



Nepal Health Sector Support Programme III (NHSSP – III)

**NHSSP QUARTERLY REPORT
APRIL 2019- JUNE 2019**



Disclaimer

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ABBREVIATIONS

ASBA	Advanced Skilled Birth Attendant
AWPB	Annual Workplan and Budget
BC	Birthing Centre
BEONC	Basic Emergency Obstetric and Neonatal Care
CAPP	Consolidated Annual Procurement Plan
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD	Child Health Division
CMC	Case Management Committee
CSD	Curative Services Division
DDA	Department of Drug Administration
DDR	Disaster Risk Reduction
DFID	Department for International Development
DHO	District Health Office
DoHS	Department of Health Services
DRR	Disaster Risk Reduction
DUDBC	Department of Urban Development and Building Construction
eAWPB	electronic Annual Work Plan and Budget
EDCD	Epidemiology and Disease Control Division
EDP	External Development Partner
e-GP	e-Government Procurement
EHRS	Electronic Hospital Reporting System
EOC	Emergency Obstetric Complication
EPI	Expanded Programme on Immunisation
EWARS	Early Warning and Reporting System
FA	Framework Agreements
FCGO	Financial General Comptroller Office
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FMoHP	Federal Ministry of Health and Population
FMR	Financial Monitoring Report
FP	Family Planning
FWD	Family Welfare Division
GBV	Gender-Based Violence
GESI	Gender Equality and Social Inclusion
GIZ	German Corporation for International Cooperation
GRB	Gender Responsive Budgeting
HFOMC	Health Facility Operation and Management Committee
HIIS	Health Infrastructure Information System
HMIS	Health Management Information System
HQIP	Health Quality Improvement Plan
HRFMD	Human Resource and Financial Management Division
HVAC	Heating, Ventilation, and Air Conditioning
IAIP	Internal Audit Improvement Plan

IT	Information Technology
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
KFW	German Development Bank
LCD	Leprosy Control Division
LMD	Logistics Management Division
LMS	Logistics Management Section
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MoFAGA	Ministry of Federal Affairs and General Administration
MoUD	Ministry of Urban Development
MoWCSC	Ministry of Women, Children and Senior Citizens
MPDSR	Maternal and Perinatal Death Surveillance and Response
MSS	Minimum Service Standards
MTR	Mid Term Review
NDHS	Nepal Demographic Health Survey
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHEICC	National Health Education Information and Communication Centre
NHRC	Nepal Health Research Council
NHSP	Nepal Health Sector Programme
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NNRFC	National Natural Resources and Fiscal Commission
NPC	National Planning Commission
NPR	Nepalese Rupees
NPSAS	Nepal Public Sector Accounting Standards
NSSD	Nursing and Social Security Division
OCAT	Organisational Capacity Assessment Tool
OCMC	One-stop Crisis Management Centre
OPMCM	Office of Prime Minister and Council of Ministers
PBGA	Performance-Based Grant Agreement
PD	Payment Deliverable
PFM	Public Financial Management
PHAMED	Public Health Administration Monitoring and Evaluation
PHC	Primary Health Centre
PHSA	Public Health Service Act
PHCRD	Primary Health Care Revitalisation Division
PIP	Procurement Improvement Plan
PNC	Postnatal Care
PPMD	Policy, Planning, and Monitoring Division
PPMO	Public Procurement Management Office
QARD	Quality Assessment and Regulation Division
QIP	Quality Improvement Plan
RANM	Roving Auxiliary Nurse Midwife

RDQA	Routine Data Quality Assessment
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SAS	Safe Abortion Services
SBA	Skilled Birth Attendants
SDG	Sustainable Development Goals
SMNH	Safe Motherhood and Neonatal Health
SOP	Standard Operating Procedures
SSU	Social Service Unit
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TABUCS	Transaction Accounting and Budget Control System
TARF	Technical Assistance Response Fund
TOR	Terms of Reference
TOT	Training of Trainers
TSB	Technical Specifications Bank
TUTH	Tribhuvan University Teaching Hospital
TWG	Technical Working Group
UNFPA	United Nations Population Fund
VP	Visiting Provider
WHO	World Health Organization
WOREC	Women's Rehabilitation Centre

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EXECUTIVE SUMMARY

Precis.

This report is the eighth Quarterly update of the Nepal Health Sector Support Programme 3 covering the period from 1st April to 30th June 2019. This has been both an exciting and challenging time for the team with most of the work being dominated by the NHSP3 Reshape/Extension Proposal (submitted to DFID on 19th June 2019). The implementation of Federalism continued within a rapidly changing health environment and with support from NHSSP, the GoN finalised the Annual Workplan and Budget (AWPB), observing a degree of flexibility in the health conditional grant to provincial and local governments indicating that lessons learned from last year's programme and budget execution had been considered in this year's planning process. NHSSP continued to have excellent working relationships with External Development Partners (EDP's), NHSP3 Suppliers and key stakeholders and this is evident in the partnership working and collaboration with USAID (joint infrastructure assessment in Karnali); GIZ (e-Health); WHO (MSS); NSI (Safe Motherhood and Newborn Road Map) and MEOR (Logframe and Extension Proposal). There were Eight Payment Deliverables (PD's) submitted and approved by DFID this quarter. An additional three PD's scheduled were delayed, these were as follows; PD 60 Report of Social Audit Findings; PD 51 – revised Standard Treatment Protocols (STP) and National Medical Standards (NMS), this was split into two components, STP will be submitted early September and NMS will be submitted end November 2019; PD 65 – Aama Programme Status Report, preliminary findings will be presented as a PowerPoint presentation in November 2019 with a final report being submitted January 2020. Final submission dates were discussed and agreed in consultation with DFID. All PD's submitted were developed in consultation with relevant government counterparts – ***Please refer to Annex 2 for the complete list. To minimise submission delays, NHSSP has committed to adjust the delivery dates in exceptional circumstances only. DFID will be notified at least two months in advance about any future proposed delays.***

Development Context

NHSSP continued to provide Technical Assistance to facilitate evidence-based support for capacity enhancement in order to address and resolve the many challenges in implementing the change processes within the health sector. Implementation of Federalism continued to progress slowly and despite the fact MOHP has begun to address issues related to this (for example, coordination between the three spheres of government and resource allocation), a number of key challenges remain including fiscal challenges and the lack of governance between the three levels of government. This quarter, MOHP formed and remobilised a number of committees to develop Laws & Bylaws in accordance with the Public Health Services Act (2018) and other relevant documents and committed to providing quality health services for all through its endorsement of the National Health Policy (2019). One of the biggest undertakings of the GoN was in commencing enactment of the Civil Servants Adjustment Act (2018). This resulted in more than 12,000 grievances being lodged, ongoing demonstrations by health worker alliances expressing dissatisfaction to the process being held, and staff refusing to go to posted locations, and in some cases, resigning. Although adjustment of 11th Grade Officials was completed, many positions were transferred and replaced with new personnel who will have to undergo orientation within their new departments. This has already had an impact on programme implementation for NHSSP, for example, in the final signing off of the Safe Motherhood and Newborn Road Map. Multi sectoral engagement also continued this quarter between the three spheres of government and all key stakeholders especially during the Annual Workplan and Budget (AWPB) processes and during the recent floods and public health emergencies (outbreak of Dengue in the Terai).

Technical assistance

Within NHSSP a new Team Leader was appointed in May 2019 to provide overall strategic leadership and management support to the team. NHSSP met all its outputs and continued to provide TA support to MOHP and the health sector in a rapidly changing health environment. Examples of which are as follows;

- AWPB for FY 2019/2020 – supported the development and preparation of this, working closely with MOHP government officials to develop business development guidelines to support AWPB processes in the new context of federalism. The AWPB was announced in Parliament by the Minister of Finance on 29th May 2019.
- Worked with provincial and local governments by extending support at the request of MOSD in Provinces 1,2,3 & 5 to support its planning processes, holding infrastructure sensitisation workshops in Provinces 2,3,Gandaki & Karnali and supporting Provinces 1,2 & 5 in planning and budgeting for maternal child health and family planning.
- Continued close collaboration with MOHP & DUDBC ensuring notices for both the decanting blocks in Pokhara and Bhaktapur Hospitals were published.
- Analysis of the level of disaster preparedness and response planning of each of the health facilities within the Learning Lab districts – assessment was completed in 5 districts, ongoing assessment for 6th & 7th districts will be completed next quarter
- Completed implementation of OCAT & MSS at municipal level (and RDQA – see below) at health facility level, gaps identified helped greatly in the AWPB process and Municipal allocation is expected to increase in each of the sites as a result of this.
- Routine Data Quality Assessment (RDQA) – this was implemented by NHSSP across all seven Provinces and selected local Palika's. In collaboration with GIZ and USAID, NHSSP developed the tools, guidelines, user manual, tutorial, dashboard and other e-learning materials which were published on the MOHP website (www.rdqa.mohp.gov.np)
- Continued supporting MOHP to scale up One stop Crisis Management Centres (OCMC) in all 55 sites (including supporting MOHP to establish two new centres) and in the roll out of the Gender Based Violence (GBV) protocol. Provided GBV Clinical Medico-legal training in all 7 Provinces to 150 Drs & 26 Forensic Scientists and held a GBV workshops for survivors in Province 3. Training was also provided to all Palika Mayor & Deputy Mayors in Chitwan districts resulting in a commitment to allocate 5.5 million NPR to support GBV survivors.
- Provided TA support to Provinces 1, 2 & 5 for planning and budgeting in MCH & Family Planning.
- 15th Five Year development Plan (now published by the National Planning Commission (NPC) - worked closely with MOHP in refining and finalising the health and nutrition and population and migration chapters of the Approach Paper for this
- National Health Policy endorsed by the Cabinet in May 2019 – provided TA support and assisted in finalising this, NHSSP is currently translating this into English which will then be disseminated to all EDP's.
- Public Health Service Act (PHSA) (this Act is expected to facilitate the reform process across the three levels of government) - continued to support MOHP in developing the regulation for this as per organisational structures across the three levels, staff adjustment has now commenced and is expected to be completed in the next quarter.

NHSSP are also members of a number of Technical Working Groups (TWG's) led by MOHP, EDP's are also members and are represented.

Overall risks of Federalism to the health sector

Although it is anticipated that the implementation of federalism will eventually improve health service delivery in the long term, challenges continue to persist, and it is crucial that these are addressed directly. These include;

- Civil Servants Adjustment Act (2018) (as mentioned above) – currently being implemented
- National health Policy (2019) – although the Government of Nepal has reaffirmed its commitment to quality health services for all, inequity in access to services especially for the remotest regions of the country continues to be a problem. Barriers linked to low income, social status and the exclusion of the poor and vulnerable will need to be eliminated by further investment in local resources and services (including human resources for health) in order to improve outcomes and reduce disparities.
- Fiscal challenges and under-execution of provincial and local budgets – staff lack the skills and knowledge to forecast revenue and expenditure which also has the potential to directly impact service delivery

Conclusions and strategic implications

Overall this has been a productive quarter for NHSSP who have coped well with the ongoing challenges of Federalism within the health sector and the appointment of a new Team Leader. With the ongoing staff adjustment process and changes in leadership positions, NHSSP are well placed to provide continuing strategic support and skills strengthening across the three spheres of government. The coming months will bring not only new challenges but also new opportunities and with a new team leader and strong team in place, NHSSP remains in a confident position to continue providing timely and appropriate support as and when required.

1 INTRODUCTION

This document aims to apprise the Nepal Federal Ministry of Health and Population (FMoHP) and the United Kingdom's Department for International Development (DFID) on the progress of the Nepal Health Sector Support Programme 3 (Programme). The reporting period is from **1st April to 30th June 2019**.

Most of this quarter was dominated by the work on the NHSP3 Reshape proposal. Discussions were held with DFID and NHSP3 suppliers and the proposal was submitted to DFID on 2nd May 2019. Following subsequent comments and discussions, the final version was re-submitted to DFID on 19th June 2019.

In the meantime, NHSSP staff have maintained excellent close working relationships with key stakeholders and other partners, these include; NHSP3 Suppliers; DFID; EDP's & MOHP. Additionally, NHSSP has continued to work collaboratively with other EDP's in the Provinces, for example, earlier this year NHSSP began an assessment of the hospital infrastructure in Karnali province at the request of MOSD, at the same time, USAID undertook an assessment of human resources and service delivery within the same 11 district hospitals. The results of these assessments will provide the province with a comprehensive picture of the condition of its hospitals to serve as a basis for its multi-year development plan. A joint report will be produced and disseminated next quarter.

1.1 THE DEVELOPMENT CONTEXT

Progressive implementation of federalism continues with MoHP addressing issues such as efficient management of the transition process, coordination between the three spheres of government, technical competency, allocation of resources, transparency, good governance and accountability. MoHP also embarked on the formation and remobilisation of a number of committees to develop laws and bylaws in accordance with the Public Health Service Act (2018) and other relevant documents, for example, Functional Analysis and Assignment (FAA). Additionally, the Government of Nepal reaffirmed its commitment to quality health services for all citizens through its endorsement of the National Health Policy (2076). The policy aims to develop and strengthen the health system in the federal context based on social justice and good governance to ensure access to, and utilisation of, quality health services for all. The policy embodies a number of strategic focus areas, examples of which include;

- Health system in the federal context
- Progressive realisation to Universal Health Care with quality, transparent, continuous and extensive health care
- Multisectoral approach, partnership and cooperation
- Special health care to highly marginalised Dalits and indigenous community
- Good governance and high investment in health sector
- Equitable health insurance
- Sector reform
- Health in all policies
- Professionalism, honesty and integrity in the health service

The National Health Policy has provisioned at least one primary hospital in each municipality and one Basic Health Centre in each municipal ward. Addressing such policy provisions will require increased investment in curative care and physical infrastructure (approximately 2400 new basic health service centres across the country), which may lead to an unbalanced distribution of resources between curative care, health infrastructure and basic public health interventions. This is an area of consideration to be discussed for the upcoming planning and sectoral negotiations, however, the implementation framework for the national health policy is yet to be fully conceptualised.

1.2 SECTOR RESPONSE AND ANALYSIS

Sector response to the ongoing development context related to federalism and its related issues continues to be sporadic and slow and as in previous quarters, there remains a clear lack of a robust and strong communication and coordination mechanism within MoHP and among the three spheres of governments for health matters, resulting in the continuation of adhoc management of issues as they emerge.

One of the major undertakings of the Government of Nepal in this reporting period was in the enactment of the Civil Servants Adjustment Act (2075). The Ministry of Federal Affairs and General Administration (MoFAGA) is the focal ministry apportioning the adjustment in consultation with the respective ministries. In health, more than 12,000 grievances have been lodged against the list published by the ministry and a team comprising of MoFAGA and MoHP have been addressing grievances towards the finalisation of the adjustment list. The adjustment of 11th grade officials have now been completed and newly deployed officials are gradually resuming their positions and although the federal MoHP and MoFAGA are making progress towards the finalisation of the staff adjustment list for all grades, its execution, with fair distribution and timely deployment of health workers of all disciplines has been challenging. The ongoing demonstrations by a number of health worker alliances showing dissatisfaction to the process indicates the complexity of the issues. Failing to implement staff adjustment smoothly will also affect service delivery for example; non-availability of health workers at the service delivery points, vacant positions, staff refusing to go to posted locations, and staff resigning from positions citing dissatisfaction to the process. Regardless of the causes, either with individuals or groups of health workers, there will be substantial changes in human resources and in the short term we are likely to face shortages of health workers in duty stations which will ultimately impede service delivery functions. Although MoHP is not completely unaware of the potential risks during staff adjustment, no back up plan has been developed to date. The management of the staff adjustment process remains a priority in this reporting period and continues to be addressed by MoHP with the nomination of a dedicated team under the lead of Health Coordination Division. We are yet to know the level of changes with the ongoing staff adjustment at each sphere of government and its implications for overall human resource management and service delivery. Proactive engagement and the functional coordination of MoHP with sub-national governments will be essential in order to be able to deploy a proper human resource management plan during, and post, staff adjustment to ensure and facilitate timely decision-making processes at each level. Currently, this remains an internal MOHP mechanism.

Another major undertaking during this reporting period was in the finalisation of the AWPB. Responding to the annual workplan and budget development process, it appeared MoHP had considered lessons learnt from the previous year's annual planning and budgeting process, for example, there was a degree of flexibility in the health conditional grants to the provincial and local governments, and, the timely initiation of the planning guideline, which stated priority policy areas and which was communicated across divisions and sub-national governments undertaking a number of active consultations at divisional level. These included central hospitals, ensuring participatory dialogue based on evidence, programme specific consultations with sub-national authorities, and most importantly, active dialogue with the Ministry of Finance and National Planning Commission on planning and budgeting. Financial governance and procurement management has also been a priority concern for the sector management in this quarter evidenced by a number of meetings of public financial management committees, realigning TABUCS to capture sub-national government expenditure, and in the finalisation of the annual consolidated e-procurement plan with updates to the technical specification bank.

