the experiences of various sector agencies in improving services and accountability in health facilities. In the reporting year, these guidelines were applied by MoHP in over 800 health facilities in 45 districts. A two-phase, 30 facility process evaluation was also carried out and a draft report submitted to PHCRD and EDPs for review. Further updates to MoHP's *Social Audit Guidelines* are expected in the year based on this report.

High level political support for ***One Stop Crisis Management Centres*** (OCMCs) helped galvanise MoHP's inputs in the year and stimulated a strong cross-ministry response. Following the earthquakes, TA supported 17 OCMCs for on-site training and carried out rapid needs assessments in SSUs in Hetauda, Kathmandu, Dhulikhel, Baglung, Dang, Panchthar, Solukhumbu, Bardiya, Tanahu, Doti and at SSUs in Bharatpur, Pokhara and Kathmandu following the earthquakes.

A national ***OCMC review*** by 82 representatives from the 16 OCMCs and central level officials from several ministries, police and EDPs took place and led to the Office of the Prime Minister and Counsel of Ministers (OPMCM) requesting that integrated multi-sectoral guidelines be prepared and the scale up of OCMCs across the country.

MoHP's ***Gender Based Violence (GBV) Clinical Protocol*** supported by NHSSP, UNFPA and JHPIEGO was endorsed by the Minister and rolled out following training in the 14 worst earthquake affected through ADRA with financial support from UNFPA. The minister also approved MoHP's ***revised OCMC guidelines***

Under **public financial management** FHD shared preliminary findings of the ***Aama Unit Cost Study*** during a well attended high level workshop in June. The main recommendation was to conduct a normative costing and vetting exercise against the actual unit cost findings. The final report is due in the final quarter of 2015. Round IX of the ***Aama rapid assessment*** was postponed due to cuts within the FHD budget.

Technical Assistance Response Fund (TARF) Funding

Ongoing TARF funded activities in the quarter included:

- Development of MoHP's new Health Act
- Support for the development of NHSS (2015-20)
- Development of the NHSS (2015-20) Implementation Plan
- Infrastructure remedial design work
- PFM/capacity building and clearing audit queries
- Developing an accounting manual and capacity building for the Social Protection and Security Office (health insurance).

Cumulative TARF expenditure to the end of September 2015 was as follows:

Descriptions	Amount
Total Fund Value	£500,000
Spent to end Sept 2015	£324,545
Additional committed to date	£140,050
Projected remaining balance	£35,405

Additional support

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

a) In Monitoring and Evaluation (M&E)

Support to MoHP from NHSSP and ICF Macro on the design and implementation of the Nepal Health Facility Survey (2015) continued. Data collection by New Era resumed following delays caused by the earthquakes and is expected to be completed in the coming quarter.

b) In Financial Management

Progress in **public financial management** in the quarter included revision of the draft financial management improvement plan (FMIP), finalisation of a training manual on reducing audit queries and preparation of the draft Aama unit cost study report. TA also worked closely with the National Health Training Centre to train MoHP finance officers in TABUCS.

c) In Essential Health Care

Despite disruptions and programme redesign caused by the earthquakes, SAVE continued its efforts to strengthen new born care in Nepal. SAVE's quarterly report is included as Annex 2.

Payment Deliverables

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

Topic	PD #	Details
CB-IMNCI	7	Completion of IMNCI FCHV level training
NFPP	FP3.2	District consultation and planning meeting completed in 2 districts
NFPP	FP4	First round of direct service provision by Visiting Providers completed in 12 non-BCs sites
TARF	Q7	TARF Quarterly invoice
NFPP	FP6	First round of mentoring/coaching visit by Visiting Providers completed in 20 BCs sites
Mngmt	M8	Quarterly report
CB-IMNCI	8	Sharing of TSV findings/follow up after training with DHO for program improvement.
Infra	3.1	HIIS updated to include data on 50% of Sub Health Posts
HPP	8.2	Final draft NHSP-3 drafted
Proc	6.3	Pharmaceutical Specifications (including Medical Commodities)
M and E	17	Disaggregated HMIS data used in AWPB planning

All final, non-sensitive documents were uploaded to the NHSSP website (www.nhssp.org.np). NHSSP's website has had 20,000 hits since Jan 2012). NHSSP's Facebook page 'likes' at the end of the quarter totalled 6500 and 260 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 heath governance and financial management (8)
Improved sustainable health financing (9)

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

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

NHSSP TA continued to provide support to LMD for executive procurement although emergency response procurement took priority over CAPP procurement, much of which was delayed for both logistical and budgetary reasons. The contract management system (CMS) developed with NHSSP support is proving helpful in making forecasting adjustments.

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)

The final report from Crown Agents focusing on a review of LMD procurement since 2010 including lessons learned and recommendations was submitted during this reporting period.

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

Roll out of the electronic Contract Management Information System (CMS) across all five regions was completed as reported in the second quarter's report. As noted, the CMS is proving helpful in tracking procurement progress and adjusting forecasts.

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

See 1.1.3

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

A value for money (VFM) case study on LMD's technical specification bank was disseminated in the quarter. This estimated a minimum return of £2.6 to every £1.0 invested in developing the bank.

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 now contains 1532 entries (472 pharmaceuticals and 1060 equipment) against combined phase 1 and 2 targets of 400 and 1100 respectively. The databank is hosted on LMD's website (www.dohslmd.gov.np) and widely used across Nepal and in the region.

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**

By the end of September 2015, 59% of MoHP's FY 2015/16's total expenditure data had been entered into TABUCS with the ministry now able to produce single page print outs showing expenditure against budget by programme and cost category. In addition, MoHP began to use TABUCS as its main vehicle for issuing annual budget authorisations to all costs centres for all annual programmes. This resulted in DoHS' finance section saving a substantial amount of time and improved the timeliness of cost centres receiving budgets.

MoHP's financial monitoring report (FMR) is now available through TABUCS and DfID can now access the report using its own username and password. A TABUCS monitoring framework is now functional. TABUCS's Facebook page now has over 1652 friends.

Anticipated NHSS (2015-20) activities include:

- additional TABUCS hardware and software support in 11 districts
- The establishment in MoHP of a Data Center with an IT section in the current financial year
- Additional TABUCS user training by NHTC
- Linking TABUCS with other MIS including the Treasury Single Account, Line Ministry Budget information system, HMIS, the Human Resource Information System (HuRIS), Health Infrastructure Information System (HIIS) and Logistics Management Information System (LMIS)
- Ensuring consistency between TABUCS and the Nepal Public Sector Accounting System (NPSAS)
- Upgrading TABUCS to include an inventory control and procurement system.

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

As noted, important advances have been made in reducing the number of audit queries through use of MoHP's new Internal Financial Control Guidelines and Audit Clearance Guidelines. In 2014/15, 45.18% of all audit queries were cleared compared with 39% in the previous year.

Key activities carried out this quarter included:

- Finalising the curriculum and running a PFM trainer of trainers (ToT) course for 80 programme managers and finance officers in Pokhara.
- Completion of several workshops for managers on the executive procurement.

Looking ahead, priority tasks include institutionalising use of the Internal Financial Control Guidelines and Audit Clearance Guidelines and introducing an effective internal control system. This may require the establishment of dedicated audit clearance units in MoHP and DoHS.

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 achieved in the year (from 33 down to 6) has improved the timeliness of reporting such that each report is now being prepared within one month of each trimester. Key related activities carried out in this quarter include:

- MoHP's PFM Committee met on 6 July and discussed the good progress being made in implementing the FMIP.
- The committee agreed to design and pilot the Planning and Financial Management Improvement recommendations in 4 tertiary level hospitals. PFMA/Crown Agents agreed to present a draft design for the pilot in next PFM committee meeting.
- Submission of FMR 2 for 2014/15 to the World Bank was achieved within 14 days of the end of the tri-mester. The FMRs can now be automatically generated by TABUCS so long as all cost centres enter their data.

Anticipated NHSS (2015-20) follow on activities include establishing a PFM committee in DoHS and developing a comprehensive PFM framework incorporating Governance and Accountability Action Plan (GAAP) and revision of FMIP and Procurement Improvement Plan (PIP) indicators.

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

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

With 84% of health facilities (375 out of 446) in 14 districts completely damaged during the recent earthquake, MoHP requested NHSSP's health infrastructure adviser to prioritise the restoration of health facilities so that essential health services can resume as soon as possible. To this end the adviser supported counterparts to:

- Conduct detailed assessments of all health facilities in the 14 worst affected districts. 13 districts have been completed so far with data uploaded to the open data kit system. Sindhuli district's assessment is ongoing.
- Support UNICEF to finalise design specifications (architectural, sanitary, electrical and structural) and construction details for prefabricated health facilities. Contracts worth NPR 1.25 billion were subsequently signed by various agencies for the supply of more than 200 pre-fab structures.
- Support MoHP during negotiations to construct permanent hospitals in selected districts. Commitments were received from EDPs to rebuild almost all of the damaged hospitals and primary health care centres (PHCCs) in the 14 hardest hit districts.
- Support KOIKA to select firms for hospital design in Mugu district in coordination with Management Division.
- Support various EDPs[2] for the reconstruction and rehabilitation of health facilities in coordination with MoHP.
- Make a presentation in Agartala, India on the Nepal earthquake, its impact and recovery strategies.
- Review technical proposals and prepare MoUs for the repair and maintenance of partially damaged buildings.

Costed architectural designs were also prepared for medical laboratories for five regional directorates and Tulsipur Zonal Hospital and submitted to the National Public Health Laboratory and DoHS for approval.

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

The updating of Management Division's web-based Health Infrastructure Information System (HIIS) with data from recently upgraded health posts continued with the support of DHOs, Department of Urban Development and Building Construction (DUDBC) district offices and regional health directorates (RHDs) but was overshadowed by district needs assessment work.

Rehabilitation of Zonal and Regional Hospitals:
Following local stakeholder review, architectural, structural, electrical and sanitary design drawings for Gangalal Hospital, Mid-western Regional Hospital Surkhet, Bheri Zonal Hospital and Seti Zonal Hospital were finalised and submitted to DUDBC for tendering. An important feature of these designs is that they have been specifically informed by local disease and morbidity data, populations and catchment areas.

[2] JICA, USAID, KOIKA, KFW, Nyaya Health, and other NGOs and INGOs.

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

Since June 2015, NHSSP has provided technical assistance to DoHS' Epidemiology and Disease Control Division (EDCD) to strengthen its disease surveillance system and initiate daily surveillance and reporting of emerging diseases with a view to improving response levels when required. In the reporting period, TA focused on data collection, data analysis, report production and dissemination and planned the expansion of early warning and reporting system (EWARS) sentinel sites intended to improve the quality and use of EWARS data. EDCD has been producing and disseminating a weekly EWARS bulletin which now includes updates from the following three surveillance systems:

1. The Early Warning and Reporting System (EWARS) contains data from January 2014 to date and can make data comparisons with the same period in the preceding year.

2. The post-earthquake hospital based syndromic surveillance system which is covering public and private hospitals in the 14 hardest hit earthquake affected districts.

3. Hospital based surveillance for cholera began on 26 July 2015 in Sukraraj Tropical and Infectious Disease Hospital, Teku and in 35 hospitals in the Kathmandu valley from 27 August 2015.

Under its rapid emergency response plan, MoHP also established an Information Management Unit under its Health Emergency Operation Centre (HEOC). NHSSP's M&E Advisor helped develop the information management system, designed district data collection tools, analysed data and prepared daily, and later weekly, situation updates to inform ministry and EDP officials. Several NHSSP advisers also worked intensively to design post disaster needs assessment (PDNA) tools and support district implementation. TA also provided for PDNA data analysis and helped prepare a central level recovery plan.

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

MoHP has now endorsed the Unified Coding System that assigns a unique code to each health facility. This was used in the quarter to update the official list of facilities with inputs from Management Division (from its HMIS and HIIS) and LMD (from its LMIS) and individual districts. The

adoption of this coding system across all health sector MIS is an important milestone in building functional linkages between data sets to allow the improved use of data for monitoring and planning purposes.

Ongoing activities included working with MoHP and EDP officials to develop an e-Health strategy and revise the Health Sector Information Strategy (2007).

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

Responding to DoHS's request, and supported by health partners, NHSSP coordinated the printing and distribution of the new HMIS recording and reporting tools for 2015/16. Supporting partners included UNICEF, UNFPA, WHO, GiZ, Save the Children, NSI, JSI, H4L, IPAS and PSI Nepal. By the end of September HMIS tools had been distributed to 38 districts with further progress hampered by political protests in the terai and the shortage of fuel caused by the closure of the Indian border.

During this quarter the M&E advisor worked closely with USAID and the MEASURE Evaluation Project technical team and its partner the Public Health Foundation, India to plan capacity enhancement for the assessment of data quality in routine information systems for MoHP officials, health partners, local research institutions and academics. These inputs are premised on an understanding that data quality will only improve once those generating it are aware of its significance, that data collectors themselves use it for local monitoring and planning purposes and, therefore, that these collectors are able to use the routine data quality assessment (RDQA) tools without assistance.

NHSSP TA are currently helping DoHS prepare a plan roll out of the RDQA tools at district and sub-district levels. Those trained will make up a resource pool to be drawn on to support this roll out.

2.1.3 Support the generation of primary information for NHSP-2

The preparation of the NHSS (2015-20) monitoring framework reported earlier in the year serves as an example of how NHSP-2 information has been used to inform new national health strategy. In the reporting period NHSSP's M&E Advisor helped MoHP prepare a results framework for (NHSS (2015-20). This is now pending Cabinet approval.

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

In addition to helping MoHP prepare 12 month post-disaster transition and recovery plans, NHSSP advisers helped:

- MoHP in a review of the health sector's earthquake response including lessons learnt
- MoHP to assess earthquake impact on health systems (esp. service availability, readiness and quality of care)
- health facilities and DHOs/DPHOs to recover key data lost during the earthquakes
- health facilities and DHOs/DPHOs to monitor service delivery and utilisation particularly in temporary camps and resettlement areas

- districts to track follow up cases, particularly HIV, TB and leprosy patients; pregnant women; and children to be immunised particularly those residing in temporary camps or resettlement areas.

The research advisor worked closely with the MoHP and the survey implementation agency to implement and monitor the Nepal Health Facility Survey (NHFS), 2015. Data collection is expected to be completed by mid-October. NHSSP's research advisor also supported MoHP for the preparation of a 'Key Findings Report' to be disseminated ahead of the main report.

NHSSP advisors provided further support to the ministry to develop the questionnaire for the Nepal Demographic and Health Survey (NDHS) planned for early 2016.

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

See 2.1.3 and 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.

Taplejung hospital conducted it 5th QoC self-assessment on 6th July 2015 and followed up on its 4th round action plan. With the exception of infection prevention, the hospital achieved 'green' status for all 15 QI domains. However, FHD's plan to provide further QI training could not be implemented due to political disturbances on the terai and a "Limbuwan" strike in Taplejung. Hetauda district hospital was unable to conduct its next round of self-assessments due to the unavailability of key hospital team members.

An evaluation of the hospital quality improvement process (HQIP) pilots in Hetauda and Taplejung hospitals was carried out in July 2015 following which FHD committed to scale up HQIP in 10 further districts (Panchthar, Ilam, Sarlahi, Rautahat, Bara, Arghakhanchi, Rolpa, Rukum, Bajura, and Achham), making appropriate budgetary provision in its 2015/15 AWPB. However, these budgets were later cut to NPR 100,000 per facility as a result of the earthquake. NHSSP TA helped prepare HQIP implementation guidelines for hospitals, district selection criteria and a schedule to guide the scale up.

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

The EHCS TA team supported FHD to follow up on implementation of action plans made to address overcrowding in Seti Zonal Hospital, Bheri Zonal Hospital, Narayani Sub-regional Hospital and six other referral hospitals receiving FHD funds. The three focal hospitals are progressing well: in Bheri and Narayani, the total number of still births in the quarter reduced significantly. No change in this regard was noticed in Seti Zonal Hospital although the number of referrals out from the hospital reduced marginally from 12 to 10.

Hospitals	Total still births	
	Mangsir 2071– Falgun 2071	Chaitra 2071 – Asar 2072
Seti Zonal Hospital	30	32
Bheri Zonal Hospital	58	43
Narayeni Sub-regional	21	9

Strategic Birthing Centres (SBCs) support in Banke District

As planned, the DPHO in Banke took forward SBC implementation activities in the district. Five birthing centers (Betahani, Hirminiya, Raniyapur, Gangapur and Laxmanpur) were selected as intervention sites and a further 5 as control sites. During the reporting period the five intervention sites implemented a free obstetric complications referral programme that was taken forward in four facilities (Gangapur, Betahani, Raniyapur and Hirminiya). Of the 11 obstetric complication cases referred to Bheri Zonal Hospital in this quarter, 10 had benefited from the free referral fund (see table below).

SN	Obstetric complication	# of cases	Outcome
1	pre-eclampsia/eclampsia	2	1 C/S and 1 ND
2	Previous C/S	2	2 C/S
3	Breech presentation	2	1 ND and 1 C/S
4	Prolonged labour	1	ND
5	Severe anemia with labour	1	ND
6	Transverse lie (twins)	1	ND, 1 still birth & 1 alive
7	Foetal asphyxia (fetal cause)	1	baby recovered
8	Foetal distress (no FHS)	1	still birth
	Total	**11 cases**	

The number of institutional deliveries in the 5 SBCs increased from 587 in 2013/2014 to 747 in 2014/15. Similarly the number of institutional deliveries in this reporting is significantly higher than in the same period in 2014/15.