Partnerships, communication and harmonisation in the sector remained intact with no notable changes compared to the previous quarter. Multi-lateral and bilateral discussions between donors and MoHP and its respective Divisions continued. A number of partners expressed interest and actively participated in the development of the health sector partnership guideline, which is now being finalised and waiting further action and endorsement from MoHP. Multisectoral engagement also continued this quarter with greater clarity on roles and responsibilities among the three spheres of government and the timely coordination and communication with relevant stakeholders, especially during the AWPB processes, and during the recent public health emergencies including the recent Dengue outbreak and floods in the Terai. MOHP is planning to organise a health sector partnership forum in the next quarter and will continue engagement with external development partners through periodic joint coordination meetings. It is important to note that the development partners have also put this high on their agendas during their bilateral discussions to strengthen sector coordination and effective aid management. The Midterm Review Report of NHSS was developed and discussed by the TWG and feedback incorporated, the final report is yet to be received by the MoHP. Following the MTR review, MOHP started internal discussions on the remaining phase of NHSS and the need for its revision in line with the federal context, new National Health Policy and 15th periodic plan. Detailed modality on process is yet to be finalised. Overall, although health sector response to federalism is in general progressive, it should be noted that sector leadership and management are yet to be fully strengthened with increased improvements in information management, communication and coordination among the three spheres of government and concerned stakeholders.

MoHP also participated in a number of national and international consultations and events including the WHO World Health Assembly in Geneva reiterating Nepal's commitment to Universal Health Coverage (UHC) and strengthening Primary Health Care in the federal context. MOHP also undertook a number of initiatives addressing some of the priority areas of sector concerns which will have long-term implications, examples include;

- Development of a Concept Note for a federal health assembly with an aim to strengthen coordination and cooperation on major health agendas among the three spheres of government.
- Nepal's participation as a pilot country in the Global Action Plan on the Sustainable Development Goals (SDGs), coordinated by WHO, which includes eleven international health and development agencies. The Global Action Plan seeks to encourage new ways for countries to work together to accelerate progress towards achieving the SDGs by 2030. Nepal has chosen strengthening primary health care and using evidence for decision making as accelerators to the SDGs.

These initiatives were (and will continue to be) closely supported by NHSSP who will continue to provide continuing strategic support, capacity building and skills strengthening.

1.3 CHANGES TO THE TECHNICAL ASSISTANCE TEAM

A new Team Leader, Lorraine Porteous, joined NHSSP in May to provide overall strategic leadership and management support to the team. An induction programme took place which included a handover from the interim Team Leader and a one-week field visit to Province 1. Additionally, a number of key introductory meetings were held with senior key government officials and EDP's.

There were two resignations this reporting period; the Quality Assurance Adviser left to take up PhD study in Australia and the M&E coordinator resigned to take up a promoted position with PSI. Both positions will be recruited for in due course.

ISSTA - Eleven ISSTA were hired during this reporting period – ***Please see Annex 1 for details***

1.4 PAYMENT DELIVERABLES

In this reporting period, 5 scheduled PD's were developed and submitted and were approved by DFID (3 were delayed)– ***Please see Annex 2 for details***

1.5 LOGICAL FRAMEWORK

A revised/updated version of the NHSP3 Log Frame was shared by MEOR, on the basis of which the NHSSP Log Frame was updated. The achievements on the outcome and output level milestones for 2018/19 have been updated as relevant. As the data-entry across all government databases for this fiscal year is still on-going and is expected to be completed in Sept/Oct 2019, the updates to the NHSSP Log Frame currently only include any data that has been entered as of June 2019. ***Please see Annex 3 for updated Log frame.***

1.6 VALUE FOR MONEY

NHSSP is committed to maximising the impact of DFID investment in Nepal by embracing Value for Money (VfM) principles in its programme. NHSSP has been reporting on five indicators which have been guided by key VfM principles, ***Economy; Efficiency; Effectiveness and Equity.***

In this quarter, the average unit cost of both international and national STTA was below the programme budget ceiling and the use of both national (41%) and international (59%) STTA compared well with NHSSP programme indicators. The use of international STTA has increased considerably since the last quarter especially in key technical areas such as policy and in the development of guidelines. Similarly, the percentage of total expenditure on administration and management (18%) was within the acceptable benchmark range. Also, this quarter, six sessions of capacity enhancement trainings were conducted to 201 participants. The average cost per participant per day incurred for national and local level trainings was £38 and £10 respectively, both well below the benchmark cost. To date, the programme has submitted 65 PD's 64 of which have been approved by the Government of Nepal and DFID. The percentage achievement is 98%. – ***Please see Annex 4 for details.*** An example of a VfM case study can also be found in ***Annex 5.***

1.7 TECHNICAL ASSISTANCE RESPONSE FUND

The 1st and 2nd instalments of TARF were paid to NHRC for “Promoting the Use of Evidence in Health Systems Strengthening through the National Summit of Health and Population Scientist in Nepal”. The last payment is due next quarter in July 2019.

There were no new applications for TARF this quarter. NHSSP continued educating Senior MOHP officials and encouraging applications in the use of TARF funds. Following recent discussions with key Ministry officials, a new application for TARF is anticipated in early July 2019.

1.8 RISK MANAGEMENT

Risks identified have been evaluated and discussed in both the weekly SMT meetings and in the DFID monthly meetings. NHSSP's approach to risk management is to identify the ongoing and potential risks that are specific to the programme. The SMT has demonstrated its aptitude in managing these risks through a proven process of risk identification; risk analysis and quantification; and implementing mitigation strategies where possible. Our ability to manage risks is further enhanced by our well-established relationships with Government of Nepal

(GoN) counterparts and other partners. Three additional risks under GHTA and two under the RHITA risk matrix have been identified this quarter, these are;

1.8.1. GHTA Matrix

- R3: Contextual – Political changes within the UK Government may lead to a reduced commitment to the aid budget, including the budget for the proposed NHSSP 3 Extension
- R4: Political - Anticipated consultation meetings with the Government of Nepal may yield a different set of priorities or approaches at federal and sub-national levels than those presented in the Reshape Extension proposal
- R19: Safeguarding - Harm, abuse and exploitation of children and vulnerable adults (includes sexual harassment and exploitation). All staff will be receiving training on this in the coming months

1.8.2. RHITA Matrix

- R15: Financial - Disagreements over land allocations at Bhaktapur Hospital may cause delays in the retrofitting work
- R16: Safeguarding – As above

Based on the analysis of the current risk matrix against given criteria, the overall risk rating for this quarter is set at medium – the updated risk matrix can be found in **Annex 6**, (*for the complete risk matrix, please see Quarterly Report January – March 2019*).

1.8.3. Other Risks

Nepal remains under a multi-parliamentary system. During this quarter there continued to be a number of small-scale politically motivated protests, demonstrations and strikes. On 26th May 2019, three Improvised Explosive Devices (IED's) detonated in Kathmandu causing 4 fatalities. Although this was deemed to be a local incident, as a result of this, NHSSP is currently updating its security protocol.

2. HEALTH POLICY AND PLANNING

Result Area: 12.1 The MoHP has a plan for structural reform under federalism

Summary: Good progress has been made in this quarter for this results area. NHSSP worked closely with MOHP in refining and finalising the health and nutrition and population and migration chapters of the Approach Paper of the 15th Five Year Development Plan (which has now been published by the National Planning Commission (NPC)), and supported the development and the preparation of the AWPB for FY 2019/20, which was announced in Parliament by the Finance Minister on 29th May. TA also engaged in finalising the National Health Policy which was endorsed by the Cabinet in May 2019 and continued its support to MOHP in developing the regulation for the Public Health Service Act (PHSA), which is expected to facilitate the reform process across the three levels of government. As per organisational structures across the three levels, staff adjustment has commenced and is expected to be completed in the next quarter.

Activity i2.1.1 Provide strategic support on structures and roles for central and devolved function

- **Ongoing:** Grievances relating to the staff adjustment notice published by the Ministry of Federal Affairs and General Administration (MoFAGA) are currently being addressed. The final adjustment Notice of the 12th and 11th level officials was published on 30th May and as a result there have been changes in federal level posts. Directors of many divisions, including the Director General of DoHS and DDA, have now changed and the newly posted 11th level officers are expected to join their new offices early July. Posting of the subsequent levels will be published soon. No specific TA inputs were requested in this quarter. Next quarter, support will be provided as per appropriate requests from MoHP.

Challenges: The delay in the staff adjustment of human resources for health has the potential to negatively affect quality and programme implementation at all levels, this may result in delays in terms of decision-making as well as programme implementation.

Activity i2.1.2 Enhance capacity of Policy Planning and International Cooperation Division (now replaced by Policy, Planning and Monitoring Division (PPMD) and Health Coordination Division (HCD) in the FMOHP) and respective Divisions to prepare for federalism.

On-time: The NPC has now finalised the approach paper of 15th Five Year Development Plan in which health and nutrition, and population and migration appear as two separate chapters. (Final version of this can be accessed at;

https://www.npc.gov.np/images/category/15th_Plan_Approach_Paper2.pdf)

NHSSP also supported PPMD to prepare the annual "Policy and Programme" for the next FY in line with the NHSS, National Health Policy and the approach paper of the 15th Five-Year Development Plan. NHSSP engaged in prioritising and aligning health sector policy and programmes with other relevant sectors, based on the feedback received from the Office of the Prime Minister and the Council of Ministers (OPMCM). In this FY, MoHP led the preparation of policy and programmes for the social sector which was submitted to the OPMCM and presented by the Rt. Hon. President in the Joint House of the Parliament.

Inputs scheduled for next Quarter. Support will be provided to prepare the implementation plans of the National Health Policy and the 15th Five-Year Development Plan and support preparation of the programme implementation guideline for the AWPB of FY 2019/20 including the monitoring framework for the "Policy and Programme". Support for the initial preparation for developing Sector Programme (next NHSS) is also expected.

Activity i2.1.3 Develop guidelines and operational frameworks to support elected local governments' planning and implementation

On-time: TA continued to support MoHP in developing the regulations for PHSA 2018. NHSSP, as a member of the TWG formed by the Curative Service Division (CSD) (along with other EDP representatives), has continuously been engaged in the drafting of the Public Health Service Regulations (PHSR). Furthermore, we are also providing TA support in the drafting of the operational guidelines and referral guidelines of BHCS package. An NSTTA has been hired to facilitate consultation with key stakeholders in the preparation of the documents.

Inputs scheduled for the next Quarter. Continuing the support for the consultation and finalisation of the regulations and operational guidelines.

Challenges: The regulation and operational guidelines depend very much on the BHCS package, however, as this has not yet been endorsed, there is a risk of delay in the final approval of these drafts.

RESULT AREA: i2.2 DISTRICTS AND DIVISIONS HAVE THE SKILLS AND SYSTEMS IN PLACE FOR EVIDENCE-BASED BOTTOM-UP PLANNING AND BUDGETING

Summary: Good progress was made towards achieving this result. In line with the Federal budget ceiling, the MoHP has completed the preparation of the AWPB for next FY which has been finalised and endorsed by Parliament. In the Learning Lab (LL) sites, TA continued to support OCAT implementation at the municipal level, and MSS and RDQA at health facility level. A consolidated report was produced synthesising the findings of the assessments and was shared with DFID, this will be discussed with MOHP next quarter following which it will be disseminated accordingly. Knowledge of the gaps that were identified by these tools helped to inform the AWPB process in the respective sites. The Health System Strengthening Officers at LL sites have played a crucial role in taking forward capacity enhancement based on the results of the assessments.

Activity i2.2.1 Develop gender-responsive budget guidelines, (incl. in Year 2 revision of Gender Equity and Social Inclusion operational guidelines)

Completed; Inputs scheduled for next quarter: Follow up on approval process; print approved guideline; engage and support PPMD to operationalise the guideline.

Activity i2.2.2 Support the Department of Health Services to consolidate and harmonise the planning and review process

On-time: The federal annual budget for the Fiscal Year 2019/20 was announced on 29th of May 2019. The MoHP budget for FY 2019/20 is NPR 42.67 billion, almost 24% higher than the ceiling originally provided for, this amounts to 3.5% of total allocation to federal entities. When the health sector conditional grant to provincial and local levels is added to this, the total health budget will be 4.49% of the total federal budget of FY 2019/20, again higher than last year (which was 4.3% of the total). For further details, **please refer to Activity i4.1.1.**

NHSSP provided strategic support in the preparation of the AWPB including consultation with the division and departments as per the framework provided by the NPC and MoF. Together with the PPFM team, HPP team provided support in preparing a guideline for facilitating in-house planning and budgeting within MoHP along with the provision of coding in TABUCS and its prioritisation of programmes and activities. Discussions with Divisions and Centers were also organised to review and refine the draft plan that was prepared by the respective entities

under MoHP. Furthermore, MoHP had a series of budget finalisation meetings with MoF to justify the need of the proposed programmes and ensure alignments of the activities across different divisions and centres.

Inputs scheduled for next Quarter: Continue support for the planning and preparation of the implementation guideline and monitoring its progress.

Activity i2.2.3 Implement learning laboratories to strengthen local health planning and service delivery

On-time: Implementation of the LL approach is progressing well. A consolidated report of the progress in the LL sites was prepared and shared with DFID on 30th June. The monthly progress report for May was also submitted. The monthly progress report of June is still being prepared and will be shared with DFID next quarter. Implementation of the OCAT and the MSS was continued in the remaining sites and completed for all LL sites by end June 2019. HSS Officers were intensively engaged at the local level in the development of the work plan and budget for the FY 2019/20 including using the evidence available which included organisational and health facility level assessments. Municipal allocation of the budget for the health sector is expected to increase in each of the LL sites for the FY 2019/20 as compared to the FY 2018/19, figures have still to be released.

Inputs scheduled for next Quarter: Assessment of the health facilities in Madhyapur Thimi municipality using MSS; Supporting in the planning process (based on evidence and gaps identified through the OCAT, MSS and RDQA) in sites where AWPB is yet to be finalised; Supporting programme implementation including the action plan of OCA, MSS and RDQA, and, preparation of various manuals (for example, Resource Manual, Participants' Handbook, and Facilitators Manual) to support NHTC to further roll out OCAT at provincial level and other local level sites.

Activity i2.2.4 Develop Leaving No-One Behind budget markers at National and local level

Completed: The LNOB budget markers guidelines were drafted and submitted to both the Policy, Planning and Monitoring Division and Population Management Division MoHP for their comments in mid-April 2019. To date, no comments have been received, this is in part due to the frequent changes of leadership within these divisions and despite frequent reminders, we are still waiting on feedback.

Inputs scheduled for next quarter: Incorporate inputs/comments received from MoHP; revise guideline and submit for approval; translate into English.

RESULT AREA: i2.3 POLICY, PLANNING AND INTERNATIONAL COOPERATION DIVISION IDENTIFIES GAPS AND DEVELOPS EVIDENCE-BASED POLICY

Summary: In this area of TA, Partnership Guideline in the Health Sector was further refined and submitted to MoHP for approval. During the process of the guideline development, a brief was also developed highlighting the growing role played by the private sector, existing forms of partnership in the sector and future perspective in shaping the partnership. MSS for hospitals has been printed and distributed to key stakeholders at federal level and final versions of the MSS for hospitals were shared by MoHP at a stakeholders' meeting in May. Following discussion at the two-day event, a pool of resource persons for MSS was created to facilitate implementation of MSS in the hospitals under the provincial governments. TA also engaged in finalising the National Health Policy endorsed by the Cabinet.

Activity i2.3.1 Conduct institutional assessments, market analysis (including political economy analysis), provider mapping for private sector engagement

Completed: The mapping of the partnerships in the health sector was completed and findings shared with the TWG led by PPMD to inform the development of the guideline for partnerships in the health sector (Activity 2.3.5). A policy brief on the partnership was also produced highlighting the growing role played by the private sector, existing forms of partnership, and future perspective in shaping the partnership.

No Inputs are scheduled for the next Quarter.

Activity i2.3.2 Update Partnership Policy for the health sector in line with that of the central government

Completed: The *Partnership Policy* for the health sector was developed and submitted to the PPICD, MoHP in 2017. Due to changes in the government, it was not endorsed. Key contents of the draft partnership policy were incorporated into the draft National Health Policy which has recently been approved by Cabinet. Furthermore, a guideline on partnership in health sector has been developed and was submitted to DFID in May 2019 (Activity i2.3.5). This has been shared with the relevant divisions and centres within MOHP for final review and feedback. It is envisaged that following incorporation of any comments received, this will be forwarded for endorsement.

No inputs are scheduled for the next Quarter. Support will be provided to MoHP for implementation once this has been approved.