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

The CEONC mentor and other NHSSP TA visited 9 districts (Palpa, Humla, Ramechhap, Sindhuli, Nuwakot, Dolakha, Sarlahi, Morang, and Parbat) to carry out needs assessments for the start up of CEONC services in Ramechhap (Manthali), Charikot, Rampur/Palpa, Humla and Parbat. TA also coordinated with VSO, UNFPA and UNICEF for the establishment of CEONC services in Manthali PHCC, Ramechhap.

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

NHSSP TA supported FHD to allocate district level budgets including CEONC funds, the ANM budget and new born free care fund. Advisers also helped FHD to revise its operational guidelines for

implementing FHD's budget for 2015/16 and to strategically deploy health staff (doctors, nurses, anesthesia assistants) to ensure the smooth running of CEONC services.

Additional technical assistance was provided to allow FHD to fill critical HR gaps resulting from fiscal constraints and provided funding to ensure the continuity of CEONC services in 8 earthquake affected districts. The latter included hiring 7 temporary ANMs in Ramechhap and Dolakha districts.

Child Health Division was supported to prepare Free New Born Care Guidelines and NHTC for a review and revision of the Infection Prevention Reference Book and the selection of advanced skilled birth attendants (ASBAs) and anaesthetic assistants (AAs) for the training in 2015/16.

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

A reproductive health coordination committee (RHCC) meeting was held on 15 July 2015 where the DHO presented SMNH activities and the progress made in 2014/15. Encouragingly, all SMNH indicators including ANC, institutional delivery/delivery by SBA, and PNC had increased. However, the planned district level procurement and distribution of new equipment recommended during the mid-term review in Feb 2015 was hampered due to political unrest in the terai.

Also in the quarter, emergency MNH funds were established in Santhakra SHP, Thinglabu HP, Change HP, Linkhim HP, Sablakhu HP, Khejenim HP and Tapethok HP. NPR 20,000 was contributed at each health facility with NHSSP matching this amount to allow MNH services to be provided to those unable to access funds quickly.

Comprehensive self assessments were conducted in the quarter to examine HFOMC capacity, MNH QoC in birthing centres and infection prevention practices in all the ten health facilities. Significant improvements were noted in HFOMC capacity against initial assessments. Regular HFOMC meetings are now held at each intervention health facility and progress against annual HFOMC action plans is monitored.

A comprehensive assessment was also carried out on MNH QoC at birthing centres. This showed that more than 95% of QoC domains had obtained green status. Significant improvements were also reported for infection prevention set up and practices. In this respect, whole site infection prevention coaching was conducted in the four health facilities where weak IP practices had earlier been identified (Khejenim HP, Sobuwa HP, Aangkhop HP and Limbudin HP). The coaching was seen to have enhanced IP knowledge and skills and IP set up in health facilities. On-site coaching of SBAs/ANMs was also conducted at six birthing centres in the quarter leading to improved infection prevention practices and SBA core skills.

Under the demand-side equity and access programme, the following activities were carried out:

- meetings with local stakeholders including local leaders;
- meetings with members of ward citizen forums and local clubs;
- interactions with recently delivered mothers;

- community group mobilisation;
- Home visits to excluded households, pregnant women and recently delivered mothers are on-going in the five EAP VDCs of the RAMP.

Collectively these interventions are seen to be improving the knowledge, skills and attitudes of community members on MNH services and practices making it more likely that utilisation of community and health facility level MNH services will increase.

The formal evaluation of RAMP by HERD began in the reporting period. Tools were revised and data collection began in late September.

2.2.7. Support to design and implementation of interventions to reach unreached population in family planning

In the reporting period, integrated FP service delivery through EPI clinics in Sindhupalchok (FP/EPI pilot), and long acting reversible contraception (LARC) services through visiting providers (VP pilot) in Ramechhap resumed following the earthquakes. 600 (39%) out of 1531 mothers who attended group health education received FP service through EPI clinics while visiting providers provided 442 implants and 20 intrauterine contraceptive devices (IUCDs) in non-birthing centre health facilities in Ramechhap district. Visiting Providers (VPs) also completed IUCD coaching in 5 out of 8 birthing centres where coaching was planned thereby enabling SBAs to provide IUCD service independently. In addition and in order to restore the quality of FP services in the post earthquake period, IEC materials were reprinted and distributed to both districts.

A mid-term review of EPI/FP interventions was carried out in two batches between 27-28th September and of the VP pilot on 13th September. Health facility in charges and the DHO team participated in the reviews and achievements and challenges were discussed and solutions agreed.

In Baitadi, the first round of VSC+ camps was organized under the DHO's leadership. A total of 37 minilaps, 13 NSV, and 3 implants were provided from 4 VSC+ sites. In Darchula, Marie Stopes International initiated a first round of VSC+ service through 4 sites. The first round will be completed by 2nd October 2015. A total of 31 implants, 7 NSV and 1 IUCD were provided as of 30 September 2015.

VSC+ camps in both districts were preceded by pre-VSC meetings with FCHVs and the airing of key message through radio broadcasts. Service providers from selected VSC+ sites were also oriented on FP service delivery guidelines and quality improvement procedure.

Summary of activities carried out in this quarter in FP pilot districts

SN	Pilot Activities	Status
1	Continuation of delivery of integrated EPI/FP services in Sindhupalchowk and VP services in Ramechhap	Continuing
2	Re-printing and supply of IEC materials damaged due to earthquake for EPI/FP and VP interventions	Completed
3	Procurement and supply of NSV, Minilap, implant, IUCD sets and equipment (OT Tables and IP equipment) to Baitadi and Darchula districts	Completed
4	Procurement of IP equipment and implant/IUCD sets to Sindhupalchowk and Ramechhap district (after EQ)	Procured and being supplied
5	Initiation of VSC+ intervention in Baitadi and Darchula	First round of camp in Baitadi and Darchula completed
6	Mid-term review completed in Sindhupalchowk and Rammechhap	Completed in both districts
7	Technical support visits to all pilot districts	Continuing

Technical support to National FP program

In addition to supporting the FP pilots, TA provided technical inputs to the following:

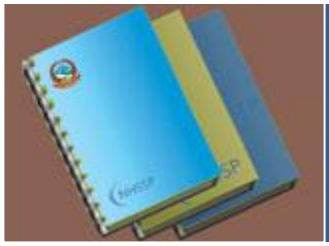
- IUCD training package review workshop organized by PSI/NHTC and COFP/C
- 2-day workshop on FACT (fertility awareness for community transformation project) organized by SC
- PDNA exercise in Dolakha and RamechhaP
- 3-day workshop on FHD program guideline development
- 2-day IP and HWCM QI workshop organized by H4L
- Series of RH Sub Cluster, FP Sub Committee meetings including LMD pipeline meeting.
- FP equipment and instrument specification verification at LMD
- Facilitated 3-days national FP supervisor's review meeting organized by FHD. Review meeting report compiled, edited and submitted to FHD.
- Facilitated a contraceptive update session for research enumerators (PPIUCD study in Nepal) organized by CREHPA/FHD
- Preparation meetings on 2nd National Family Planning celebration day.

TA also provided inputs on:

- The draft FP budget in FHD's 2072/73 AWPB
- Drafting chapters on NSV and the IP training package at the request of H4L/NHTC
- A draft strategy on long acting and permanent method (LAPM) prepared by PSI/FHD
- Drafting and preparing talking points and presentation for FHD and the health secretary
- Accompanying a high level team from DFID to Gorkha district
- Provided inputs on FP2020 Rapid Response Fund proposal writing to UNFPA/FHD and Jhpiego.

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

SCI's quarterly progress report for the quarter 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

Despite earthquake related disruptions, the NHSP-3 development process concluded in the quarter with the final document renamed the Nepal Health Sector Strategy (2015-20). The NHSS (2015-20) officially began in mid-July 2015 but the development of an accompanying implementation plan has been affected by post-disaster reconstruction and rehabilitation priorities which have seriously cut into the budgets and plans of the various departments and centres. Further, while NHSS (2015-20) is seen to capture medium term sector needs well, EDP funding commitments – especially those for the pool fund – remain unclear, thereby hampering MoHP financial planning.

TA continued its support to MoHP for the preparation of its Post-disaster Recovery Plan and served on several technical and coordination committees, revising plans and budgets as required.

Having supported the NHSS process from its formulation through to its endorsement NHSSP's Policy and Planning adviser moved on from the NHSSP team.

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

As noted the NHSS (2015-20) strategic document and results framework were approved by cabinet but the AWPB was seriously affected by post-earthquake priorities. In response to urgent earthquake related needs, DfID announced a GBP 10 million MoHP-led Health Sector Transition and Recovery Programme to be managed by Options/OPM.

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

This work stream is now to be taken forward under NHSS (2015-20).

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)

To date, GESI training has been used by NHSSP as an educational tool to support policy-makers and service providers at all levels in the ministry with more than 2000 personnel from 31 districts trained. The main objective of this training is to ensure that key actors are GESI-aware and mainstream GESI principles in their work including GESI responsive planning and support to marginalised clients including GBV survivors. Such training continued in this quarter with the focal person of Population Division and staff from PHCRD, Public Health Officers, Supervisors, ANMs, Health Post In-charges, Staff Nurses, PHN Officers participating. The training included a visit to a health post at Amangvangang VDC.

ToR were prepared for an assessment of the effectiveness of GESI training including identifying capacity gaps and real and perceived needs and addressing key issues identified by trained service providers. CVs of potential consultants for this assignment are currently being reviewed.

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

In order to review progress and develop a road map for the future direction of SSUs, a 2 day annual review workshop was held based on the findings of the recently finalised SSU evaluation. Participants included MoHP officers, the regional director from central regional health directorate, medical superintendents, doctors, SSU chiefs, and the concerned hospital staff of the eight pilot hospitals (Seti Zonal Hospital, Bheri Zonal Hospital, Western Regional Hospital, Bharatpur Hospital, Koshi Zonal Hospital, Bir Hospital, Paropakar Maternity Hospital and Kanti Children Hospital). The Secretary of MoHP inaugurated the workshop.

The annual review highlighted the progress made by pilot SSUs in terms of (i) enhancing their capacity to correctly identify and serve target groups in compliance with SSU Guidelines, (ii) better target the poor and other target groups and assess client satisfaction, (iii) contribute towards good governance of health facilities by increasing transparency and accountability, (iv) enhance awareness of target groups on the free or partially free services available, and (v) free up a significant amount of the time care providers spend identifying target groups and deciding on exemption of fees. As a part of this review, highly instructive meetings were held at Bir hospital, Kanti hospital and Maternity hospital on the effectiveness of SSUs in central level hospitals.

The SSU roadmap developed recommends a) replication of the SSU model in other referral hospitals; b) SSU capacity enhancement to expand its role to coordinate with other hospital based social protection programs including nutrition, geriatric, mental health; c) standardising the benefits packages to target groups; d) improving budgeting systems for free and partially free services; e) updating the SSU Guidelines and f) adapting the SSU model in central hospitals and other facilities.

A further activity in the quarter was preliminary scoping and orientation of key officials for the establishment of SSU at Hetauda hospital which is likely to take place in November 2015.

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

The draft social audit evaluation report was shared with PHCRD director and other key members of MoHP, EDPs (H4L and GIZ) and other concerned stakeholders for their feedback and is expected to be finalised in October.

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

During the Office of the Prime Minister and Counsel of Ministers' (OPMCM) national review Nepal's various GBV programmes were described as 'scattered, fragmented and vertically planned'. It was noted that several sectors manage independent programmes leading to duplication of efforts and poor coordination. Accordingly the OPMCM has decided to develop integrated 'umbrella' guidelines to improve the coordinated delivery of services to GBV survivors.

ToR for the preparation of these guidelines were finalized in the quarter following extensive follow up with OPMCM, Ministry of Women, Children and Social Welfare (MWCSW) and MoHP, and suitable consultants identified. A steering committee was formed, headed by MWCSW's Secretary, together with a technical working group with members from Ministry of Federal Affairs and Local Development (MoFALD), National Planning Commission (NPC), Ministry of Peace and Reconstruction (MoPR), Police Headquarter, Ministry of Education (MoE) and MoHP.

A second lobbying success was the endorsement of GBV clinical protocol by MoHP's minister. This will help service providers management cases appropriately including the provision of immediate health care, psycho-social counselling, the collection and preservation of medico-legal evidence and developing systems for referral, follow-up and reporting. The protocol was the result of a participatory process involving multi-sectoral stakeholders with UNFPA providing financial support and JHPEIGO logistical arrangements. TA also worked with Population Division and UNFPA to implement GBV clinical protocol training in the 14 worst earthquake affected districts through ADRA with financial support from UNFPA. The GBV clinical protocol will be rolled out over time to service providers at all levels.

Also in the quarter, OCMC counsellors from eight districts (Morang, Sunsari, Saptari, Kaski, Kalikot, Dang, Pyuthan, Achham) received refresher training on psychosocial counselling with technical support from NHSSP TA and funding from UNFPA while key health and government officials from Hetauda hospital were oriented on the amended OCMC guidelines. Planned activities include forensic training for medical officers of OCMCs, SSUs and hospitals.

A further achievement was OPMCM's circulation of a memo to line ministries instructing them to strengthen and scale-up OCMCs across the country. NHSSP TA helped prepare an action plan to support these efforts which was shared with Population Division. This includes roll-out of the GBV clinical protocol in all health facilities and alliance building with multi-sectoral stakeholders for integrated services to address GBV.

Indicator 3.3: Aama unit costs identified

3.3.1 Review the Aama Programme

The final draft report of the Aama programme review was produced and sent for review. Findings from the Aama unit cost study and Aama review are expected to be instrumental in shaping the second generation of Aama programme.

As a result of budget cuts following the earthquake, FHD was unable to conduct its ninth round Aama rapid assessment and subsequently requested NHSSP to provide technical and financial support to carry it out in the coming quarter.

An assessment of functionality of the Aama Programme in earthquake affected districts was undertaken. Restoring full functionality of Aama is a key objective of the Health Sector Transition and Recovery Programme and supportive measures will taken in the coming period under this programme.

Looking forward, **k**ey activities for NHSS (2015-20) include harmonising the Aama programme within a broader framework of social health protection, and further developing modalities for involving private sector institutions in implementing Aama through state non-state partnerships.

3.3.2 Conduct Unit Cost Analysis of Aama

The draft Aama unit cost study report was finalized and sent to core team members for final review with the aim of issuing in October. The NHSSP health financing team in Nepal will then write a policy guidance note to translate findings into policy level recommendations. Here it should be noted that the proposed discussion on normative costing for maternal and newborn condition could not be carried out due to competing FHD priorities. Accordingly, the unit cost study team will now initiate these discussions and prepare a separate report to help inform the next generation of the Aama programme.

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

As noted, key ongoing activities include drafting a note for policy makers and others on key issues such as the continuity of Aama in private health facilities and identifying ways to improve implementation modalities.

To this end a short document on the costing of new born care was prepared for FHD officials. This provided key guidance on costing approaches and issues to consider when updating implementation modalities.

A second note was prepared highlighting some of the challenges involved in integrating newborn care in the Aama programme. Discussions were also held on how FHD and CHD should take forward newborn care activities following which it was decided both divisions would implement their own newborn care activities.

A rapid assessment of Aama Programme functionality in earthquake affected districts was completed and a draft report produced.

ToRs were prepared for the Aama related activities described in the post-earthquake extended work plan, These cover rapid assessment IX, an Aama stock take and design of the next Aama generation of the programme. A research assistant was recruited to assist with these activities.

4. Payment Deliverables

The following payment deliverables were submitted in the reporting quarter:

Topic	PD #	Details
CB-IMNCI	7	Completion of IMNCI FCHV level training
NFPP	FP3.2	District consultation and planning meeting completed in 2 districts
NFPP	FP4	First round of direct service provision by Visiting Providers completed in 12 non-BCs sites
TARF	Q7	TARF Quarterly invoice
NFPP	FP6	First round of mentoring/coaching visit by Visiting Providers completed in 20 BCs sites
Mngmt	M8	Quarterly report
CB-IMNCI	8	Sharing of TSV findings/follow up after training with DHO for program improvement.
Infra	3.1	HIIS updated to include data on 50% of Sub Health Posts
HPP	8.2	Final draft NHSP-3 drafted
Proc	6.3	Pharmaceutical Specifications (including Medical Commodities) approved by stakeholders and uploaded to LMD Website
M and E	17	Disaggregated HMIS data used in AWPB planning

The following publications were prepared in the reporting period:

Quarterly Progress Report (April-June 2015)
Quarterly Progress Pulse Report (April-June 2015)
Remote Areas (Pulse Report)
Options Security Manual (Draft)
Overcrowding Workshop Reports (Bheri, Seti Zonal Hospitals and Narayan Hospital)
QoC Toolkit Implementation and Monitoring Mechanism Report
Report on National Workshop on the Review and Future Direction of OCMCs
Pharmaceutical Specifications (Including Medical Commodities)
Training completion report for NHFS
MoHP Budget Analysis Report 2010/11–2014/15
Final draft NHSP-3

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

Save the Children

Technical Assistance for the Strengthening the New-born Care Program in Nepal

Save the Children International/SNL-DFID Program in Nepal

ACRONYMS

ARI	:	Acute Respiratory Infection
BCC	:	Behaviour Change Communication
BEOC	:	Basic Emergency Obstetric Care
CB-IMCI	:	Community Based Integrated Management of Childhood Illness
CB-NCP	:	Community Based Neonatal Care Program
CHX	:	Chlorhexidine
FCHV	:	Female Community Health Volunteer
HF	:	Health Facility
HMIS	:	Health Management Information System
HP	:	Health Post
IMNCI	:	Integrated Management of Childhood Illness
LBI	:	Local Bacterial Infections
MDG	:	Millennium Development Goal
MNH	:	Maternal and Neonatal Health
OPD	:	Outpatient Department
ORS	:	Oral Rehydration Solution
ORT	:	Oral Rehydration Therapy
PHCC	:	Primary Health Care Center
PNC	:	Post Natal Care
PSBI	:	Possible severe bacterial infections
RH	:	Reproductive Health
SBA	:	Skilled Birth Attendants
VDC	:	Village Development Committee

Introduction

Since March 2014, Save the Children has been providing technical assistance to MoHP to support the implementation of the Community-based Integrated Management of Neonatal Childhood Illness (CB-IMNCI) program at Health Facility (HF) and community level. In addition, Save the Children has provided support to strengthen Maternal and Neonatal Health (MNH) activities in the targeted project implementation districts of Rasuwa, Nuwakot and Nawalparasi.