Activity i2.3.4 Review existing policy and regulatory framework for quality assurance in the health sector

On-time: The MSS for Hospitals have been printed and the e-copy uploaded onto the NHSSP website, this is also in the process of being uploaded to the MOHP website. The MSS sharing meeting on 23 May 2019 by Quality, Standard and Regulation Division (QSRD)/MoHP included the following participants; Hon. State Minister of Health, Secretaries, Directors and Section Chief of Departments, Divisions and Centres. During the meeting, changes brought by the MSS at the district level hospitals was shared and senior officials of the MoHP highlighted the importance of rolling out MSS across all levels for improving the readiness and quality of health services. Additionally, a workshop was held on 10th & 11th June 2019 to orientate staff from the provinces on MSS (primary and Secondary Hospitals). 70 participants (approximately 10 officials per province) attended and included Medical Superintendents, Matrons, and Laboratory staff. This is part of QSRD efforts to build a resource pool at the provincial level to facilitate the implementation of MSS in the hospitals under the provincial government.

The MSS for health posts was further refined by CSD after incorporating the learning of the implementation of MSS for health posts in selected LL sites. The MSS for health post and the overall MSS implementation guideline are now in the final stages of approval. MoHP has provisioned budget in the FY 2019/20 for the implementation of MSS at the health facilities functioning at each level.

A TWG¹ has been formed by CSD to develop regulations for the Public Health Service Act (PHSA) 2018. The detail has been discussed in activity i2.3.1 above.

Inputs will be continued next Quarter: Support will be provided to develop the resource pool for MSS for Tertiary Hospitals and to CSD to finalise the BHCS operational guideline and referral guidelines. It should be noted that further delay in the approval of BHCS will affect the

¹ Key officials from MoHP, DoHS, GIZ, WHO, UNICEF and NHSSP

finalisation of the guideline and possibly service delivery at the local level. Support for printing the MSS (for health posts) and the MSS implementation guideline when finalised, are also expected for next quarter. Continued support for the finalisation of the regulation of the PHS Act will also be provided.

Activity i2.3.5 Assess institutional arrangements needed for effective private sector engagement (PD 49)

Completed: The "Guidelines for the partnership in the health sector" were further refined based on feedback received from DFID, EDPs, international STTA and MoHP officials. Both English and Nepali versions of the guidelines were produced and submitted to MoHP and DFID in May 2019 (please see i2.3.2. above).

Inputs scheduled for next Quarter: Support will be provided to PPMD in the implementation of the partnership as per the guideline.

Challenge: Delay in the approval of the guideline by MoHP may delay the implementation of the same. NHSSP is following up for its speedy approval and implementation.

Activity i2.3.7 Revise/update major policies based on findings and emerging context

Completed: TA was provided to MoHP in the finalisation of the National Health Policy (NHP) 2019 including consistency check of the contents and copyediting. MoHP had submitted the Policy to the Cabinet during the last Quarter which was endorsed on 25th May with slight modifications. Following endorsement, MoHP disseminated it by holding a press conference on the 1st June 2019. The endorsed policy document has 25 policy statements and 146 strategies. NHSSP is currently translating this into English.

Inputs scheduled for next Quarter. Implementation support will be continued.

RESULT AREA: i2.4 FMOHP HAS CLEAR POLICIES AND STRATEGIES FOR PROMOTING EQUITABLE ACCESS TO HEALTH SERVICES

Summary: This quarter has seen significant progress on GESI policy level work. The Health Sector Gender Equality and Social Inclusion (GESI) Strategy has been endorsed by the Cabinet's Social Committee and sent to Cabinet for approval, which will provide the opportunity to revise and strengthen MoHP's GESI institutional structures and progress other policy level initiatives. The Disability Inclusive Health Service Guidelines and LNOB budget markers were developed and submitted to MoHP, progress was also made on the Mental Health Strategy and Action Plan which is ongoing.

Activity i2.4.1 Revise health sector Gender Equality and Social Inclusion Strategy (PD 18)

Completed: The Strategy has been endorsed by the Cabinet's Social Committee and sent to Cabinet for approval.

Inputs scheduled for next quarter: Print the strategy; disseminate to a wide audience; initiate development of GESI Strategy Implementation Plan for federal level.

Activity i2.4.2 Revise and strengthen GESI institutional structures, incl. revision of guidelines in Year 2

Delayed: Establishment of the mechanism will be initiated after approval of the strategy by Cabinet. Due to delayed approval of the revised GESI strategy by Cabinet, this activity has been currently postponed.

Inputs scheduled for next quarter: Initiation and establishment of GESI institutional mechanism at MoHP.

Activity i2.4.3 Revise the National Mental Health Policy and develop a mental health operational plan

In progress: MoHP has instructed the Epidemiology and Disease Control Division (EDCD) not to develop a Mental Health Policy as the revised National Health Policy will cover key concerns and areas of mental health. EDCD therefore has been developing a Mental Health Strategy and action plan (in line with the NHP), with technical support from WHO and other partners. NHSSP has been providing inputs in each stage of the drafting process.

Next quarter: Support finalization of the mental health strategy and action plan.

Activity i2.4.4 Develop guidelines for disabled-friendly health services (PD 42)

Completed: Disability inclusive health service guidelines were developed in the last quarter. The TWG has reviewed and finalised these at a national workshop and they have now been translated into Nepali and submitted to EDCD/LCDMS for approval.

Inputs for next quarter: NHSSP will facilitate approval of guideline as required and print.

Activity i2.4.5 Revise Social Service Unit and One Stop Crisis Management Centre (OCMC) Guideline

On-going: MoHP has decided to revise SSU operational guidelines in the next quarter based on the feedbacks/suggestions received at the national review held in June 2019.

Inputs for the next quarter: Revise the SSU operational guideline; print revised OCMC and SSU guidelines.

Activity i2.4.6 Develop Standard Operating Procedures for Integrated Guidelines for Services to gender-based violence (GBV) survivors (Year 1), and support roll-out of National Integrated Guidelines for the Services to Gender-based Violence Survivors (Year 2)

Postponed/Delayed: This activity was postponed by the MoWCSC in consultation with MoHP due to ongoing staff changes and transfer of the Joint Secretary who had supported this. A meeting has been held with the new joint secretary (Ms Rudra Sharma) regarding this to share concerns and plan further action next quarter.

No inputs are scheduled for the next quarter.

Activity i2.4.7 National and provincial level reviews of One-stop Crisis Management Centres and Social Service Units

Completed: Successfully completed annual review of OCMC, SSU and Geriatric health services in Janakpur organized by MoHP in the presence of Madam Secretary, Dr Pushpa Chaudhary and Chief Specialist, Dr Sushil Nath Pyakurel. Participants (66) came from 33 hospitals in Provinces 1, 2 and 3. The forum enabled the sharing of key areas of revised health sector GESI strategy, cross learning, sharing of good practices and clarification on the confusion/misunderstandings and orientation regarding the new provisions of OCMC and SSU

in the changed context. The review program provided a good opportunity to reflect on the progress made, lessons learned, and identify the key areas of support for effective functioning of OCMC, SSU and Geriatric Wards to strengthen the health services and systems. Workshop participants also requested MoHP to organize medico-legal training to medical officers, psychosocial counselling training for the OCMC focal persons, roll out of GBV Clinical Protocol and capacity building training to social service unit staff. There was also a request for the development of a Geriatric strategy and action plan. MoHP assured all they would focus on these requests in next year's AWPB. Discussion also included rehabilitation support to GBV survivors as one of the biggest challenges in working in collaboration with local and provincial levels.

No inputs scheduled for next quarter.

Activity i2.4.8 Capacity enhancement of GESI focal persons and key influencers from the MoHP and DoHS on GESI and Leave No-one Behind aspects

Delayed: Orientation to MoHP and DoHS will proceed when the revised GESI Strategy receives Cabinet approval. Due to delayed approval, this activity has been halted.

Inputs scheduled for next quarter: Orientation to FMoHP and DoHS on revised GESI Strategy.

RESULT AREA: I2.5 MOHP IS COORDINATING EXTERNAL DEVELOPMENT PARTNERS TO ENSURE AID EFFECTIVENESS

Summary: In this area of support, a Joint Consultative Meeting (JCM) between MoHP and EDPs was organised which focused on the progress towards preparation of the AWPB. The JCM was organised along with the Mid-Year Review of 2018/19.

Activity i2.5.1 Support strengthening and institutionalisation of Health Sector Partnership Forum

Delayed: The MoHP is yet to define the date for the Partnership Forum in consultation with EDPs.

Inputs scheduled for next Quarter. Support will be provided to organise the Partnership Forum meeting once a date has been confirmed.

Challenges: The Partnership Forum has been due since last year. NHSSP has been following up with MoHP to propose a date, however, this has not been seen as a priority for MoHP. This will also require input from EDPs to follow up on this.

Activity i2.5.2 Support partnership meetings (Joint Annual Review, Mid-year review, and Joint Coordination Meeting) (PD 26 & 58)

On-time: The Mid-year review and Joint Consultative Meeting was organised at the MoHP hall on 15th May 2019. Summary note of the discussion was prepared and shared with EDPs for the review which is to be finalised through mutual discussion between MoHP and EDPs.

Inputs scheduled for the next Quarter: Support will be provided to conduct next JCM on the agreed date, the date has still to be agreed between MoHP and the EDPs.

Activity i2.5.3 Map technical assistance and update the FMoHP technical assistance matrix

Not scheduled: Support will be provided next quarter, if required, once the framework is agreed upon.

Activity i2.5.4 Support mid-term review of the National Health Sector Strategy

On-time: The NHSS MTR team submitted the draft report to the TWG and presented the findings of the review to the TWG and other key stakeholders on 21st June 2019. After the sharing workshop, the MoHP consolidated the feedback from the stakeholders and shared this with the MTR team on 26th June for it to be incorporated in the report. The MTR Team is expected to submit the revised report to the MoHP in July 2019.

No specific inputs are scheduled for the next Quarter. Recommendations of the MTR will be considered while providing TA.

Other Activities:

1. Successfully completed review workshops (13 & 14 June 2019) at Lalgadh, Dhanusha and (23 & 24 June 2019) at Dang on existing social auditing guidelines. Participants were from the MoSD, Provincial Health Directorate, Municipalities, District Coordination Committee and Health Offices of all provinces.
2. A one-day workshop on the long-term rehabilitation of GBV survivors was held on 8 May 2019 with local government heads and deputy heads (7 Palikas), DDC members, representatives/chiefs of I/NGOs and Bharatpur hospital management team. The Chief of District Coordination Committee was also present at the event. NHSSP Advisors oriented the participants on the OCMC concept, modality and the current status of OCMC at Bharatpur hospital. The ongoing conversation highlighted the need for adequate resources to manage the GBV cases requiring further support beyond the stipulated time (45 days). At the end of the workshop, an action plan was developed and “rehabilitation management committee” formed to manage the GBV cases requiring long-term rehabilitation and support. The committee will be headed by the Deputy Mayor of Bharatpur metropolis, the other 6 Deputy Mayors’ of the Palikas will be the Members.
3. NHSSP supported the organisation and preparation of meetings and orientation briefings with hospital management, OCMC and SSU for the UK Minister - Baroness Sugg’s visit to Provincial hospital, Surkhet. NHSSP attended alongside DFID and the Minister’s team, visits took place within the Aama ward, OCMC and SSU. Information was provided and discussions held. The visit was deemed a success.

3. HEALTH SERVICE DELIVERY

RESULT AREA: i3.1 THE DOHS INCREASES COVERAGE OF UNDER-SERVED POPULATIONS

Summary: This quarter has seen good progress. Site assessments for new CEONC sites were carried out and strategic decisions taken. CEONC functionality was similar to the previous quarter with 89% of the sites functional, NHSSP also facilitated FWD decisions about CEONC providers transfers based on monitoring evidence. Despite delays, the mHealth project has also progressed well with decisions on the prototype now having been made by NSSD based on evidence from the formative research. Support to FWD for monitoring PNC home visit was continued and the orientation of 11 more palikas were completed this quarter. In three LL sites, the FCHV training needs assessment was completed and this will be used for planning FCHV capacity strengthening. The VSP programme was implemented through a mobile camp approach in three provinces. GESI related activities such as establishment of two new OCMCs, roll-out of the GBV clinical protocol, the GBV Clinical Medico-Legal Training and site visits for coaching mentoring have also progressed well. A one-day workshop entitled “You are Not Alone” was held with GBV survivors in Province 3.

Activity i3.1.1 Support expansion, continuity, and the functionality of Comprehensive Emergency Obstetric Neonatal Care (CEONC) sites

NHSSP continued support to FWD to improve coverage of CEONC services, especially in remote areas.

a. Site selection and the establishment of new CEONC services as per AWPB and mentoring

Ongoing: On request from FWD and Province 1, NHSSP supported site assessments in Damak hospital and Mirchaya PHCC. Recommendations included CEONC services at Mirchaya PHCC were not to be established as good CEONC services were available within 30 minutes distance and instead it was recommended establishing CEONC services at Damak hospital as there was a recognised need for this in the area, existing staff and facilities at the hospital were adequate to start the services, and, the local municipality and Province 1 planned to upgrade the hospital to 50 beds and one of the CEONC services could be included as a part of this upgrade.

Inputs scheduled for next Quarter. Visits to Rukum (East) for the feasibility assessment at Rukumkot PHCC and to Damak hospital to facilitate starting the CEONC services.

b. Improving reporting, monitoring, and response mechanisms

Ongoing: Functionality of CEONC sites stayed similar to previous quarter.

Of the 84 CEONC sites (in 77 districts) monitored, a total of 74-76 sites were functional and C-section services provided over the last three months. Among 72 districts with established CEONC services, 65 districts had a functioning CEONC site for this reporting quarter and three more districts had a functioning CEONC service site for two months². Four out of 72 districts did not have functioning CEONC services for the three month period (**Table 1**).

Table 1 Status of CEONC functionality over the Quarter April- June 2019

	Provinces							Total	Last Quarter
	P1	P2	P3	P4	P5	P6	P7		
Existing sites	16	8	14	10	13	11	12	84	84

² Three months not functioning (Udayapur, Kalaiya, Dolpa and Malangawa hospitals; one month not functioning (Manthali PHCC, Chautara hospital and Tanahu hospital)

	Functioning								
Chaitra	14	6	14	9	13	10	10	76	73 (Poush)
Baisakh	13	6	12	10	13	10	10	74	74 (Magh)
Jestha	15	6	12	8	13	10	10	74	76 (Falgun)

During this reporting period, a total of 12 sites were not functional for 1-3 months. The reasons for non-functioning included; difficulty in recruiting service providers at four sites (two were new sites), absence of OT nurse due to study leave at one site, OT closed due to maintenance at one site, no cases for the entire month at two sites and providers referring patients to other sites at four sites.

NHSSP supported monitoring and reporting to the Safe Motherhood Section Chief and Director of FWD on the functionality status of all CEONC sites. Monitoring was done through a combination of long-distance phone-based follow-ups as well as joint visits with FWD to the CEONC sites in order to improve reporting and response mechanisms. TA also provided HR situation analysis to FWD/DoHS/FMoHP to support appropriate transfer of C-section service providers including doctors, anaesthetists and nurses and for minimising the effects of the “staff adjustment process”. A list of CEONC providers is also being drawn-up for the Health Secretary and FWD director to support rational decisions. An official memo for the development of CEONC functionality reporting mechanism with quality of care reporting was submitted to the director general by SMNH section chief.

Inputs scheduled for next Quarter. Continued monitoring, technical support and facilitation for HR transfer to ensure functionality of CEONC sites, especially to problematic and newly established sites. Development of the reporting application (CEONC and quality of care) once approval from the DG. Developing an HR list of CEONC sites for addressing the effects of “staff adjustment” on CEONC sites and continued advocacy.

Potential challenge: Staff adjustment process may result in mismatch between CEONC fund and staff gaps resulting in unavailable service providers in a few sites. NHSSP is making efforts to avoid this through providing monitoring data and other evidence to FWD to enable better decision-making.

c. Caesarean section monitoring and implementation of study recommendations

Ongoing: FWD have budget allocation in the AWPB 2019/20 to introduce the Robson classification and monitoring institutional C-section at selected hospitals with high C-section rates in public and private hospitals. Introduction of this in selected hospitals through the Nepal Society of Obstetricians and Gynaecologists (NESOG) has been scheduled for after the Aama implementation guideline is revised (expected to be completed in July 2019).

Inputs scheduled for next Quarter: Discussions and planning with NESOG for introduction of the Robson classification in Province 5.

Activity i3.1.2 Support the FHD and District Health Offices to upgrade health posts with Basic Emergency Obstetric and Neonatal Care services

Changed: As reported in previous quarters, based on recommendations of the SMNH roadmap 2030, the focus will be on supporting any expansion of BEONC sties at strategic locations in hill and mountain areas.

Inputs scheduled for next Quarter: NHSSP will work on SMNH roadmap recommendations following endorsement.

Activity i3.1.3 Support the Primary Health Care Revitalisation Division to assess Community Health Units and modify guidelines

Ongoing: No meetings were organised on FCHV strategy during this reporting quarter. The strategy is being led by NSSD and mainly supported by CARE Nepal. NHSSP is an invitee to the meetings to make technical contributions to the strategy.