Following the earthquake that struck Nepal in April 2015, Save the Children identified savings within the project budget and realigned its workplan to address immediate needs in two severely affected project districts, specifically Nuwakot and Rasuwa. However, activities in the third district of Nawalparasi continued as normal. This quarterly report provides an overview of the activities conducted and progress made within the project period of July to September 2015 in both the earthquake-affected and non-affected districts.

1. CB-IMNCI revitalisations support to HFs and FCHVs

On the 25th of April, a devastating earthquake struck Nepal and severely affected 14 districts, including two of the targeted project districts; Rasuwa and Nuwakot. The earthquake killed more than 8,000 people and millions were left homeless. In addition, the health system in Rasuwa and Nuwakot was significantly impacted, with widespread damage to health facilities. Many Female Community Health Volunteers (FCHVs) in the affected districts also became homeless, and lost most of their medical equipment and supplies, such as medical drugs, job aids and forms, during the destruction of the health facilities.

Display of different essentials items to FCHVs

In light of this damage, the revitalisation of IMNCI and MNH services at both health facility and community level in earthquake affected districts became a key priority. CHD and FHD sought support from partners and prepared a list of 30 essential CB-IMNCI/MNH items to distribute to FCHVs. They also requested support to provide psycho-social counselling to FCHVs to aid the revitalisation of health services at a community level. Therefore, in support of the CHD and FHD, Save the Children in Nepal committed its support to help revitalise CB-IMNCI services across all VDCs in Rasuwa and Nuwakot.

FCHVs receiving the IMNCI/MNH essentials bag

The objectives of the additional support in Rasuwa and Nuwakot are listed below:

- To revive and maintain the CB-IMNCI program in health facilities, focusing on recording, reporting and under 5 case management
- To motivate and encourage FCHVs to continue to provide MNCH services in their communities
- To supply IMNCI/MNH essential supplies to FCHVs to motivate and enable them to continue to provide MNCH services.

The post-earthquake context and the monsoon season created a challenging environment to meet these objectives within a limited timeframe. However, Save the Children contracted two consulting firms (IDF in Nuwakot and Kamana Health in Rasuwa), who had been previously engaged in the project, to facilitate and manage the activities in close coordination with DHO and HF staff. These activities were conducted in Rasuwa from 6th to 18th of July 2015 and in Nuwakot from 21st July to 12 August 2015.

The revitalisation support team consisted of DHO supervisors, Save the Children district staff and facilitators from the recruited consulting firms. The team visited 17 out of 18 HFs in Rasuwa. Langtang VDC in Rasuwa was not included, as 200 people from this VDC had died and the remaining community was displaced. However, in Nuwakot, the team visited and conducted activities in all 63 HFs.

In preparation for the revitalisation support, Save the Children provided a one day orientation session for facilitators of the consulting firms to train them on the approach and tools. During the revitalisation activities, the first two hours focused on observations at HFs of CB-IMCI OPD registers, MNH records and reports. Following the observation exercise, the OPD register team attempted to identify any gaps in case management and subsequently provided support to improve and strengthen recording, reporting and case management of under 5 and under two months of age. The team also supplied CB-IMNCI treatment protocols and other program materials at the HF that were totally destroyed. Due to time constraints, health workers' knowledge and skills couldn't be assessed. However, the HF in-charges were requested to prepare an action plan for the upcoming three months based on the post-earthquake context. A copy of the action plans had been handed over to the DHO program focal points for further follow up and support.

In the second session of the revitalisation, the team conducted an introduction round with FCHVs and shared the objectives of their visit. The team also discussed the impact of loss of life, injury and other physical and emotional challenges due to the devastating earthquake. During the visit all FCHVs were counselled to remain calm and encouraged to continue to provide MNCH services in their communities. During the event, 236 FCHVs received CB-IMNCI /MNH essential supplies in Rasuwa and 1,124 FCHVs in Nuwakot.

FCHVs are ready to go in their home after receiving an orientation and IMNCI/MNH essentials in Nuwakot

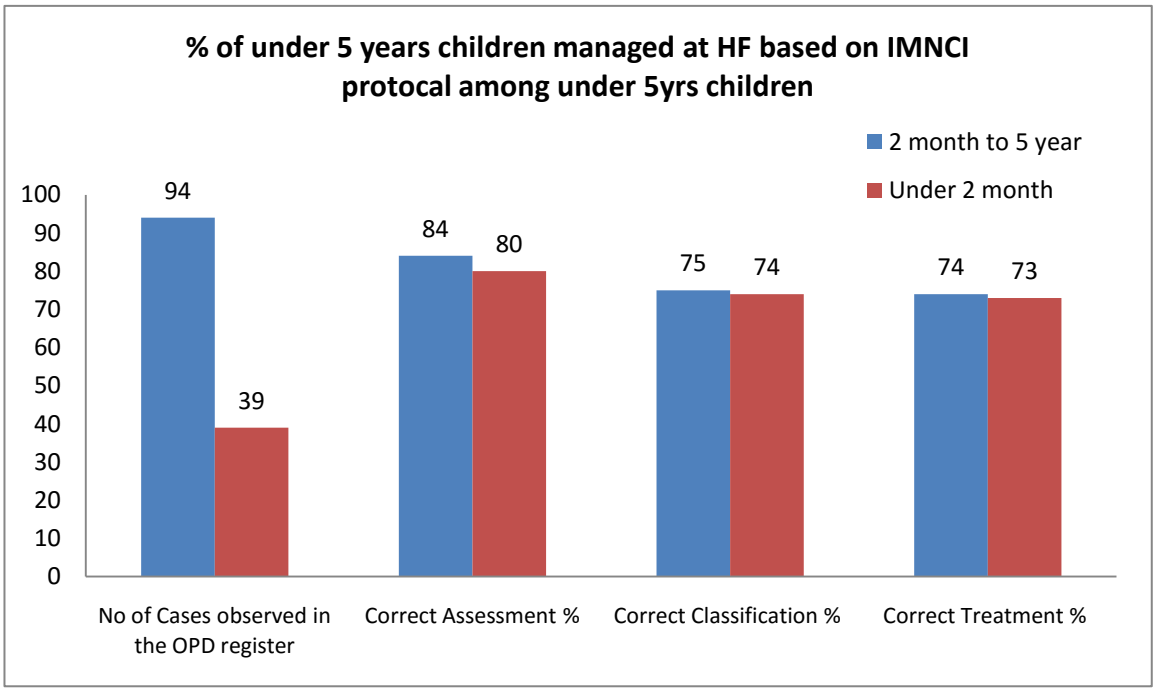
After completing this event, a short debriefing session was conducted at the DHOs. Teams outlined the findings and progress of the events and passed on undistributed FCHVs essentials to DHOs to distribute

at a later stage as needed. In addition, the action plans developed by health facilities were handed over to the CB-IMNCI focal person at the DHO.