Inputs scheduled for next Quarter: NHSSP will provide inputs to the FCHV strategy as requested.

Activity i3.1.4 Facilitate the design and testing of Reproductive, Maternal, Neonatal, Child, and Adolescent Health; Family Planning; and nutrition innovations

Ongoing: NSSD and the Technical Advisory Group (TAG) are in agreement with the proposed processes for developing and piloting the mHealth tool shared by BBC Media Action (NHSSP's technical partner for this innovation). The following activities were completed this quarter:

- Sharing of formative research findings with NSSD and DFID
- Final formative research report submitted to NSSD and NHRC
- Development of two concepts for human centred design testing in three districts and shared with NSSD and DFID.
- Selection of health messages and further development of concepts into one final prototype.
- Agreement of the evaluation methodology by BBC Media Action with NHSSP, MEOR and DFID

Results from the first round of user testing to finalise prototype are yet to be shared by NSSD and IT section of MoHP with the TAG due to staff changes including the appointment of a new DG.

Inputs scheduled for the next Quarter: Sharing the human centred design process and final prototype with TAG (to be presented by NSSD); Sharing and agreement of evaluation methodology with NSSD (and TAG if necessary), submission to NHRC for approval; Complete development of the prototype into a fully functioning tool with all audio content and the supporting physical job aid/IEC material; training of 800 FCHVs across three districts

Potential challenge: Agreement on evaluation methodology with GoN counterpart. Possible delay in implementation due to Monsoon effects (landslides and floods) in the three districts.

Activity i3.1.5 Support the FHD/Child Health Division (CHD)/PHCRD and DHO to improve RMNCAH and FP services in remote areas

a. Planning support in remote areas

On-time: NHSSP has provided planning support in three remote Palikas³ for the 2018/19 AWPB planning and undertook a budget analysis which showed increased allocation of local Palika's budget for health as compared to previous year. Continued off-site technical support was provided to these Palikas especially in following implementation guidelines. Follow-up visits are planned after the 2019/20 AWPB processes have been completed for a case study on actual implementation based on the AWPB from last year.

Inputs scheduled for the next Quarter: Onsite visit and follow up to the three Palikas on implementation of their AWPB 2018/19, review their AWPB 2019/20 and develop a case study report.

b. Performance-based incentive to encourage productivity and retention of Skilled Birth Attendants

³ Bigu and Gaurishankar Gaunpalika in Dolakha and Umakunda Gaunpalika in Ramechhap

Ongoing: Supported FWD in monitoring the PNC home visit programme (an incentive-based programme) as well as the planning meetings at Provincial level. Although budgets for 2018/19 were allocated for 51 Palikas, only 33 Palikas initiated this after they received the budgets directly from FWD in early 2019. There have been challenges for the remaining 18 Palikas as the budget was meant to be channelled through the Provinces, this has led to significant delays. Of these, 11 have now completed the orientation programme and home visits will begin in FY 2019/2020, the remaining 7 Palikas have not yet received the budget amount allocated. NHSSP aims to analyse HMIS data on coverage of three PNC visits in implementing Palikas for three years: 2016/17, 2017/18 and 2018/19 in order to identify any trends and/or improvements. This will be undertaken when the HMIS data entry for 2018/19 has been completed by the GoN.

Inputs scheduled for the next Quarter: NHSSP will support FWD for following up on budget allocation and approvals for FY 2019/2020 and develop capacity enhancement plan for Palikas. Detailed HMIS data analysis to understand the contribution of PNC home visit programme on PNC coverage per protocol will also be undertaken.

c. Implement social mobilisation and behaviour change approaches

Ongoing: Experience from planning with Palikas showed that local governments were committed to support FCHV capacity strengthening, NHSSP will support this in the LL sites. Three LL sites (Dhangadhimai, Itahari and Ajayameru) have completed an FCHV training need assessment, and LL based HSS officers have advocated for budget allocations for FCHV basic training in AWPB 2019/20.

Inputs scheduled for the next Quarter: TA will complete FCHVs' training needs assessment report of the remaining sites and ensure budget allocation for capacity strengthening. Technical support for FCHV basic training will be provided in coordination of NHTC/PHTC in selected LL sites.

i3.1.6 Support the FHD and District Health Office to scale-up Visiting Providers, Roving Auxiliary Nurse Midwives, and Integration of Family Planning in EPI clinics

Ongoing: NHSSP TA has continued off-site monitoring of VSP and RANM implementation in the Provinces and municipalities and has also advocated and lobbied with FWD for a scale-up plan of VSP programme to 96 municipalities in 33 districts and RANM programme to 105 municipalities in 35 districts through the AWPB of 2019/20.

a. Visiting Service Providers

Over this reporting period, Provinces 5, 3 and 6 implemented the VSP programme, but the implementation approach is different to that provided in the implementation guidelines. Existing IUCD/implant providers were gathered at one health facility to provide IUCD/implant services and provinces conducted these IUCD/implant events over 1 or 2 days at the health facility, similar to mobile IUCD/implant camps.

	Events conducted at:	Events Planned next quarter at:
Province 3	Jiri hospital, Dolakha,	Dudhauri. Sindhuli district
Province 5	Thada PHCC, Arghakhanchi	Tansen, Palpa district
Province 6	Chhedagad Urban health unit, Jajarkot Mangri HP, Mugu Babiyachaur HP, Surkhet.	

NHSSP coordinated with FPAN (in Jiri), ADRA Nepal (in Thada Arghakhanchi) and focal person of Provincial Health Directorates of Provinces 3 and 5, for organising mobile

IUCD/implant service provision events. FWD and ADRA provided job aids for service providers during these events.

b. Roving Auxiliary Nurse Midwives (RANM)

RANM programme was implemented this quarter in all planned 46 municipalities. NHSSP supported the RANM programme through off-site management support to health coordinators (HC) of municipalities and by updating the status of programme implementation. Review of the RANM activity and capacity enhancement of RANM and HCs through group meetings/workshops at selected venues has been delayed as these activities have been advised for after the GoN staff adjustments have been completed.

A complete picture on impact of RAMN programmes implementation on RMNCH indicators will be reported in next quarter after HMIS reporting has been finalized for the FY2018/19. Province 7, with the support of NHSSP and Save the Children, will conduct a one-day RANM programme review meeting workshop in Dhangadhi Kailali in July 2019.

c. FP/EPI

Provided technical/facilitation support for re-orientation sessions on the FP/EPI integration in 2 districts - Parbat and Bajhang (the programme had been started here in 2015/16). FWD has now planned provincial level FP/EPI integration orientation programmes for FY 2019/2020.

Inputs scheduled for the next Quarter. NHSSP will continue to monitor VSP and RANM implementation. Support will also be provided for revision of implementation guidelines.

Challenge:

VSP implementation through Provinces: Provincial Health Directorates need further clarity on concept of VSP or completely resisted VSP approach. In this FY 2018/9, the VSP programme activity was planned to be implemented at Provincial level, however, the Provincial Health Directorates have a poor understanding of the VSP concept which has affected their response to the programme, and some were completely resistant. Only 3 Provinces actually implemented VSP, but this was modified and not as per programme guideline. For FY 2019/20, FWD has allocated budget at Palika level for future implementation of the VSP programme.

Capacity enhancement of RAMN: Delayed recruitment of RAMN and geographical challenges affected plans for on-site capacity enhancement as organising them in groups was not feasible.

13.1.7 Support the FHD to expand the provision of comprehensive Voluntary Surgical Contraception

Ongoing: The VSC camps have continued in this quarter and as per programme update reports (end of June 2019) made available by 3 suppliers (FPAN, MSI and EAG), a total of 1209 female sterilization, 732 male sterilization, 53 IUCD insertions and 429 implant insertion services were provided from 136 sites, 236 camp operational days and 29 districts (**Table 2**).

Table 2 Provision of VSC services

Item/Suppliers	FPAN		MSI		EAG	
	Apr-Jun	Cumulative	Apr-Jun	Cumulative	Apr-Jun	Cumulative
NSV	171	410	149	243	0	79
ML	5	790	23	101	0	318
IUCD	4	45	6	8	0	-
Implant	8	394	8	35	0	-
# VSC camp sites	5	73	27	38	0	25
# of camp days	13	125	39	64	0	47
# of districts covered	3	16 (of 21)	4	8 (of 43)	0	5 (of 6)

Inputs scheduled for the next Quarter. NHSSP will continue to support FWD to collect VSC camp information/reports from the suppliers.

Challenges: Two of the 5 supplier/agencies did not initiate activities citing non-conducive programmatic, financial and other technical issues. For the three other supplier/agencies who initiated activities, the number of VSC cases who received services was far below from what was expected. Out of a total of 40,000 expected cases of VSC from this outsourcing programme, only 1941 VSC clients received VSC services through 3 suppliers – MSI, FPAN and EAG. FPAN and MSI are established FP service providers in Nepal with many years of expertise and experience. Although FWD did not expect a large turnout of VSC clients/cases, the very low numbers were unexpected. Some key reasons for this appear to be: (1) long delay in contracting and outsourcing which seriously impacted the time left for uptake of services, (2) unavailability (low demand) of VSC clients at this time of the year due to seasonal agricultural demands, (3) budget norm fixed by FWD for VSC case/client is not adequate for most suppliers/agencies (4) no budget allocated or built in the package for demand generation, transport cost, monitoring, and pre-VSC preparation and post VSC follow up (5) lack of coordination between province, hospital and municipalities/districts (6) weak coordination support from FWD to provinces & municipalities (7) standard proposed for VSC team (e.g. 5 per team) and case/client limit per day (e.g. 3 for mountain, 5 for hill and 10 for terai) was challenging (8) previous VSC camps conducted in districts by other partners and (9) inadequate support from GoN staff mostly due to civil service staff adjustments, this an ongoing process and will continue for some time. Lessons learned will be informed and planned for in FY 2019/20. In addition, VSC services in 2019/2020 will not be outsourced by FWD (outsourcing has been a one time activity for FWD). This activity has been given to the Provinces and some Federal level Hospitals.

3.1.9 Support to the MoHP for improving delivery of nutrition interventions

Ongoing: NHSSP is integrating nutrition messages into the SBA strategy, SBA training strategy and implementation plan, SBA training manual and the clinical mentor's guideline. An SBA strategy review meeting was organised by FDW and NHTC on 23-24 June 2019 with more than 50 stakeholders from government, partners and academia participating. Following presentations from FWD, NHTC and NSSD, the participants debated at length on the value of continuation of SBA training eventually agreeing this would continue till 2025. Current plans for the midwifery cadre, which will produce 800 midwives by FY 2024/25 (aking on the SBA functions) were also debated. Major challenges identified included; quality of training and quality of services at training sites, continuing education of trainers, accreditation of trainers, skill retention strategy for SBA and follow-up after training, enabling environment for SBAs and proper deployment of trained staff at the appropriate service sites.

Further meetings were delayed due to change of both directors of FWD and NHTC. The delay in SBA strategy revision has also meant that refresher training of SBA trainers and clinical mentors has also been delayed (challenges with Tipanni approval from previous FWD Director). However, FWD and partners have agreed to integrate messages from Birth Preparedness package and Nutrition in the HMIS ANC card. The draft HMIS ANC card was submitted to FWD director by SMNH section chief for official approval.

Inputs scheduled for the next Quarter: Finalisation of revised draft SBA strategy and training strategy; draft SBA training manual; draft SBA mentoring guidelines and tools.

3.1.10 Strengthening and scaling up of OCMCs

Completed: During this quarter, following half day orientations with hospital management committees, hospital staff and multi-sectoral stakeholders, new OCMCs were established in

hospitals in Parbat and Myagdi districts^{4,5} Additionally, OCMC Case Management Committee (CMC)⁶ meetings were held in four provincial and zonal hospitals⁷. This provided an opportunity to assess the functionality of OCMCs; types of cases being reported, types of services being provided, referrals and the current status of the case/survivor. This information was then used to guide the CMC on how OCMCs can be strengthened to respond to the needs of survivors. As requested by CMC, TA finalised the OCMC Referral Directory and presented it at Hetauda OCMC. The referral directory includes specific information on services available at referral facilities, how to access them (e.g. phone numbers, procedures, hours of operation, the cost of services etc.) and a contact name. The directory also includes information on other activities the organizations undertake to address the issues of GBV (e.g. research, advocacy, educational campaigns, sensitization, training, production of materials, etc). In addition to routine quantitative data collection, important and powerful qualitative data is also being obtained on the impact of OCMCs on individual lives (**see Box 1 below**).

Box 1

Case #1: a woman in her mid-20s with mental health problems was living on the street and began a relationship with a man who also had mental health problems. She became pregnant and was brought to the OCMC when she went into labour. She delivered at the OCMC and stayed there for a week post-delivery because she had no home to return to. The OCMC invested time in finding an agency to provide a safe home to the mother and baby and mental health care. Funds from the OCMC referral fund were used to transport the mother and baby to KOSHISH an NGO where they stayed for six months. In the meantime, the father received mental health care. The municipality and local organisations provided funds to build the family a home; OCMC and other organisations collected funds for basic living utensils, and OCMC provided funds for poultry. The family moved into their home and are running a small poultry farm.

Case #2: a 27year old married woman with three children who lived with her husband in a joint family set up experienced repeated sexual, physical and emotional abuse from her husband. She says, "he refuses to register our marriage and also refuses to make my citizenship. He has also denied registering the birth of our children in the respective ward." OCMC staff provided multiple counselling sessions to the wife and counselled her husband to register the marriage and citizenship of his wife; which he did. OCMC also accompanied the wife to register her children at schools and met with the headmaster. Both schools provided scholarships to the children.

During this reporting period, as previously mentioned, GBV Clinical Medico-Legal Training was completed in Province 2, Gandaki Province, Province 5, Karnali Province and Sudur Paschim Province and included 113 Medical Officers. In all 7 provinces, a total of 150 doctors (133 Medical Officers and 17 specialists) have now gone through this first round of training and have enhanced their capacity to undertake medico-legal examinations (Box 2).

Box 2

"GBV medico-legal training has been an eye opener for many of us. It provided us a different dimension of learning from what we were doing during the examination of cases related to sexual assault, rape and other forms of violence. Before, our understanding was kind of limited to physical examination (see if the hymen was ruptured or not, presence of sperm etc.) but after the training, we realised that there is far more we should be doing... such as look for the sign/symptoms of struggles, voice, expressions and overall mental and physical state of the victim etc. Furthermore, we learned to fill the reporting format for GBV/rape cases more appropriately."

Dr. Manoj Ghimire, Medical Superintendent, Beni hospital, Myagdi.

⁴ Parbat district hospital and Beni district hospital

⁵ District police, district attorney, deputy mayor, women police cell, safe home, CDO, I/NGOs and others

⁶ CMC plays a vital role for the effective functioning of OCMC. This committee includes 7 members – medical officer, emergency in-charge of the hospital, district police officer, officer from women police cell, district attorney, representative from safe home and OCMC focal person. The CMC members meet once a month or as required for the management of cases that are complex in nature or cases requiring advance treatment/s or referral to the higher centers.

⁷ Provincial hospital Surkhet Pokhara hospital (western regional hospital), Bharatpur hospital and Hetauda hospital

⁵. By Prof. Dr. Harihar Wasti, Lead Trainer of Clinical Medico-legal Training, Chief Consultant Forensic Medicine NAMS Bir Hospital

Inputs scheduled for next quarter: Strengthen newly established OCMCs; scope 2 new OCMCs⁸; GBV clinical medico-legal training of medical officers from hospitals with no trained doctors on GBV medico-legal.

Challenge: Multi-sectoral cooperation and collaboration to ensure integrated one-door services to GBV survivors and regular meetings of OCMC district coordination committees have been challenging especially for newly established OCMCs. Long-term rehabilitation support for survivors remains the biggest challenge. Continuous mentoring and monitoring support has been provided to ease the challenges to these OCMCs.

Support the strengthening of OCMCs through mentoring/monitoring and multi-sectoral sharing and consultation

Ongoing: Site visits have been held for coaching, mentoring and monitoring in seventeen OCMCs⁹ (both, new and old covering hilly and *terai regions*) and meetings held with district-level multi-sectoral stakeholders to review progress, challenges and achievements in OCMC strengthening. At the Federal level, TA facilitated a quarterly meeting with multi-sectoral partners, MoHP/GESI section and Nursing and Social Security Division/DOHS. The meeting enabled stakeholders to understand each other's scope of work, share progress with activities and identify avenues to strengthen GESI activities and integration.

A one-day workshop entitled "You are Not Alone" was held with GBV survivors in Bharatpur metropolis (Province 3) and Hetuda in coordination with local GBV networks and in the presence of the District Coordination Committee Chief. In each workshop, the presence of survivors was substantial (40 in Bharatpur and 43 in Hetauda). The main objective of the workshop was to strengthen the survivors' network to boost their self-esteem and empower them to be advocates/champions and motivators to fight GBV. A participant's view on the workshop is given in Box 3 below. The workshop has allowed them to see that they are not alone and has built solidarity among women who have confronted similar circumstances enabling them to find their voice. A similar workshop is planned at Saptari district next quarter.