A case of Haku VDC, Rasuwa: *FCHVs of Haku VDC had lost everything including their houses, land and food stocks after the earthquake. Since the HF's were destroyed, they also lost all the health related materials which they had previously used, including their bags. At the end of revitalization program, they looked cheerful and happy while receiving the program materials and their uniform (sari) and new bags. They were glad to resume MNCH services in their community after receiving essential supplies.*

Findings from the revitalisation support

- Most of the HFs in Rasuwa used amoxicillin to treat the pneumonia cases. In Rasuwa, there were 78 cases of under 5 pneumonia registered, out of which 91% of cases were treated with amoxicillin after the earthquake. Likewise in Nuwakot, 293 out of 308 cases (95%) were treated by amoxicillin.
- Regarding the under 5 diarrheal cases, the HF in Rasuwa provided diarrheal treatment to all 174 registered cases with zinc and ORS, whereas in Nuwakot, 97% of cases were treated with zinc and ORS (545 out of 559 cases).
- Although limited in number, there was evidence of cases of infants under 2 months being managed in HFs after the earthquake. Only three HFs (Safrubeshi HP Laharepauwa HP and Ramche HP) registered five under 5 cases. In Nuwakot, 61 under 2 month cases were registered after the earthquake. Among them, ten are classified as PSBI and 20 as LBI. In addition, eight cases were treated with Gentamycin and two cases were referred at district hospital.
- Based on the available data from Nuwakot, the under 5 case management conducted by the health workers has improved. As an example, 84% of cases for children aged 2 months to 5 years were assessed correctly whereas 75 per cent were classified correctly and 74 per cent were treated correctly as per the protocol. Similarly, 80 percent under 2 months cases were assessed correctly whereas 74 per cent were classified correctly and 73 per cent were treated correctly as mentioned in the protocol. It was not possible to receive similar information from Rasuwa.



- The HMIS system was not functioning after the earthquake in four HFs in Rasuwa and 15 HFs in Nuwakot. The DHO had not compiled the HMIS data as their time and efforts had been focused on post-earthquake management across the two districts.
- At the end of the revitalisation activities, all FCHVs expressed gratitude after receiving the CB-IMNCI/MNH essential supplies. They also expressed their commitment to continue to provide MNCH services in their communities.

Lessons learned

- It would have been more effective to distribute CB-IMNCI/MNH essentials immediately after the earthquake. However all FCHVs appreciated this support at the time it was provided.
- Psychosocial counselling to FCHVs was found to be very effective in motivating the FCHVs and helping them to adjust back to daily work/ life style.
- Supportive monitoring visits are important in the early post-earthquake situation from DHO and central level.

Recommendations

- DHO should prioritize efforts to recommence regular data collection for the HMIS/LMIS system.
- DHO should provide a regular supply of program commodities to HFs and FCHVs.

2. Health Facility level CB-IMNCI Review Monitoring Meeting in Nawalparasi

To improve and maintain programme quality, IMNCI review meetings have been carried out in Nawalparasi. The main objective of the review meeting was to assess progress/achievements, as well as the strengths, weaknesses, opportunities and challenges of the CB-IMNCI programme in health facilities. In addition, the meetings aimed to develop action plans/recommendations for further improvement and guide the future programmatic directions of the program. As per the suggestion of the CB-IMNCI Chief, this activity was conducted at the beginning of the Nepali Fiscal Year, from 23rd July to 3rd August 2015 at district headquarters. Altogether, 93 participants attended the review meeting from 75 Health facilities.

Save the Children supported the review sessions by developing guidelines to conduct the meetings, which consultant facilitators were oriented on. In line with these guidelines, two day meetings were held and involved all HF in-charges. On the first day of the review sessions, all HF in-charges presented the performance of their respective health facility, focusing on the predefined indicators. Constructive feedback and suggestions were then provided by DHO, program focal persons, statistical officers, and store keeper/supervisors on their presentation. On the second day, discussions were held on the performance of the Health facilities and the strengths, weaknesses, opportunities and challenges for the health facilities were also discussed. During the review all HF in-charges were requested to conduct a peer review of CB-IMNCI OPD registers to provide suggestions to improve recording and reporting and/ or case management. The feedback was shared among participants. Based on errors found in the OPD registers, a short orientation was provided that focused on under 5 /under 2 month case management, using IMNCI wall charts. In the final session of the review meeting, HF staff prepared their action plans based on identified gaps in the IMNCI/MNH program.

Key findings based on the presentation of HF in-charges are provided below:

- **Use of Amoxicillin to treat Pneumonia:** After the implementation of CB-IMNCI, amoxicillin is being used for the treatment of under 5 pneumonia cases. In the Fiscal Year 2070/2071 (July 2013 to June 2014), 31 percent of the under 5 pneumonia cases were treated with amoxicillin whereas in the past Fiscal Year 2071/72 (July 2014 to June 2015) around 32 percent of pneumonia cases were treated with amoxicillin. In Nawalparasi, HF level training on CB-IMNCI training was completed in January 2015.

- **Use of Zinc and ORS for the treatment of diarrhoea:** In the past Fiscal Year 2071/2072 (July 2014 to July 2015) around 8,695 under 5 diarrhoea cases were reported at health facilities in Nawalparasi. Among them 77 percent of children under five were treated with zinc and ORS, whereas in Fiscal Year 2070/2071 (July 2013 to July 2014) treatment of ORS and Zinc was 69 percentage. Some of the patients missed zinc treatment due to inadequate quantity in HF.

- **Management of under 2 months cases by Health Facilities:** During the review meeting, under 2 months case management was discussed and observed CB-IMNCI OPD register and found that data was not consistent for this age group. However with the available information, there were some cases of under 2 months sick infants enrolled by some health facilities, which are shown Table 1.

Table 1: Number/Percentage of cases of infants under two months enrolled in HFs in 2070/71 and 2071/72

Indicator	Frequency (n)		Percentage (%)	
	70/71	71/72	70/71	71/72
Under 2 months sick babies enrolled in HF	712	937	2.93	3.9
PSBI cases	62	109	8.71	11.63
LBI case	493	536	69.24	57.20
Jaundice	19	32	2.67	3.42
Hypothermia cases	0	9	0	0.97
Treatment by Gentamycin	62	90	100	83

- **Management of severe cases:** Based on the treatment guidelines, if treatment is not available at HF level to manage the under 5 severe cases, they should be referred to higher level health facilities. FCHV information against this indicator was not possible to gather. However referral cases by HF are presented in Table 2 below.

Table 2: Referral cases of infants under 2 months and children under 5 years

Indicators	Frequency (n)		Percentages(%)	
	70/71	71/72	70/71	71/72
Total number of under 2 months sick young infants enrolled	712	937	2.93	3.9
Referral of under 2 months cases by HF	38	40	5.34	4.27
Total number of under 5 yrs sick children enrolled	39737	40153	59.7	60.3
Referral of under 5 yrs cases by HF	91	106	0.23	0.26

- **Availability of CBIMNCI logistic materials:** The availability of logistic materials among 57 Health facilities is outlined in Table 3. Information on logistic material availability from 17 HFs could not be retrieved.

Table 3: Number and percentages of HF with available logistic materials (n=57)

Item name	No of HF institutions with availability	Percentages Materials (%)
CB-IMCI register	46	80.70
Timer	53	92.98
Thermometer	50	87.71
Weighing Machine	46	80.70
Dee Lee Suction/penguin suction at Birthing centres	22	100
Bags and masks at birthing centres	22	100

Table 4: Availability of CB-IMNCI medicines

Item name	No of HF institution with availability	Percentage (%)
Insulin syringe	40	70
Gentamycin (inj)	43	75
Amoxicillin	47	82.4
Zinc	48	84

ORS	57	100
Cipro Tab	55	96.4
CHX gel	50	88
Vitamin A capsules	54	95
Albendazole	57	100

To address any weaknesses or gaps identified during the performance presentation, each health facility prepared an action plan for the betterment of the CB-IMNCI program. One copy of the action plan was handed over to the program focal person and one copy to the HF in- charges. The program focal persons (CB-IMNCI/PHN) will monitor these action plans and follow up within the timeframe outlined in the action plan.

Recommendations

- A refresher course should be provided, with a focus on the classification/management of < 2 months cases for the reinforcement of CB-IMNCI program and use of data.
- There should be provision of a separate IMNCI OPD in each HF for improving case management and proper recording.
- It is important that there is regular, timely and adequate supply of logistics and commodities from DHO.
- It is important that there is regular supportive monitoring along with onsite coaching /feedback from district focal persons and DHO.
- There should be Behaviour Change Communication activities conducted to raise awareness in the community focusing on timely seeking of services for sick neonates and under 5 children.

3. Second Round Joint Technical Support Visit (TSV) and Onsite Clinical Coaching at Birthing Centres

During this reporting period, a second round of joint TSVs was conducted in almost all birthing centres in Rasuwa and Nuwakot, except for those that were newly established. These TSVs were conducted after earthquake and emphasis was given to the re-establishment of the birthing centres that were completely damaged as a result of the earthquake. For all other birthing centres which were partially affected by the earthquake, the TSVs had a great focus on providing clinical onsite coaching to strengthen confidence among the SBAs and non SBAs and improve their ability to conduct their daily jobs. The TSVs were conducted by Save the Children central and district staff in coordination with the DHO focal persons and MNH consultants. The second round of TSVs had been carried out in Nawalparasi in the previous quarter.

In Nuwakot, most of the health facilities and birthing centres sustained damage from the earthquake; out of 22 birthing centres, ten were completely damaged and the remaining 12 were partially damaged. Similarly in Rasuwa, five out of 12 birthing centres were totally damaged and five others were partially damaged.

During the TSVs, essential materials for mother and newborn care were distributed such as newborn beds, blankets and wrappers for newborns and mothers, wrappers for and mother, bed sheets, thermometers, newborn weighing scales, BP instruments sets and IP supplies as well.

Table 5: Total Number of Health Facilities visited in Second Phase TSVs

Districts	No of Birthing Centres	No of BEONC sites	No of CEONC sites	Total
Nuwakot	19	2	1	22
Rasuwa	9	1	1	11
Total visit	**28**	**3**	**2**	**33**

4. Third Round of Joint TSVs and Onsite Clinical Coaching at Birthing Centres in Nuwakot

The third phase of TSVs focused on the Nuwakot district where most birthing centres were damaged and severely affected by the earthquake. These centres had been revitalised during the second phase of TSVs and subsequently required more coaching support. Therefore the third phase of TSVs focused on clinical coaching in these clinics, with a particular focus on efficient implementation of infection prevention practices. After the earthquake, patients as well as service providers working at the HF were more prone to infection and/or diseases and it was therefore important to provide coaching for protection and prevention from infection. In total, the third phase of TSVs were carried out in 19 birthing centres, 3 BEONCs and one CEONC site of the district.

5. Orientation on Infection Prevention for Nursing Staff and Health workers at Birthing centres

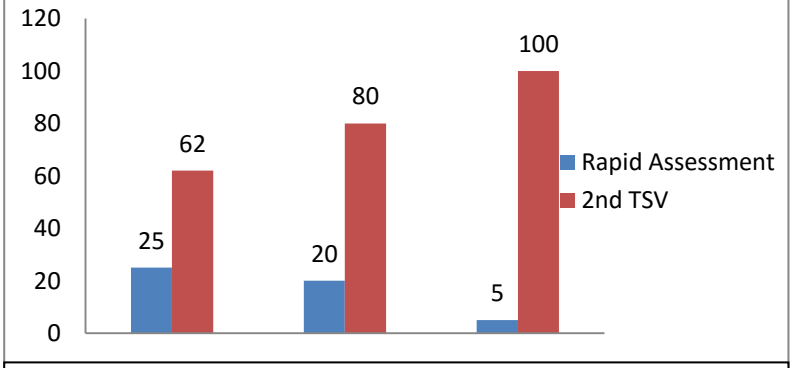


Chart 1: Percentage of Birthing Centres with complete set of IP supplies

Following the earthquake, many health facilities have been operating in temporary shelters or tents, meaning that the risk of infection is very high if preventive measures are not used properly. Therefore a two day orientation session on infection prevention practices was organized at a district level from 23rd to 24th June 2015 and 25th and 26th June 2015. Similarly, an orientation at birthing centres was organized between 28th June to 18th July 2015. A total of 51 service providers including SBAs, non SBAs and health workers working at birthing centres, BEONC and CEONC sites were trained as IP needed to be adopted as a universal precaution by all staff involved in health services. A two day IP orientation session was also conducted in Nawalparasi from 14th to 16th July 2015, where 30 service providers, nurses and ANMs were trained. Currently, the service providers are regularly practicing the decontamination process in 0.5 % chlorine solution, and are also using protective barriers while conducting deliveries and providing newborn care. To enhance the IP practice at birthing centres,

IP supplies were provided at the birthing centres. A comparative chart (Chart 1) of available IP equipment is illustrated in the above graph, where it is shown that the availability of IP equipment has increased in all three districts.

6. Assessment of the project

In the last phase of this project, a rapid review assessment was carried out from 1st to 14th August across all three districts, with the support of external resource persons: Dr. Steve Hodgins from SC/US and Abdul Haq Waheed and Ehtisham Ul Hassan from SC/UK. The main objective of the assessment was to capture lessons learned from implementing the CB-IMNCI programme and strengthening the MNH activities /birthing centres, with the aim of informing decision making and planning for similar future work by DoHS and its partners.

The assessment methodology and tools were designed and developed in consensus within the team on the design, methodology, tools and schedule for review and assessment. The team was divided into two groups, with one group visiting Nawalparasi and the second group visiting Rasuwa and Nuwakot to conduct the assessment. Following the field visit, a one day workshop was conducted as a 'feedback session' with field officers of SCI, The detailed rapid review methodology and findings can be found in the Rapid Review report that has been submitted as Deliverable 9 of the project.

7. Printing and supply of Materials to Family Health Division

As requested by FHD, the following materials were printed and supplied to concerned divisions. The printed materials will be used as resource materials for managing the maternal and newborn cases.

Table 6: List of printed and supplied materials to FHD

S.N	Name of Resource Materials	Number
1	National Medical Standard vol III	1000
2	National RH Protocol for SN/ANMs	1000

8. Regular Technical Support to DHO and HFs

SCI's district based staff have been continued to provide regular technical support to the DHO during this reporting period on the following tasks:

- Assisted DHO statistical officer to enter the HMIS/LMIS information received from health facilities.
- TA support to DHO staff to conduct health facility level quarterly meetings.
- Participated in the planning for reconstruction/re-establishing the health facilities in earthquake affected districts such as Rasuwa and Nuwakot.
- Coordinated with store-keepers to supply MNCH commodities at health facilities.
- Assisted the DHO to prepare a district annual report and presentation for the regional level review meeting.

- DHO of Nawalparasi had conducted multispectral Nutrition Programs in six different VDCs. SCI field based staff provided TA support to conduct this activity at VDC level as requested by DHO of Nawalparasi.

9. Meeting with NHSSP

A meeting has been held with Dr. Maureen Daring from NHSSP on 18 September 2015. The objective of the meeting was to discuss and secure approval on the proposed activities for a no–cost extension period until November 2015. As a result, the following activities were approved to be carried out during the no-cost extension period.

- Procurement of Neonatalie: 40 Neonatalie will be procured for the birthing centres in Rasuwa and Nawalparasi.
- TSV at birthing centres of all three districts to enhance the skill of SBA/Nursing staff for resuscitation.
- Support to FHD for revision of MNH training package
- Update and print MNH complication management Job Aids for birthing centres
- Printing of BPP mothers cards for the three project districts.

Annex- I

Guidelines for the Revitalization of CB-IMNCI at Facility and FCHV Level

Introduction

Since March 2014, Save the Children has been entrusted to undertake the ***'Technical Assistance for Strengthening Newborn Care'*** project. The aim of the project is to support the Child Health Division (CHD) and Family Health Division (FHD) to develop a Community-based Integrated Management of Neonatal Childhood Illness (CB-IMNCI) package and to directly support in the strengthening of maternal and neonatal health (MNH) services.

As Nuwakot and Rasuwa have been worst hit by the devastating earthquake on 25 April, 2015 killing thousands of people in these two districts alone and leaving more than 80 percent of people homeless. The quake also severely affected the health facilities including the critical maternal and child health services. Given the huge impact in the health facilities efforts to re-establish the CB-IMNCI and MNH services are deemed essential in reviving the services in these two project districts.

The CB-IMNCI service revitalization aims to revitalize the CB-IMNCI services in the health facility and FCHV level. The program will focus on technical support visit at Health Facility and FCHV package distribution which will ultimately support in re-establishing the CB-IMNCI services with enhanced morale of health workers and FCHVs.

Objectives of TSV for revitalization of IMNCI program at Health Facility

- To revive the CB-IMNCI program post-earthquake in the affected districts
- To improve the quality of CB-IMNCI program
- Coaching to HF staff on two months to 5 years and under two months /neonatal case management.
- Support to improve the overall program management components e.g. recording/reporting, supplies, supervision, monitoring etc.
- Sensitize DHO/DPHO and supervisors on strength and weakness of HFs performances.
- Replenish the supplies and equipment e.g. chart booklet, recording/reporting forms, Job aids, timers etc.
- Support to prepare an action plan based on the performance of HF (findings/gap)

Procedures for TSV

- Visit the concerning districts and brief the DHO on the program objectives.
- Orient to the district supervisors on TSV tools, process and their roles.
- Coordinate with management team to arrange the logistics.
- Group division: Based on the number of Health facilities.
  - Five teams for Nuwakot
  - Two team for Rasuwa
- Prepare joint schedule for visiting Health Facility and share the schedule with the respective HF In-charge.

- Based on the coordination with program focal person and DHO store keeper, prepare the essential drugs and logistics e.g. OPD Register, Chart booklet, ARI Timers and drugs based on the health facility demand/requirement.
- Visit health facilities and reach at the opening hour (10:00AM) so that the team could optimize their work throughout the day.
- Introduce with the health facility in-charge, brief about the visit, share objectives and brief on the procedures and request them to provide enough time.
- Observe the under 5 case managed by health workers if available and fill out the TSV tools accordingly.
- Observe the record of recent two cases for both age group from the CB-IMNCI OPD register and fill out the monitoring tools.
- Observe the under 5 case managed by health workers if available and fill out the monitoring tools accordingly.
- Observe the most recent, last two cases for each age group from the CB-IMNCI OPD register and fill out the monitoring tools 1 and 2 accordingly.
- Observe the FCHVs report and verify/compare the HF level monthly report and provide your suggestion accordingly.
- Find out the gap as per the observation, cases from OPD register and provide onsite coaching using CB-IMNCI OPD register and Chart booklet
- Supply the necessary materials.
- At the end of your visit, request HF in-charge to prepare an action plan for upcoming three months period.
- Provide one copy to HF in-charge and another to D/PHO.