Box 3

"Workshops like this makes us feel that we are not alone. We get space to share our feelings and what we have gone through. In doing so, we get empowered to tell our stories, to believe in ourselves, to chase our dreams and to see our own potentials. Pain has taught us so much...most importantly; realization that we should be united at all times and should never give-up. Through the network and support from OCMC, we have learned different skills such as soap, sanitary pad and cotton bag production in small scale. Some of our friends have started other agro-economic works and a few have been doing well in sewing/clothing etc." . "Can we have a program like this at least twice a year?"

- Survivor: from the Survivors workshop, Hetauda

A, five-day training on Basic Psychosocial Counselling was also held for 46 OCMC staff/focal persons from 43 OCMC based hospitals. The participants were divided into 3 groups and parallel sessions were conducted at NHTC training halls with the support from 3 partner agencies¹⁰. Since the participants were from 43 OCMCs, the training helped them to build common understanding and provided them the opportunity for cross-learning and sharing of the challenges, bottlenecks and opportunities in moving forward.

⁸ Mahottari and Siraha.

⁹ Sarlahi hospital, Sarlahi; Gaur hospital, Rautahat; Kalaya hospital, Bara; Manthali PHC, Ramechhap; Chautara hospital, Sindupalchowk; Prithvi Chandra hospital, Nawalparashi; Taulihawa hospital, Kapilvastu; Baitadi hospital, Baitadi; Doti hospital, Doti; Mangalsen hospital, Achham; Bajura hospital, Bajura; Tishuli hospital, Nuwakot; Dhading hospital, Dhading; Gorkha hospital, Gorkha; Daumali hospital, Tanahu; Sindhuli hospital, Sindhuli; and Sagarmatha hospital, Saptari.

¹⁰ Transcultural Psychosocial Organisation (TPO), CVICT and CMC Nepal

Inputs scheduled for the next quarter: Mentoring and follow-up support to select newly established OCMC hospitals; multi-sectoral orientation at Phaplu hospital, Solukhumbu; and conduct “You are Not Alone” workshop with GBV survivors in Saptari district.

3.1.11 Supporting the roll-out the GBV clinical protocol

Ongoing: The roll-out of the GBV clinical protocol has also been completed in 5 more hospitals¹¹. Following on from the four days’ training of trainers (ToT) held in the previous quarter, the trainers conducted On-the Job Training (OJT) to service providers of the two hospitals. The training helped to educate a majority of health personnel in the institution about the epidemiology of physical, sexual, and psychological violence against women, including the magnitude of the problem, patterns of violence in the surrounding community, and the impact of violence on women’s health (**Box 4**). The OCMC itself has served an increased number of survivors after the implementation of the training as reported by the hospitals. Between 15th July 2018 and 15th January 2019, a total of 3050 cases were served by 44 OCMCs of which children below 18 made up 32% (968) and 83 survivors were above 60. Out of the total number of cases, rape and attempted rape is 39.5% (1205) followed by physical and mental abuse 50% (1517). The training has also contributed to inter-departmental referrals within the hospital and referrals from other neighbouring districts and partners as reported by the OCMC staff during the annual review 2019 presentation.

Box 4

“Before, I saw problems that did not fit into what I had learned. Now I am more efficient [after the TOT]. I have a new approach, and I know that many pathologies for which I did not find an explanation have to do with violence. In addition to being more humane, now I see the patient as a whole.”

-Dr Sushma H, from Hetuda hospital

Inputs scheduled for next quarter: Follow-up support and monitoring of training sites; Conduct 1 batch TOT on GBV clinical protocol (15 persons) from 4 selected hospitals.

3.1.12 Rolling out the GBV Standard Operating Procedures (after approval)

Not scheduled: The Standard Operating Procedures (SOP) will be developed once the Integrated Guidelines for Services to GBV Survivors are approved by Cabinet.

3.1.13 Scaling up Social Service Units

Completed: Scoping for the establishment of SSU at Dadeldhura hospital and Tulshipur hospital was completed during this quarter. MoHP has allocated budget from AWPB for the SSU establishment in both hospitals in the FY 2019/20.

Inputs scheduled for the next quarter: Support the establishment of new SSUs at Dadeldhura and Tulshipur hospitals; Scoping mental hospital, Lalitpur for the SSU establishment; update the status of all 35 SSUs including reporting for the dashboard.

Support for the capacity enhancement of SSUs through mentoring, monitoring and online reporting workshops.

Ongoing: Site visits were made to SSUs¹² for coaching, mentoring and monitoring. Hospital reports show that more than 595,173 target group patients have received free and subsidized services from SSUs since their establishment. Total target group patients in 2018/2019 (July

¹¹ Hetauda hospital, Hetuda; Lumbini zonal hospital, Butwal; Prithvi Chandra hospital, Nawalparasi; Provincial hospital, Surkhet and Bheri Zonal hospital, Nepalgunj.

¹² Provincial hospital Surkhet, Bharatpur hospital, Western Region hospital and Bir hospital

15, 2018 – May 2019) were 170,143 of which 49% were female. The largest group of beneficiaries were classified as poor (46.00%) and senior citizens (39.00%) with smaller numbers of people classified as persons with disabilities (4.30%), and others (10.70%).

Inputs scheduled for next quarter: Mentoring and follow up support to select new SSUs; plan capacity building for five new SSU based hospitals.

i3.1.14 Capacity building to put LNOB into practice

Completed: Half-a-day orientation was provided on GESI-GBV and LNOB to local government ¹³ officials of Parbat, Magyadi districts and Bharatpur Metropolis. Each presentation was followed by a question-answer session and discussion. The orientation has helped the local government officials to have broader understanding of what LNOB stands for, especially in reaching the unreached. Also, the orientation provided guidance for them when planning and designing the programmes at local level. The orientation has been appreciated by members of local government and partners.

Inputs scheduled for the next quarter: Orientation on GESI-LNOB and targeted interventions in provinces 2 and 5. Provide TA support to IOM/Nursing Department for the inclusion of GESI in their curricula.

RESULT AREA: i3.2 RESTORATION OF SERVICE DELIVERY IN EARTHQUAKE-AFFECTED AREAS

Summary: Progress in this area has been mixed. The preliminary and formative work on the skill transfer on basic physiotherapy skills to HAs has progressed well. Needs assessment has been completed, the training curriculum has been approved and the training materials are being developed. However, due to the staff transfers within GoN, the baseline data gathering for evaluation and the training of the HAs have been postponed until August & September respectively, updates will be provided in next quarters report. In the area of mental health, the note on the Standardisation of Psychosocial Counselling Curricula was prepared and shared with EDCD and NHTC and partners.

i3.2.1 Skills transfer to paramedics and nursing staff to perform physiotherapy technicians' functions in two earthquake-affected districts

Ongoing: During this reporting period Humanity & Inclusion (HI) - the implementing partner for the intervention - completed the needs assessment in three programme intervention districts (Dhanusha, Dolakha and Dhading). The overall purpose of the need's assessment was to assess health assistants' needs, assess potential training site needs and assess the referral practices from community to the health facility and between facilities. Findings from the need's assessment were included in PD 59 submitted to DFID in April 2019. NHTC, NHSSP and HI jointly drafted the Physiotherapy training curriculum for the Health Assistant level for the core skills approved by the TWG/NHTC, findings from the need's assessment were referred to while drafting the curriculum. As per NHTC decision, the draft curriculum will be pretested in Nuwakot district (i.e. outside of the three pilot districts in order to prevent contamination for evaluation purposes in three intervention districts). As a part of regular monitoring and quality assurance, six fortnightly follow-up meetings were held with the implementation and evaluation partners. The GoN staff adjustment process has affected the timelines for training of HAs and the baseline data collection for the evaluation. As per the revised timelines, NHSSP proposes to undertake the baseline survey in early August 2019

¹³ Mayor, Dy Mayor, Chief District Committee Chair, District Coordination Officer, District Attorney, Chief Justice of District Court, Chief of District Bar Chapter, Education Officer, Local party leaders and Chair of hospital development committee and others

after the HA reshuffle has been completed and conduct the first round of training by mid to late August 2019. A justification Note which impacts the submission date for Part 2 of PD 59 was submitted to and accepted by DFID in May 2019.

Inputs scheduled for next Quarter: Finalize Physiotherapy training curriculum based on findings obtained from pre-testing in Nuwakot district, including any feedback provided by TWG/NHTC from a planned workshop to be held in July 2019. Complete training in two intervention districts (Dolakha and Dhading).

Challenge: Ongoing uncertainties about staff transfers are a challenge to timely implementation. NHSSP will be monitoring the situation and will update and inform DFID accordingly.

i3.2.2 Support the institutionalisation of mental health services

Completed: A concept note on the Standardisation of Psychosocial Counselling Curricula was prepared and shared with EDCD and NHTC and partners¹⁴. A meeting was held with these divisions and partners to move the process forward. It was agreed that NHTC will lead the overall process for the standardisation of curricula with technical support from NHSSP.

Inputs scheduled for next quarter: Standardising psychosocial counselling curricula under the leadership of EDCD and NHTC.

RESULT AREA: i3.3 THE MOHP/THE DOHS HAS EFFECTIVE STRATEGIES TO MANAGE THE HIGH DEMAND (OF MNH SERVICES) AT REFERRAL CENTRES

Summary: There has been progress in this area despite some delays. The SMNH Roadmap has been reviewed and final updates based on FWD inputs have been made. This is now with the new FWD Director for final sign-off and submission to MoHP. The "National Nursing and Midwifery Policy, Strategy and Action Plan (2019-25)" has also been submitted for official approval by MoHP. Plans for a comprehensive review of Aama have been finalised and agreement to conduct the Annual Aama Rapid Assessment through the TARF was agreed with DFID. The TARF committee will meet early next quarter once the TARF proposal has been received from MOHP.

i3.3.1 Safe Motherhood and Neonatal Health (SMNH) Programme Review and the development of the SMNH Roadmap 2030

Delayed: The draft SMNH Roadmap 2030 (PD 32 submitted to DFID) was reviewed by FWD staff and the previous Director in mid-June. Revisions and updates based on their feedback were made. It is expected the final draft will be submitted by consultants to NHSSP early next quarter who will submit this to the SMNH section of FWD. ToRs for costing of the SMNH Roadmap have been developed, and the methodology discussed.

Inputs scheduled for next quarter: Follow up with FWD for final sign-off and submission to FMOHP for endorsement of the SMNH Roadmap; Costing of the Roadmap to be undertaken with the help of specialist STTA. Dissemination of the roadmap by FWD with financial support from NHSSP and WHO.

¹⁴ CVICT, TPO, CMC and Koshis and ManavSewa Ashram

13.3.2 Support the MoHP/DUDBC to upgrade infrastructure for maternity services at referral hospitals

Ongoing: The SMNH Roadmap 2030 and the draft “National Nursing and Midwifery Policy, Strategy and Action Plans (2019-25)” included establishment of a nurse/midwife led birthing unit at referral hospitals with either more than 300 deliveries or 500 deliveries per month, at 12 referral hospitals have been submitted for official approval by MoHP.

Inputs scheduled for next Quarter: Develop advocacy materials on nurse/midwife led birthing unit to be included at infrastructure work-stream meetings and develop trainings.

13.3.3 Support the implementation and refinement of the Aama programme

Ongoing: A new ToR for PD 65 Aama programme implementation status report in public facilities was shared with DFID. A series of meetings were organised to discuss the scope of this PD and it was agreed to conduct a wider Aama review from both the financial and quality of care perspectives. ToRs for two international and two national consultants were developed and the proposed PD will review Aama programme implementation under federalism, BHCS and Social Health Insurance. A workshop to revise the Aama implementation guideline will be held by FWD in July 2019.

Inputs scheduled for next Quarter: Planned workshop as above, international and national short-term consultants recruited and contracted; literature review completed, a detailed methodology and tools developed and implemented accordingly.

Support FHD planning, budgeting, and monitoring of Aama and other selected DSF programmes at the revised spending unit level

Ongoing: Upon request from FWD, TA provided support in evaluating the technical proposal for Aama Rapid Assessment (RA) round XII. In late May, it was advised that the DoHS evaluation committee had decided not to undertake the RA citing the main reason for this was that it could not be completed by the end of the fiscal year. Aama RA budget for the next fiscal year has now been secured through MoHP’s budget.

In discussion with DFID, it was agreed to conduct Aama RA from TARP fund and a TARP proposal and ToRs have been prepared accordingly. It was agreed to additionally collect quality of care (service delivery) primary data alongside the RA data collection which will support the Aama review. This will be an additional task for the third party undertaking the RA and will be funded through a separate NHSSP budget (i.e. not TARP). It is planned a meeting with the TARP committee will be conducted mid July and the RFP for Aama RA will be published.

Inputs scheduled for next Quarter: Quality of care tools developed to be used alongside the RA data collection. Third party selection, support in methodology finalisation, tool update, training and field implementation.

RESULT AREA: 13.4 CONTINUOUS QUALITY IMPROVEMENT INSTITUTIONALISED

Summary: Progress in this area has been good. NHSSP has co-ordinated the planning and budgeting for MSS implementation in federal hospitals and Health Posts and has advocated for development of e-reporting system for FY 2019/2020. Budgets for these have been now allocated. The QIP processes have been undertaken in a number of hospitals as well as birthing centres. The assessment results however show a stagnation or slight decline in the scores at the hospital level due to challenges in implementing action plans, which are a result of fund-flow problems. At the birthing centre level, progress has been good as palikas have been focusing on birthing centre improvements. A number of CEONC mentors have now been trained and their reach has been widespread covering 277 facilities and 774 providers. NHSSP

has also completed the drafting of the STP for BHCS, which will be submitted for endorsement next quarter following a technical peer review.

13.4.1 Support the DoHS to expand implementation of Minimum Service Standards and modular HQIP

a. Minimum Service Standards

Ongoing: MOHP developed, revised and endorsed the MSS tools for primary, secondary “A” and secondary “B” and tertiary hospitals and health posts this FY 2019/2020. NHSSP HPP team provided TA support to MoHP to develop and revise the tools and in coordination with WHO, supported MoHP to organise training for MSS trainers. NHSSP SD team co-ordinated the planning and budgeting for MSS implementation in federal hospitals and Health Posts and advocated for the development of an e-reporting system for FY 2019/2020. Curative Services Division (CSD) has allocated total budget 2,500,000 NPR for starting MSS implementation at federal hospitals and an equal amount of budget (2,500,000 NPR) for MSS recording and reporting system digitization at federal level. They have also allocated budget in each province (about 800,000 to 1,400,000 NPR) for HP level MSS implementation orientation to all 753 Palikas and 150,000 NPR per Palika for management of equipment and material for implementing MSS.

Inputs scheduled for next Quarter: Inputs will be provided to CSD to develop an annual MSS implementation guideline for FY 2019/2020. Support will be provided to Provinces to develop a Palika capacity enhancement plan (orientation plan) especially in Province 2 and 5. NHSSP (SD and HPP teams) will support CSD for developing MSS implementation guideline and capacity enhancement of Palika to implement MSS at HP in FY 2019/2020.

b. Hospital and Birthing Centres Quality Improvement Process (HQIP and BC QIP)

Ongoing: Of the 26 new hospitals planning to introduce HQIP, 14 hospitals (8 FWD, 1 Province 7, 5 NGO partner supported) introduced it. In two sites, FWDs could not introduce HQIP due to errors in listing hospital names in official approval process (Tipanni paper). In Province 5 and 2 the budget was used for other activities under hospital improvements. In Province 7 HQIP was introduced at Bhajang hospital with NHSSP support.

Of the total 44 hospitals where HQIP had been introduced previously, 28 were due for another round of assessments and action planning in this reporting quarter. Among these, 18 hospitals¹⁵ completed the self-assessments. Despite a lack of funds, a majority of hospitals have conducted HQIP at least once every 6 months and over the last 6 months, 35 hospitals (80%) have conducted the assessment twice. Only 9 hospitals¹⁶ did not conduct HQIP over two quarters. However, as reported in previous quarters, the lack of budget from FWD/MoSD/local Palikas has affected implementation of actions as per their plans in FY 2018/2019.

Usually, in the absence of HQIP implementation budget, hospitals have drawn used Aama institutional re-imburements to make the improvements and fill the gaps identified through HQIP. However, this FY, Aama institutional re-imburement has been reported to have been reduced due to the high incentive provision to mothers which the hospitals have to prioritise¹⁷.