Revitalization of CB-IMNCI at FCHV level:

After completing the HF's TSV, the second hour or half day should be utilized for revitalization of CB-IMNCI at FCHV level. During the revitalization the following guidelines should be followed by TSV team.

Objectives for revitalization:

- Sharing experiences with all FCHVs on the post-earthquake situation to release their stress and trauma from the shock.
- Receive information on FCHVs' performance after the earthquake.
- Motivate and encourage FCHV to provide their support to the mothers (ANC/PNC), neonates and under 5 children in their wards.
- Highlight/update the major contents on MNCH program. (ANC, institutional delivery, postnatal care, ENC including use of CHX, danger/referral signs of under two months, under 5 children, 4 home rules to treat diarrhoea/use of ORS and zinc, use of foot length card)

Schedule of CB-IMNCI revitalization orientation at FCHV Level:

Duration: 4 hour

S.N	Contents	Time	Remarks
1.	Registration	15 minute	
2.	Introduction round	15 minute.	
3.	Objective of orientation	15 minute	
4.	Experience sharing from all FCHVs during earthquake	1 hour	
5.	Discussion on their performance, what they are doing to support ANC, delivery/PNC, neonates and under 5 Children	30 minute	
6.	Encouragement and motivational speech	15 minute	
7.	Major content update based on IMNCI flip chart/Job aids (use of Misoprostol tab at Nuwakot)	1 hour	ANC, Preparation for delivery, maternal Danger signs, ENC/use of CHX, Newborn danger signs, <5 danger signs, Use of ORS/zinc, Use of foot length card, EPI
8.	Distribution of IMNCI/MNH essentials to all FCHVs (Open the bag and show and brief an use of each items)	15 minute	
9.	Closing	10 minute	

Annex 2

List of CB-IMNCI and MNH essentials distributed to FCHVs.

By the end the re-vitalization session, the following materials have been distributed to all FCHVs. SCI procured and supplied the materials. Family planning contraceptives, Iron tablets and paracetemol were distributed from the DHO store:

1. Soap-3
2. Tooth brush-1
3. Tooth paste-1
4. Small towel-1
5. Sanitary pad-2
6. Tissue package-1
7. Biscuits big-2
8. Sugar- ½ kg
9. Beaten rice-2 kg
10. Nail cutter-1
11. Kettle- 1
12. Catamol-20 tab
13. ORS-5 packets
14. Betadine-1
15. Zinc -2 strip
16. Handiplast- 10
17. Condom - 20 pcs
18. Pill- 3 cycle
19. CHX tube -3
20. Iron tab- 200 tab
21. Chlorine tab- 500 tab
22. Miso tab- 9 tab
23. CDK 3
24. Foot length card – 5 card
25. IMNCI and CHX Job aid- 1
26. IMNCI Fliers- 1
27. Recharge card -NRS.100
28. Gloves- pair
29. FCHV sari- 1pc
30. Bag to keep all these items

Annex – III

Guidelines of District level review monitoring meeting on CB-IMNCI Program

Background:

A district level performance review meeting is one of the key quality maintenance activities of the CB-IMNCI program. This activity can be carried out once in a year with engagement of all HF in-charges or relevant health workers. The main objective of the meeting is to review the CB-IMNCI activities in the district and guide the future programmatic directions of the program. Depending upon the feasibility, this can be a standalone activity or can be integrated with other regular activities. The most appropriate venue would be the Ilaka/reporting HF and/or at the district headquarter. The number of participants should not exceed 25 HWs however the ideal size would be 20-22 per batch and subsequently the number of batches will depend upon the number of health workers in the district and the logistical capacity of the DHO. The review meeting will involve basically two phases: the preparatory phase and the implementation phase.

Preparatory Phase:

During the preparatory phase, the DHO should prepare and send an invitation letter to the health facilities along with review meeting guidelines. The guideline should specify that the health facility in-charges are requested to prepare the presentation on the performance of MNCH program of the past six months or one year stressing the following indicators. Along with the presentation, HF in charges should be directed from the DHO to avail the CB-IMNCI OPD register in the meeting

Key Indicators to be analyzed

a) Total number of trained and untrained HW on CB-IMNCI package.
b) Total number of FCHV trained /untrained on CB-IMNCI package.
c) Total number of under 5 children registered.
d) Total number of pneumonia cases treated with amoxicillin among ARI cases.
e) Total number of diarrheal cases treated with ORS and Zinc (HF and FCHV level).
f) Total number of under 2 months cases registered and classified PSBI, LBI
g) Total number of under 2 months PSBI cases treated with injgentamycin and oral amoxicillin
h) Total number of under 5 and under 2 month cases referred by HF and FCHV.
i) Total number/percentage of ANC/first/forth comparing with their target.
j) Total number/percentage of pregnant women received Iron tab compared with their target.
k) Total delivery conducted at BC/BEONC sites compared with estimated delivery of their catchment area.
l) Total number of newborn applied CHX compared with estimated live birth.

In addition, the HF in-charges should also be directed to present the stock update as of the reporting period of following CB-IMNCI commodities in the health facility:

1. IMNCI/MNH treatment protocols at HF and BC
2. CB-IMCI OPD register
3. ARI timer
4. Bag and mask

5. Thermometer
6. Weighing scale
7. Deeley suction/penguin suction
8. Insulin syringe
9. Delivery set (for BCs only)
10. Gentamycin inj (Vile)
11. Amoxicillin tab (250 mg)
12. ORS
13. Zinc tab
14. Cipro tab (250 mg)
15. Cipro ear drop
16. CHX tube
17. Oxytocin inj (For BCs only)
18. Vitamin A cap
19. Albendazole tab
20. Mgso4

Implementation Phase

This is a two day activity. On the first day, all the HF in-charges need to present the performance of their health facility focusing on the above indicators/information. Therefore the DHO's statistical officer and CB-IMNCI/MNH focal person should prepare well ahead of the meeting which will allow for cross validity checks. The DHO, program focal person, statistical officer, store keeper/supervisors should provide concrete/creative feedback and suggestions on their presentation, so that HF staff could improve their performance accordingly. After completing the presentations from HF in-charges, district focal persons should highlight the major issues on program indicators, case management and supplies etc.

On the second day, continuation of the outstanding presentations if any should take place. After completing the presentation session, the following activity needs to be carried out:

1. **Group work:**

Divide the participants into 4-5 groups and request them for group work and plenary discussion. The plenary discussion should include the following key discussion points:

a) After implementation of CB-IMNCI/strengthening of BC/BEONC sites, what are the positive/negative outcomes at your HF?
b) What support do you need further to improve/maintain IMNCI and MNH services at your HF?

2. Review the CB-IMNCI OPD register:

Exchange the OPD register among the participants and request them to provide suggestions for improvement focusing on errors/mistakes/misclassification in recording and reporting and/ or case management. The DHO focal person and consulting facilitators should facilitate all the groups. These facilitators should remark and note the areas of errors/ mistakes/misclassification.

- Ask HF in-charges to provide suggestions based on their observation on the OPD register, this can be done in peers.

3. Coaching Session:

Based on the errors/mistakes in the OPD registers focusing on under 5 /under 2 month case management, facilitators should coach the participants using the IMNCI wall chart. This should be done in the plenary.

- During the coaching session, focus should be provided on the revised dose of amoxicillin and review the contents for management of under 2 months cases.
- Orient them about the use of hand book and flex.
- Inform them about coordination with drug retailers' focusing on rational use of drugs to manage diarrhoea, ARI and PSBI cases.

4. Action Plan preparation, signing and submission:

In the last session, HF staff should prepare their action plan based on the gap of IMNCI/MNH program. The CB-IMNCI consultant facilitator and program focal person can facilitate this session. They should submit the at least 2 copies of the signed work plan (one copy to DHO focal person and another copy for their official use). Also request them to orient the other health workers at their respective HFs on the action plan, important feedback and suggestions, provided during the meeting.

5. Distribution of commodities to the HWs:

As per their requirement/stock out, IMNCI related dugs, equipment, protocols, Flex (16" X 23") and hand book should be distributed and further encourage them to send their demand forms in a timely manner to reduce stock outs.

7. Closing Session:

-Reflection from the participants on review meeting

- DHO should provide the closing remarks and end the session

8. Financial settlement: Payment should be done based on the Government rules and regulation