¹⁵ Charikot PHC, Dolakha, Manthali PHC, Ramechhap, Sub-regional hospital Dadeldhura, Jaleswor hospital Mahottari, Salyan district hospital, Bajura district hospital, Rapti Zonal hospital Tulsipur Dang, Rolpa district hospital, Rautahat Gaur district hospital, Pyuthan district hospital, Lahan hospital Siraha, Parbat district hospital, Syanja district hospital, Lamjung community hospital, Hetauda hospital Makawanpur, Kalaiya hospital Bara, Udayapur istrict hospital, Malangawa hospital Sarlahi

¹⁶ Jiri, Mugu, Kalikot, Nawalparasi, Dailekh, Khotang, Bhojpur, Sindhuli and Rapti Sub-Regional hospitals (Rapti Academy of Health Science)

¹⁷ A doubling of incentive for mothers for institutional delivery was announced by the Prime Minister after the budget allocation was completed, which resulted in extreme shortage of Aama fund especially at end of FY

Tables 3 and 4 show scores achieved by the 18 hospitals from self-assessments in this quarter. Unlike previous quarters, the score achieved for both quality domains and signal function readiness declined in this quarter, this is highly likely due to a lack of funds to implement action plans.

Table 3 HQIP self-assessment scoring: 8 quality domains readiness (18 hospitals)

8 QUALITY DOMAINS		Green		Yellow		Red	
		Last assessment	Current assessment	Last assessment	Current assessment	Last assessment	Current assessment
1	Management	4	5	14	12	0	1
2	Infrastructure	12	11	6	5	0	2
3	Patient Dignity	8	8	7	9	3	1
4	Staffing	12	12	6	6	0	0
5	Supplies and Equipment	6	5	10	11	2	2
6	Drugs	1	1	14	13	3	4
7	Clinical Practice	3	3	11	8	4	7
8	Infection Prevention	3	4	13	8	2	6
Total		49	49	81	72	14	23

Table 4 HQIP self-assessment scoring: Signal function readiness (18 hospitals)

9 SIGNAL FUNCTIONS		Green		Red	
		Last assessment	Current assessment	Last assessment	Current assessment
SF1	Parenteral antibiotics	14	16	4	2
SF2	Parenteral utero tonic drugs	11	9	7	9
SF3	Parenteral anti-consultants	17	16	1	2
Sf4	Manual removal of placenta (MRP)	11	11	7	7
SF5	Removal of retained products (MVA)	16	15	2	3
SF6	Assisted vaginal delivery (Vacuum)	17	14	1	4
SF7	New born resuscitation	17	17	1	1
SF8	Perform blood transfusion	11	13	7	5
SF9	Perform surgery (CS)	15	15	3	3
Total		129	126	33	36

FWD and MoSDs plan to continue implementation of HQIP alongside MSS implementation for coming FY 2019/2020, HQIP tool covers detail services readiness of MNH and the practice components; and complements MSS which looks at overall services availability. To ensure ease and improve reporting and monitoring of HQIP (alongside clinical mentoring and CEONC functionality), a mobile application for reporting will be developed with the support of NHSSP. An official approval process (memo) is being submitted to DG for approval.

BC-QIP (at the birthing centres), was done at 215 health facilities in this quarter, to date, this has been introduced in 369 health facilities. At 16 HPs/PHCCs, a second round of QIP assessments were carried out in June 2019, of these, data have been analysed. Table 5 below shows BC-QIP assessment scores in all 13 domains and 7 signal functions. NHSSP TA will follow-up with health facilities to find out the reason for lower FP scores and will plan for improvements next quarter.

Table 5 MNH readiness QI scores (16 health facilities)

Quality Domains		Base-line (%) 2017/2018	End-line (%) 2018/2019
Environment	Management	90	100
	Referral	77	94
	Electricity	53	88
	Water and Sanitation	67	77
	Patient Dignity	70	83
Resources	Management	53	56
	Staffing	63	68
	Supplies and Equipment	65	72
	Emergency Drugs	53	61
Practices	Postnatal service	47	71
	Partograph	46	75
	Family Planning	72	66
	Infection Prevention	43	61

7 Signal functions (readiness)	2017/2018	2018/2019
Parenteral Antibiotic	52	88
Parenteral Uterotonic	58	71
Parenteral Anticonvulsant	64	83
MRP	47	70
MVA	48	58
Assisted vaginal delivery (vacuum)	69	66
New born resuscitation (NBR)	75	96

Challenge: The major challenge has been availability of funds for action plans to identify gaps. To overcome this, FWD intends to integrate HQIP with the clinical mentoring process in 2019/20 FY and both will be conducted twice a year by clinical mentors. Approximate 100,000 NPR per CEONC site has been allocated for HQIP and clinical mentoring at CEONC sites in FY 2019/20.

Inputs scheduled for next Quarter: Support FWD for continued monitoring of the old HQIP sites. Support development and implementation of mobile reporting and monitoring through dashboard. The revised Aama implementation guideline will include HQIP self-assessment to ensure MNH service readiness as a requirement for CEONC and BC/BEONC sites.

3.4.2 Support the FHD to scale up on-site mentoring of Skilled Birth Attendants

Ongoing: As reported previously, a total of 46 districts are currently implementing SBA clinical mentoring (2018/19). NHSSP has continued to provide coordination support to FWD to implement the Palika level coaching and mentoring programme. 182, out of 369, Palikas that received a budget from FWD have implemented clinical onsite coaching this quarter. NHSSP also supported FWD and NHTC to develop clinical mentors training through quality assurance. A total of 35 clinical mentors (three batches) have been trained from 8 new coaching districts¹⁸ (including some replacements for old districts). To date, a total of 152 clinical mentors have been trained from across 58 districts (99 till FY 2017/2018 and 53 in FY 2018/2019). Resources for training the majority of SBA clinical mentors is from FWD and other partners (GIZ, OHW, CARE including NHSSP) who have provided the budget to train 41 clinical mentors. NHSSP also supported FWD in the capacity enhancement of district clinical

¹⁸ East Rukum, Nawalpur, Sarlahi, Dhanusha, Palpa, Syanja, Baglung, and Doti.

mentors through training and onsite support at CEONC and birthing centre sites. In this quarter, support was provided to nine clinical mentors based in Darchula, Bajhang, Bajura, Bara and Nawalpur districts.

Across 182 Palikas that have implemented the intervention, 74 district clinical mentors were mobilised to visit 277 health facilities and coached 774 MNH service providers. A total of 1521 MNH service providers from 495 health facilities have received SBA clinical coaching from 142 clinical mentors so far. Among these mentees, 35 received follow up coaching (second on-site visit) by the end of June 2019. Table 6 below shows improved scores on knowledge, decision-making, and practical skills between 2017/2018 and 2018/2019 in all selected areas except in assisted delivery (vacuum delivery)

Table 6 SBA clinical coaching scores (35 mentees)

		% 2017/2018	% 2018/2019
Knowledge		78	87
Decision making skills	Management of shock due to PPH	59	67
	Plotting Partograph	52	70
	Management of Eclampsia	55	68
Practical skills	Condom Tamponade	26	53
	Normal delivery	66	75
	Assisted Delivery	15	7
	New-born resuscitation	64	77
	Kangaroo mother care	37	74
Following referral process		0	70

Preliminary work on developing/scoping for an online/mobile app-based system that can be used by clinical mentors for monitoring and reporting on clinical mentoring, CEONC functionality and QIP findings is being done internally in NHSSP. A formal sign-off (Tippani) by FWD director is awaited and will be followed up next quarter.

Challenge: Previous district health offices (and public health nurses) were well aware about clinical mentor development and the mobilization process. After the federal structure, the mentoring budget goes to Palika and Palika health coordinators who are not yet aware about mentor availability and the process of mentoring. Therefore, off-site coordination to each and every coordinator in 369 Palikas is challenging. Government staff adjustment process is also expected to affect the placement of trained clinical mentors in the coaching mentoring implementing districts.

Inputs scheduled for next Quarter: TA will support the FWD and NHTC to develop clinical mentor development guideline and continue coordination and follow up to Palika coordinators and clinical mentors to complete onsite clinical coaching in the remaining Palikas. An online/mobile app will be developed. Review and update training of clinical mentors from all implementation sites.

3.4.4 Support revision of the standard treatment guidelines/protocols and roll out of the updated guidelines

Ongoing: The Standard Treatment Protocol (STP) for BHCS package has been drafted and is near completion. A 2-day consultative workshop on 22-23 April 2019 was organised by CSD (TWG) with intended users of the STP – doctors, health assistants, auxiliary health workers and nurses. There were 31 participants and their technical inputs (i.e. clinical) were sought on specific chapters of the STP. Participants also provided inputs in writing and presentations on the feasibility of the protocol for those working at HP/PHCC levels and on any missing information. This feedback was incorporated into the draft STP.

Inputs scheduled for next Quarter: A peer review of the STP will be done by three specialist consultants. After the BHCS package is endorsed the STP will be shared with MoHP directors for finalisation. Possible support to roll out STP of BHCS package.

i3.4.5 Prevention of Anti-Microbial Resistance support including infection prevention, sanitation, and waste management at health facilities

Ongoing: Inputs this quarter have been through QIP and clinical mentoring processes. Peer review of the STP for BHCS will include a review from an AMR perspective, rational drug-use and monitoring.

Inputs are scheduled for next Quarter: Monitoring HQIP data and facilitate for improving infection prevention practices in all HQIP implemented hospitals. Possible support to roll out MSS in selected hospitals.

i3.4.6 Support the NHTC (FHD and CHD) to expand and strengthen training sites focusing on SBAs, family planning, and newborn treatment

Delayed: Roll-out of Training Management Guidelines (TMG) by NHTC with the support of NHSSP in new sites was not possible due to a change of NHTC leadership and NHTC's other priorities during the reporting period. Although NHSSP TA had advocated NHTC for allocation a budget for this activity from the DFID FA through the AWPB of 2019/20, this could not be achieved due to 'donor funding ceiling'. NHSSP will orient the new Director and will advocate for budget/time allocations.

Inputs scheduled for next Quarter: Advocate with new Director for roll-out of TMG. In coordination with NHTC and FWD, will also conduct a follow up skills assessment and coaching/mentoring of FP/SAS/SBA trainers at Pokhara Academy of Health Sciences and selected SBA training sites (i3.1.9).

RESULT AREA: i3.5 SUPPORT FWD IN PLANNING, BUDGETING, AND MONITORING OF RMNCAH AND NUTRITION PROGRAMMES

Summary: NHSSP TA has largely been focused on the support to AWPB processes in various areas including QI, CEONC, FP etc. Similar APWB advocacy and support has been provided at the LL sites based on the priorities identified through OCA.

i3.5.1 Support the FHD, CHD, and PHCRD in evidence-based planning and monitoring progress of programme implementation and performance

On-going: TA continued the support to FWD, CSD, NSSD, NHTC and NHEICC on evidence-based planning and budgeting for central level AWPB for 2019/20. TA also supported and advocated with Provinces for allocating budget for quality improvement interventions and for CEONC fund and monitoring C-section at hospitals. The "National Nursing and Midwifery Policy, Strategy and Action Plans 2019-2022" has been submitted to MOHP for endorsement.

NHSSP TA also supported FWD in preparing annual report (2017/18) for Family Planning, Adolescent Sexual and Reproductive Health, and Safe Motherhood and Newborn section in coordination with E&A workstream. Other technical support in this area included technical inputs for finalization of Decision Making Tool (DMT) and WHO medical eligibility criteria (MEC) for contraception wheel implementation guideline provided to FWD; Bidders FP commodity (implant, oral pill, DMPA and IUCD) verification at logistics section of Management Division, and, advice on Sayana Press pilot design briefing session to Ipas and FWD.

Inputs scheduled for next Quarter: Support and advocacy at two LL sites for local level planning. Continued advocacy and follow up with selected Palikas for allocating budget for quality improvement interventions and for continuity of CEONC service sites.

i3.5.2 Capacity enhancement of local government on evidence-based planning, implementation, and monitoring of programmes aimed at LNOB and quality of care

Ongoing: In partnership with NHTC facilitators and NHSSP HPP workstreams, one OCA workshop was conducted in Madhayapur Thimi Municipality (26 to 30 May 2019) of Bhaktapur district, with 25 participants (this is a GIZ supported palika). The standard OCA workshop format was followed. To date six OCA workshops have been completed and six capacity development plans (CDPs) have been developed. At the seventh LL site in Kharpunath (Humla district, Karnali) the OCA workshop was not organized as this is supported by the USAID funded project (Strengthening health system for Better Health). The approved activities in the CDPs have helped advocacy for appropriate budget allocations in the AWBP of the LL palikas. These processes were facilitated by the NHSSP HSS Officers. Five LLs sites are directly coordinating with concerned divisions and centres under MoHP (e.g. Management Division for infrastructure development and drug procurement process; NHTC for training), as per needs identified in their respective CDPs.

During this reporting period a Learning Brief on "OCA and its Institutionalization" and the OCA User's Guide have been drafted. The draft DAG (disadvantage group) manual to be used in all LLs sites to develop capacity of the facilitators for social mapping of the DAG population was also reviewed.

Inputs scheduled for next Quarter: Follow up CDP plans in six LLs, including orientation on OCA User's Guide for the facilitators.

i3.5.3 Support to the FHD and CHD for monitoring of free care

Not scheduled: Continued support to monitor Aama programme through rapid assessment is reported in i3.3.3.

Inputs scheduled for next Quarter: As above

Extra –planned or un-planned activities (not included in the inception plan)

During this reporting period contributed in the following HRH planning and deployment areas:

- Provided TA to TWG/NSSD (Nursing Security & Service Division) and produced "Draft Nursing & Midwifery Strategic Action plans (2019-2027)
- Provided TA to TWG/FWD and produced Draft SMNH Roadmap -2030

4. PROCUREMENT AND PUBLIC FINANCE MANAGEMENT

RESULT AREA: i4.1 EAWPB SYSTEM BEING USED BY THE MOHP SPENDING UNITS FOR TIMELY RELEASE OF THE BUDGET

Summary: The main activity for MoHP in this quarter has been planning and budgeting for FY 2019/20 and the PPFM team has supported this by preparing the consolidated budget at federal level. NHSSP also supported in organising the PFM committee meeting. The committee has specifically suggested to explore the main reasons behind virement and the results of this will be presented in the next meeting of the PFM committee next quarter. Bayalpata and Okhaldhunga hospitals also presented their PBGA models in the PFM committee meeting. The process of updating FMIP and IAIP has been started and the international consultant has provided his report on the review of the internal audit. The second FMR of FY 2018/19 has been finalised and was submitted to DFID.

Activity i4.1.1 Develop AWPB Improvement Plan and report quarterly on progress - including training to the concerned officials

On-time: In FY 2019/20, 68.78 billion has been allocated for federal, province and local government in health. MoHP received approved budget of NPR (42.67) billion (62.03%) for 2019/20 through the Red book. Similarly, provincial and local governments received NPR 4.88 billion (7.10%) and NPR. 21.23 billion (30.87%) respectively. MoHP and its entities have prepared their AWPB which has been entered and uploaded to LMBIS.

Activity i4.1.2 MoHP Budget analysis report with policy note produced by HRFMD using eAWPB

On-time: ToR for budget analysis has been finalised in consultation with MoHP. The ToRs for STTAs have been completed and two consultative meetings with MoHP officials were organised.

The budget analysis for FY 2019/20 will be started in next quarter.

Activity i4.1.3 Revise eAWPB to include 761 spending units and prepare a framework for eAWPB

Completed: Updates have now been completed which have upgraded the existing eAWPB, allowing it to interface with LMBIS, SUTRA and other financial systems. The 'chart of activities' is included in the eAWPB, which allows all levels of government to capture the budget expenditure on activities of all sources (conditional, equalisation and local etc.).

Inputs scheduled for next quarter. The suggestions from the independent review of TABUCS will be included in the TABUCS update. The new chart of activities has been updated in TABUCS and the new version of TABUCS will be implemented in coming FY2019/20.

Activity i4.1.4 Prepare a Framework for an Annual Business Plan

Completed: MoHP has developed the business plan guideline. USAID/PFMSP has taken the initiative to prepare the MoHP, DoHS, DOA and DDA business plan and NHSSP will support in the preparation of business plan for Sahid Ganga Lal Heart Hospital. This will be additional to NHSSP's support to the ongoing private not for profit hospitals.

Inputs scheduled for next Quarter. The business plan will be prepared and finalised. NHSSP will support in preparing business plan for Okhaldhunga Mission Hospital and Bayalpata Hospital.

RESULT AREA: i4.2 TABUCS IS OPERATIONAL IN ALL MOHP SPENDING UNITS, INCL. DUDBC

Summary: In this reporting period concept of 'chart of activity' has been finalised and included in TABUCS software. Monthly expenditure report has been prepared using TABUCS and the findings presented in the meeting of the PFM committee. The expenditure from TABUCS has also been used in preparing the FMR-2 of FY 2019/20. NHSSP's IT supplier provided basic orientation on the maintenance of hardware to recently recruited MoHP's IT officers.

Activity i4.2.1 Revise TABUCS to report progress against NHSS indicators and disbursement-linked indicators

On-time: In this quarter, a new 'chart of activity' is included 'in TABUCS (updated version). The user manual and training manual are currently being updated. The TIU has endorsed the draft.

Inputs scheduled for next Quarter. The new version of TABUCS will be implemented in FY2019/20 incorporating all of the above-mentioned activities.

Activity i4.2.2 Support MoHP to update the status of audit queries in all spending units

Ongoing: With support from USAID /PFMSP, the audit queries of MoHP until FY2002/03 are currently being collected and will be entered in TABUCS next quarter, please note; information from FY2003/04 to FY2011/12 has already been entered. The verification of audit queries from FY 2012/13 is ongoing and will be entered in TABUCS by end of August 2019.

Inputs scheduled for next Quarter. The updates on the audit queries will be presented in the next meeting of PFM committee.

Activity i4.2.3 Support MoHP to update the systems manual, a training manual and user handbook of TABUCS and maintenance of the system

On-time: The system manual, training manual and user handbook of TABUCS has been updated following the chart of activity.

Inputs scheduled for next Quarter. TABUCS will be handed over to MoHP.

Activity i4.2.4 Support TABUCS through the continuous maintenance of software/hardware/connectivity/web page

On-time: Ongoing support was provided, for example, in addressing the IT related issues from 47 spending units, this included maintenance of server. NHSSP's IT supplier has also provided basic orientation on the maintenance of hardware to recently recruited MoHP's IT officers.

Inputs scheduled for next Quarter. This will be handed over to the Ministry.

Activity i4.2.5 Update TABUCS to be used in the DUDBC, and to include data on audit queries

On-time: Ongoing support was provided.

Inputs scheduled for next Quarter. TABUCS will be handed over to DUDBC.

Activity i4.2.6 TABUCS training and ongoing support to the DUDBC and concerned officials

On-time: Completed.

Activity i4.2.7 TABUCS monitoring and monthly expenditure reporting

On-time: This is an on-going process. There are no significant changes in this quarter.

Inputs scheduled for next Quarter. Ongoing support

Activity i4.2.8 Conduct a rapid assessment and evaluation of TABUCS

Completed: Independent consultant has submitted their report.

Further inputs are planned for next Quarter. NHSSP will address the recommendations from the Rapid Assessment and update TABUCS accordingly.

Activity i4.2.9 Support the annual production of Financial Monitoring Report using TABUCS (PD 75)

On-time: This is an on-going process.

Inputs scheduled for next Quarter. The preparation of final FMR for FY 2018/19 will be started.

RESULT AREA: i4.3 REVISE, IMPLEMENT, AND MONITOR THE FMIP

Summary: MoHP has reviewed the internal control directives endorsed by the FCGO. Several consultative meetings were organised to update MoHP's internal control guidelines and the process of updating FMIP to FMSF has started. The inputs from PPFM team were useful in preparing the second draft. The final draft of FMSF will be presented in the next PFM committee meeting.

Activity i4.3.1 Update internal control guidelines

Completed: FCGO has developed the Internal Control System Directives 2019 and its template for all GoN entities. According to this directive, every GoN entity should develop and rollout the internal control system. MoHP is currently updating its FMIP following the FCGO directives.

Inputs scheduled for next Quarter: NHSSP will organise a validation workshop to finalise internal control guidelines in the federal context. This will require the involvement of the sub-national governments.

Activity i4.3.4 Finalise, print and disseminate the Financial Management Improvement Plan (FMIP)

Ongoing: The PFM Committee meeting decided to revise the existing FMIP and rename this as Financial Management Strategic Framework (FMSF). A draft revision has been prepared and was shared with the national and international consultants for comment and review, comments have now been included in the second draft. After the presentation in the PFM committee next quarter, the draft will be presented in the validation workshop.

Inputs scheduled for next Quarter. FMSF will be presented in the workshop and finalised.

Activity i4.3.5 Support monitoring of the FMIP in collaboration with the PFM and Audit committees

Ongoing: A PFM team led by Finance chief of DoHS with NHSSP team visited Surkhet, Salyan, Rukum and Dang on 15-19 April 2019. The team discussed on process, availability of trained staff and the timeliness of audit and its responses. The findings of the visit were shared

at the PFM Committee meeting held on 27 May 2019. At this meeting, the Committee also decided to use the planning and budgeting guidelines, business plan guidelines and update the virement made in FY 2018/19.

Inputs scheduled for next Quarter. Joint visit planned to the above.

Activity i4.3.7 Build the capacity of the MoHP and the DoHS officers in core PFM functions

On-time: MoHP conducted, with the financial support of USAID (PFMSP), a workshop on audit clearance at Dhulikhel on 18-19 June 2019 for federal level 16 hospitals. Similarly, DoHS also conducted PFM workshops throughout the country at five federal and provincial sites in May & June 2019. NHSSP/PPFM team provided technical support in all workshops.

Inputs scheduled for next Quarter. Once the training manual has been completed, a workshop will be conducted to build the capacity of MoHP and the DoHS officers in core PFM functions.

Activity i4.3.8 Support the process of institutionalising the internal audit function through IAIP and internal audit status report (PD 63)

Achieved: An independent international consultant reviewed the internal control and internal audit process and submitted the report.

The Internal audit status report (PD) was presented at the PFM Committee meeting on 27 May 2019 and was subsequently also submitted to DFID. In summary, there is some progress on the internal audit responses more than in the previous year. All internal audit data are mentioned in TABUCS.

Activity i4.3.9 Work with HRFMD on potential PFM system changes required in the devolved situation

On-time: The TA team provided a series of updates on PFM and procurement in development partners' meetings. PIP, IAIP, FMIP, and TABUCS are key strategic documents and systems and need to be revised and updated in the context of Federalism. NHSSP is supporting, and will continue to support, MoHP to have wider level discussions to ensure the current guidelines and systems address changing needs and that these talk to each other. In this quarter support has been provided to province 2 and 6 in procurement process and PFM training to the 40 accounts from these provinces.

Inputs scheduled for next Quarter. Consultative meetings will be organised at provincial level (Karnali Province, and Provinces 2 and 5).

Activity i4.3.10 Support to the PFM & Audit committee

Ongoing: The last formal meeting of the PFM committee was held (in the presence of Secretary of MoHP of FY 2017-18 and chaired by the Chief of PPMD) on 27 May 2019. The progress of FMIP and PIP, revision status of FMIP, status internal audit report 2017-18, status of final audit of FY 2017-18 and the status of PBGA implementation by Naya Health (Bayalpat hospital) and United Mission to Nepal were discussed, Okhaldhunga hospitals were also present in the meeting. The committee decided to upload the audit queries of the spending units in TABUCS.

Inputs scheduled for next Quarter. Regular meeting of the committee will be organised and, when applicable, we will recommend MoHP to invite NHSSP PPFM and USAID's PFM-SP teams.

Activity i4.3.11 Support MoHP in designing, updating, and rolling out a Performance-Based Grant Agreement in Hospitals

On-time: Bayalpata hospital and Okhaldhunga Mission hospital presented their PBGA module in the PFM committee meeting. Mr Secretary and chairperson of the committee have since shown their interest to visit these hospitals. The committee has decided to initiate a PBGA discussion in public hospital named Sahid Gangalal hospital. In order to monitor the PBGA in these two hospitals the committee decided to prepare the business plan using the current guidelines.

Inputs scheduled for next Quarter. Joint visit to both hospitals, NHSSP will support them in preparing business plans.

Activity i4.3.15 Expansion of PBGA in selected hospitals

Not scheduled:

Inputs scheduled for the next Quarter. Initiating dialogue with the national heart hospital and initiating PBGA process in Okhaldhunga Mission Hospital.

Activity i4.3.19 Discuss with the best performing governments and provider on PBGA modality

A team from Bayalpata and Okhaldhunga mission hospital presented their modalities in the PFM committee – as above (i4.3.11).

Inputs scheduled for next Quarter. Sharing workshop with best performing PBGA hospital.

Activity i4.3.20 Initiate PBGA learning group

Completed: This is a loose forum, which has issue-based discussions as and when they are needed. One meeting was held in the previous quarter.

Inputs scheduled for next Quarter. A meeting will be organised at an appropriate time during the forthcoming quarter which will include sharing from best implementing PBGA hospitals.

RESULT AREA: i4.4 LOGISTICS MANAGEMENT DIVISION IS IMPLEMENTING STANDARDISED PROCUREMENT PROCESSES

Summary: Monthly update in the implementation of CAPP has been prepared and shared with the PPFM-oversight agency. The meeting with DFID, WB and KfW was organised and took place to prepare a second draft of NHSPPSF. The updated report has been shared with the PPFM- oversight agency. In this reporting period support (in procurement process) has been provided to the MoSD from province 2 and Karnali province.

Activity i4.4.4 Preparation of SOP for Post Delivery Inspection and Quality Assurance

Ongoing: Both the Senior Pharmacist and STTA Pharmacist have been recruited; SOP for Post Delivery Inspection is in progress. For Quality Assurance in procurement of drugs, a market analysis and revision of technical specifications is underway. A ToR for Market Analysis has been submitted to MD/LMS and is awaiting approval.

Inputs scheduled for next Quarter. A first draft of market analysis will be prepared and shared in the meeting of CAPP monitoring committee.

Activity i4.4.5 Review Draft Standard Bidding Document of Framework Agreements (FA) and support its endorsement by the Public Procurement Monitoring Office (PPMO)

This activity is merged with i4.4.7.

Activity i4.4.6 LMD (now LMS) Capacity building on standardised procurement processes

Ongoing: Capacity building including support to the procurement clinics and systematic support on procurement functions is ongoing. In this quarter, 13 clinics were supported (in addition to the 12 from last quarter).

Inputs scheduled for next Quarter. On-going embedded support.

Activity i4.4.7 Support PPMO for endorsement of SBDs of FA

Delayed: NHSSP, at the request of the public procurement monitoring office (PPMO), reviewed the draft document prepared by the PPMO Consultant and provided comments/suggestion on behalf of DoHS-MD.

Inputs scheduled for next Quarter. In addition to continuous follow-up at PPMO, we will request MoHP to follow up at PPMO to speed up the process. This is due to organisational reform at PPMO.

Activity i4.4.8 Preparation and endorsement of SOP of FA

Delayed: (See 4.4.7 above) As the SBD is not endorsed and announced by PPMO, the preparation of its SOP has not been initiated. PPMO is also preparing a Procurement Guideline for Framework Contracts. NHSSP is in regular contact with PPMO.

Inputs scheduled for next Quarter. No inputs are scheduled for the next Quarter until the SBDs have been issued by the PPMO and are ready to use

Activity i4.4.9 Provide TOT on FA through exposure/training

Delayed: (See 4.4.7 above) Due to lack of SBD for FA, procurement under FA could not be initiated.

Inputs scheduled for next Quarter. Following completion of CAPP, training on FA will be provided to MOHP spending units.

Activity i4.4.10 Train the DoHS staff on FA

No inputs are scheduled for the next Quarter (**see 4.4.7 above**).

Activity i4.4.11 Orient suppliers on FA

Delayed: As the standard bid document (SBD) has not been endorsed and announced by the PPMO, the preparation of its use and orientation is delayed (**see 4.4.7 above**).

Inputs are scheduled for the next Quarter. As above

Activity i4.4.12 Revise and update the Procurement Improvement Plan

Ongoing: The Nepal Health Sector Public Procurement Strategy Framework (NHSPPSF) has been prepared and has been shared with the EDPs and MoHP. PFM-SP is also going to support provinces to prepare Provincial PIP. The inputs from EDPs were received and have been included in the second draft.

Inputs scheduled for next Quarter. NHSSP will organise a workshop for endorsement of the NHSSPSF and prepare a comprehensive PIP.

Activity i4.4.13 Train all the DoHS divisions on CAPP preparation and execution

Ongoing: Continuous support is being providing to prepare the CAPP and its execution.

Inputs scheduled for next Quarter. Presentations will be kept in LMS's system.

Activity i4.4.14 Establishment and regular meeting of the CAPP Monitoring Committee

On time: The seventh CAPP Monitoring Committee meeting was organised on 30th April 2019 at the DoHS. Progress of procurements against the CAPP were appreciated and instructions were given to expedite the remaining procurements needed during this fiscal year. The CAPP Monitoring Committee decided to conduct a market analysis of pharmaceutical products and updated the technical specifications of equipment and drugs in the TSB.

The current status on procurement execution as of June 2019 is 94.44% in terms of number of items, and 99.24% in terms of planned value; this shows progress when compared to the status in June 2018, which was 70.83% procurement execution in terms of number of items and 86.78% in terms of planned value. Similarly, the use of online e-GP in June 2019 is 98.8% against that of 61.80% in June 2018.

Inputs scheduled for next Quarter. The eighth CAPP Monitoring Committee meeting will be organised and held in July 2019.

Activity i4.4.15 e-CAPP designed, tested, provide training and implement

Completed: The e-CAPP designing, development and training was completed. The implementation of e-CAPP is planned from the coming FY.

Inputs scheduled for next Quarter. e-CAPP implementation training will be continued.

Activity i4.4.16 CAPP produced within the agreed period

On-time: The new CAPP for the FY 2076-77 (2019-20) will be prepared on time, with support from NHSSP. The data entry of the Federal HIs in the eCAPP system is ongoing.

Inputs scheduled for next Quarter. The consolidated electronic annual procurement plan will be formed by the eCAPP system, this will be discussed in a workshop and finalised.

Activity i4.4.17 Review of the Public Procurement Act and Public Procurement Regulation for Health Sector Procurement in coordination with the PPMO

Ongoing: Meetings with PPMO is a continuous process. The sixth and seventh amendment on Public Procurement Regulation has been endorsed by the cabinet. The amendments have been applied in procurement by DoHS.

Inputs scheduled for next Quarter. NHSSP will support MOHP in updating NHSSPSF in line with the revised PPA.

Activity i4.4.18 Preparation of SBDs for the Procurement of Health Sector Goods

Partly Completed: The SBD for the procurement of Health Sector Goods had already been prepared and submitted to the PPMO. Continuous discussion and presentations are now underway at the PPMO. NHSSP efforts will be continued for endorsement of a separate SBD for Medical Goods.

The bidding documents currently being used by the DoHS for procurement of medicines are customised SBDs of PPMO for procurement of goods, with allowed changes in the necessary sections. NHSSP was involved in preparing this customised bidding document. The World Bank procurement team has recently reviewed the bidding document being prepared, as well as the one currently being used by the DoHS for procuring medicines, to verify its suitability for DLI assessment. They found that the bidding document currently being used by DoHS follows good practices and was accepted for reporting compliance with DLI. Other health sector institutions too are using the same document for procurement of medicines.

Inputs scheduled for next Quarter. Continuing efforts will be made to obtain endorsement of separate document from PPMO.

Activity i4.4.19 Training for the DoHS staff and suppliers on Catalogue Shopping, Buy-Back method and LIB

Suspended: This activity has been suspended because the PMO has not yet issued necessary Standard Documents for these methods (**see 4.4.18 above**). If the PPMO requests capacity building programme on these procurement modalities, we will provide technical support.

No inputs are scheduled for the next Quarter.

Activity i4.4.20 Capacity building on Procurement System in federal, provincial, and local government

Ongoing: Capacity building on the use of Standard operating procedures (SOPs) for the standardisation of the procurement of drugs and eGP is being continued as previously (i.e. through visits to Provincial Health Directorates, Health Offices, and Provincial Ministries of Social Development and by providing long-distance support through telephone). NHSSP has also supported bid processes for procurement of Vitamin A and Fortified Flour published by LMS of DoHS/MD on behalf of Province 1, 3, 4 and Karnali.

A procurement module and session plan for provincial procurement training has been prepared and an institutional arrangement for conducting the trainings now needs to be established.

Inputs are scheduled for next Quarter. NHSSP will focus support for provincial procurement trainings and will also be responsive to requests to facilitate some sessions at similar capacity building training/workshops organised by other levels of government or partners.

Challenge: As there are a large number of procurement units if local governments are included, the capacity of NHSSP to effectively facilitate implementation and monitoring at all of these remains a challenge. Extra HR may be needed to provide technical assistance to the provincial government.

Activity I1.1.24 Organisation of Suppliers' Conference

Completed: Suppliers' Conference organised on 28 April 2019. Forty-nine representatives from suppliers were present and raised their concerns and issues. The issues were discussed and addressed in the CAPP Monitoring Committee meeting, for example, request for timely response on the queries on the specifications and contract submission deadlines.

No Inputs are scheduled for next Quarter. This activity happens once a year.

5. EVIDENCE AND ACCOUNTABILITY

RESULT AREA: *i5.1* QUALITY OF DATA GENERATED AND USED BY DISTRICTS AND FACILITIES IS IMPROVED THROUGH THE IMPLEMENTATION OF THE ROUTINE DATA QUALITY ASSESSMENT SYSTEM

Summary: Good progress has been made this quarter in this result area. The web-based Routine Data Quality Assessment (RDQA) system has been developed in collaboration with GIZ and USAID and rolled out at all seven provinces and selected local levels. The tools, guidelines, user manual, tutorial, dashboard and other e-learning materials were developed and published on the MoHP website (www.rdqa.mohp.gov.np) last year. The RDQA was first implemented in the LL sites through NHSSP support and MoHP has subsequently provided orientation to all of the seven provincial health directorates and some selected local governments on the use of this. The provinces in turn have been supporting local governments to roll out the RDQA through the funds from the conditional grant provided by MoHP. NHSSP is now supporting the public health facilities in the LL sites in monitoring the progress of the action plans developed to address the gaps identified. The RDQA is undertaken biannually, and as these measures are institutionalised at the facility and the respective governance units, it will help improve the data quality and its use at all levels, particularly at the point of data generation.

Activity i5.1.1 Support the development of Routine Data Quality Assessment (RDQA) tools for different levels and their rollout (PD 33)

Completed: The web based RDQA tool along with the eLearning materials (PD 33) were approved by DFID in April 2018.

No inputs are scheduled for the next Quarter.

Activity i5.1.2 Support the institutionalisation and roll out of RDQA at different levels

Ongoing: NHSSP, in collaboration with the Integrated Health Information Management Section (IHIMS), supported the municipal health team to implement the web based RDQA at the public health facilities of the LL sites. By the end of May 2019, the RDQA had been implemented in all the public health facilities of the five LL sites. The roll out process has mainly included orientation to the municipal health team and facilitation at the health facilities on how to carry out the assessment using the tools. In the two remaining LL sites, the SSBH programme (USAID) is supporting the implementation of RDQA in Kharpunath Rural Municipality and Karnali Province. IHIMS is planning to support this in Madhyapur Thimi Municipality next quarter.

RDQA provides two types of scores i.e. data verification score, which measures the accuracy of the data, and information management system assessment score which measures the effectiveness of the system. Facilities scoring 90-110% score on data verification and an average 2.5 to 3 score on system assessment are considered to have achieved benchmark in RDQA until the next RDQA instance. *Figure 1* below shows the averages of the data verification scores of the health facilities in each of the LL sites. The average scores across the LL-sites are in the range of 60 – 80 which is lower than the benchmark of 90 -110 indicating that there is a discrepancy between recording and reporting of the data at the health facility level.

Figure 1 Average data verification score by LL sites

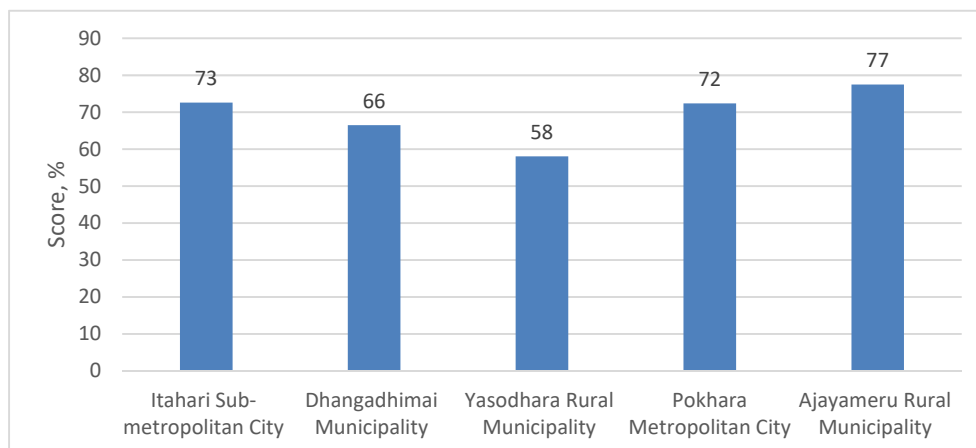
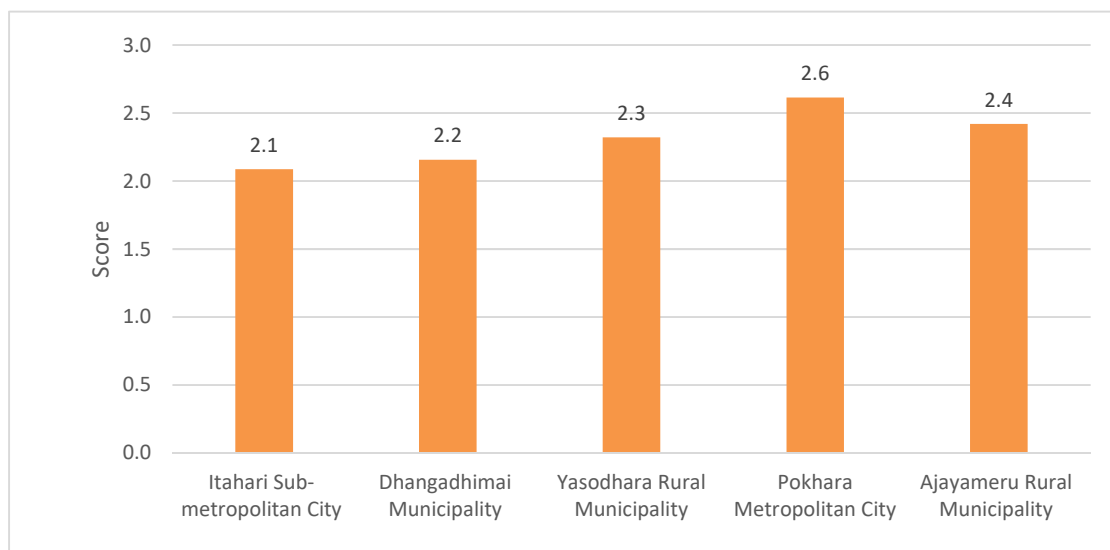


Figure 2 below shows the averages of the information management system assessment scores of the health facilities from each of the five LL sites. The average system assessment score i.e. 2.6 in Pokhara Metropolitan City indicates that the information management system is functioning well at the health facilities here. However, the average system assessment score in health facilities of other LL sites are slightly below the benchmark of 2.5 indicating that there is need for some improvements to be made.

Figure 2 Average system assessment scores by LL sites



RDQA is being rolled-out in other areas and in this quarter PPMD MoHP provided orientation to all of the seven Provincial Health Directorates to roll it out at Palika and health facility level. Based on the findings of the RDQA, each of the health facilities developed an action plan to improve quality and use of the data and the overall information management system.

Inputs scheduled for next quarter: Continuous follow up of the progress on the action plans developed as a part of the RDQA implementation.

Challenge: Despite the availability of, and, access to the tools and e-learning materials on the MoHP website, there are challenges with implementing and institutionalizing RDQA as a routine practice by health facilities and the governance units. NHSSP will continue to support the MoHP in developing and disseminating lessons learnt, showcasing success stories,

updating the online system (to make it more interactive and user friendly) and in developing a close online/web-based monitoring and need based on-site mentoring from the federal and provincial levels.

RESULT AREA: i5.2 MOHP HAS AN INTEGRATED AND EFFICIENT HEALTH INFORMATION SYSTEM AND HAS THE SKILLS AND SYSTEMS TO MANAGE DATA EFFECTIVELY

Summary: Progress is on track in this result area. Using opportunities opened-up as a result of the restructuring of MoHP in the federal context, MoHP has made efforts towards the integration of the various management information systems and linking them with the planning processes. With the aim of developing an integrated information management system, the Integrated Health Information Management Section was formed under the Management Division, Department of Health Services and made responsible for improving and ensuring the functionality of each individual routine MIS, including the surveillance systems in the health sector, enabling them to have better linkages with each other in leveraging the ICT. Monitoring and Evaluation is now integrated within the Policy Planning and Monitoring Division at MoHP.

The NHSSP in collaboration with DFID/MEOR, WHO, GIZ and USAID, supported MoHP to develop the 'Health Sector M&E in Federal Context' - an M&E guideline for the three spheres of governments; and the National eHealth Guideline to provide a framework to standardize, integrate and harmonize the eHealth initiatives in the country. All provinces and local governments have been oriented on online reporting of HMIS data through the DHIS2 platform, and around 70% of the health facilities had reported through it as of the end of June 2019. IHIMS plans to finalize and disseminate the HMIS data of the fiscal year 2018/19 by September 2019 and this is a significant improvement in quickening the data reporting processes, which earlier used to take 7-8 months. MoHP and the provinces have also prioritized implementation of the electronic health record (EHR) systems at the hospitals and MoHP has initiated the process of developing a guideline to standardize the EHR systems across the country.

Activity i5.2.1 Support the development of a framework for improved management of health information systems at the three levels of federal structures

Ongoing: The development of 'Health Sector M&E in Federal Context', an M&E guideline was completed last year.

Inputs scheduled for next quarter: NHSSP will continue supporting MoHP in implementation at all levels.

Activity i5.2.2 Support the effective implementation of the defined functions at different levels

Ongoing: NHSSP engaged with the IHIMS and the local governments at the LL sites to support them in planning their health sector M&E activities in line with the 'Health Sector M&E in Federal Context' guideline. In this quarter TA supported the IHIMS to plan and facilitate the Training of Trainers (ToT) sessions to orient the provincial officials on the electronic reporting of HMIS data through the DHIS2 platform. Local governments in the LL sites were also supported to develop a workplan and monitor progress based on the organizational capacity assessment (OCA) focusing on their defined functions.

Inputs scheduled for next quarter: Continued supporting of the LL sites.

Activity i5.2.3 Support the development, implementation, and customisation of the Electronic Health Record System (PD 45)

Ongoing: NHSSP supported MoHP to design a modular Electronic Health Record (EHR) system for different levels of health facilities (PD 45), this was approved by DFID in December 2018. Following this, a series of focussed consultations were held within MoHP and with EDPs on installing and implementing the EHR system at different levels of health facilities. NHSSP is supporting MoHP in introducing EHR in at least one facility in each province (Activity 2.2 of Aid Memoire) and is currently working with the Ministry on the assessment of digital readiness of public health facilities in all LL sites, and in the tertiary level hospitals managed by the federal government, to initiate the EHR.

Inputs scheduled for next quarter: TA will initiate the process of EHR installation and implementation in one facility in one of the seven LL sites.

Activity i5.2.4 Support the development and institutionalisation of an electronic attendance system at different levels

Ongoing: TA support to this initiative is limited and is focused on improving use of data/information collected to better manage human resources. Progress on this has been delayed due to the current staff adjustment processes and the changes in MoHP leadership. NHSSP is now engaged with the IT section at the MoHP to reactivate the dashboard at the Ministry to make best use of the data.

Inputs scheduled for next quarter: At the subnational level, NHSSP will continue supporting the LL sites to maximize data-use, support will not include procurement and installation of the devices.

Activity i5.2.5 Support the expansion and institutionalisation of electronic reporting from health facilities

Ongoing: NHSSP is engaged at the strategic level with IHIMS to plan and implement the training package to build local government capacity on e-reporting of HMIS through the DHIS2 platform. This quarter IHIMS provided ToT to all seven provincial health teams and the provinces thereafter provided training to all the local governments. TA has also been supporting the Management Division to improve the quality and coverage of HMIS reporting by reviewing data and providing feedback on the errors made at different stages of data processing. As of the end of June 2019, 76% of the health facilities had reported to HMIS for the fiscal year 2018/19, whereas, as shown in Table 7, it was 98% last year (2017/18). This is because it had taken almost 7 months after completion of the fiscal year to get the final data (Table 7). This year province data shows that while 83% facilities in Sudurpashchim had reported, only 66% had in Province 1 (Table 7). NHSSP is supporting to finalize the HMIS data of the current fiscal year 2018/19 and make it public by September 2019.

Table 7: HMIS reporting status: FY 2017/18 and 2018/19 (till end of June)		
	2017/18 (2074/75) 16 July 2017 to 15 July 2018	2018/19 (2075/76) 16 July 2018 to 30 June 2019
Nepal	96.3	76.1
Province 1	94.9	65.7
Province 2	95.2	77.2
Province 3	95.3	77.8
Gandaki Province	93.6	76.6
Province 5	100	76
Karnali Province	97.5	81.1
Sudurpashchim Province	98.2	83
Note: Source HMIS. Data extracted on 30 June 2019		

NHSSP is also supporting MoHP in establishing a strong mechanism to help timely reporting of data from health facilities. For other reports, the Cabinet has decided to establish an

institutional mechanism for regular, timely and complete reporting from health facilities to the local governments; from local governments to the health offices; from the health offices to the provincial health directorates; and from the directorates to the Department of Health Services.

In the LL sites, NHSSP is coordinating with the IHIMS/DoHS to ensure timely e-reporting from facilities.

Inputs scheduled for the next quarter: NHSSP will prioritize follow-up and onsite coaching to ensure timely e-reporting in LL sites that have weak reporting.

Activity i5.2.6 'Support the development of OCMC and SSU modules in DHIS2 platform.'

Ongoing: NHSSP is continuing to work with MoHP to review the OCMC and SSU recording and reporting tools so that they can be adapted for an online reporting system using the DHIS2 platform. The technical discussions with the IT experts for customization of the DHIS2 software are tailoring it to the specific needs of the programmes currently underway. This will help build functional linkages with the HMIS.

Inputs scheduled for next quarter: Development of the reporting tools for DHIS2 platform.

Activity i5.2.7 Support the development of a guideline for effective operationalisation of e-health initiatives (PD 66)

Ongoing: NHSSP, in collaboration with WHO, GIZ and Medic Mobile, supported the Quality Standards and Regulation Division (QSRD) MoHP to develop the 'National eHealth Guideline'. The objective of the guideline is to provide a framework to standardize, integrate and harmonize the eHealth initiatives in the country. NHSSP managed the process of developing the guideline and the document was informed through various avenues including technical inputs from an international expert¹⁹; information from - 'Discussion on harnessing digital technologies to strengthen health systems'²⁰; and consultations with subnational governments to seek their inputs on the guideline²¹. The draft guideline was shared with the eHealth Technical Working Group and other stakeholders at a workshop held by MOHP on 29th & 30th May 2019 and subsequently updated incorporating all feedback. NHSSP has supported the translation of the guideline into Nepali for submission to the Minister and Cabinet for endorsement. The English version of the guideline was submitted on time to DFID on 30th May 2019, however, this could not be approved until translation into Nepali had taken place. This will be completed and submitted for approval early next quarter.

Inputs scheduled for next quarter: After endorsement, any updates to the Nepali version of the guideline will be translated back into the English version for dissemination.

RESULT AREA: /5.3 MOHP HAS ROBUST SURVEILLANCE SYSTEMS IN PLACE TO ENSURE TIMELY AND APPROPRIATE RESPONSE TO EMERGING HEALTH NEEDS

Summary: Progress in this result area has been delayed particularly with regard to use of data from the systems in responding to emerging needs. There have been positive moves however towards strengthening and expanding existing surveillance systems, particularly MPDSR and EWARS. The MPDSR implementation guideline has been revised in line with the

¹⁹ Dr Peter Drury, an independent digital health consultant for policy and strategy in developing countries

²⁰ Consultative meeting held on 12 April 2019, at MoHP under the chairpersonship of the Hon. Deputy Prime Minister & Minister MoHP

²¹ A small team comprising members from the FMOHP and EDPs including NHSSP visited selected subnational governments - the Provincial Health Directorates, local governments and health teams from the 11th to 14th May 2019.

structural changes in the federal context; and EWARS reporting tools have been developed in DHIS2 platform for better linkage with the HMIS.

Activity i5.3.1 Support the strengthening and expansion of Maternal and Perinatal Death Surveillance and Response (MPDSR) in hospitals and communities

Ongoing: NHSSP provided technical inputs in revising the MPDSR guideline in the federal context. NHSSP is continuously engaged with the FWD, WHO and USAID for better implementation of MPDSR in this. There have been focussed discussions around collaboration with provincial academies of health sciences for strengthening and expansion of MPDSR; development of e-learning packages; improving digitization of the recording and reporting tools; and analysis of the data collected so far to better inform the decision-making process in general and in particular, the 'response' component of the system. In response to the request from FWD, the TA facilitated the review of MPDSR in Province 1, Itahari from 2-5 June 2019; and in Province 5, Butwal from 16-18 June 2019.

Inputs scheduled for next quarter: NHSSP will continue supporting implementation of MPDSR (as per the revised guideline in the LL sites and in hospitals under the federal government) and will support MPDSR monitoring through a scorecard system at LL sites.

Activity i5.3.2 Develop and support the implementation of a mobile phone application for FCHVs to strengthen MPDSR

Delayed: The objective of this initiative is to support FWD in using mHealth technology for reporting/notification of maternal deaths from FCHVs as a part of strengthening the MPDSR. The TA continued technical discussion with the IT section of the MoHP, FWD, WHO, Medic Mobile, GIZ and BBC Media Action but the process of developing the tools has not yet been initiated as discussions are still ongoing around the role of FCHVs, their capacity to use the mHealth technology, supply of the devices to them, scalability and sustainability of the system. NHSSP has strongly recommended for postponement of this initiative until the FCHV strategies and community health services strategies have been finalised.

No inputs scheduled for the next quarter:

Activity i5.3.3 Collaborate with health academic institutions to enhance their capacity to lead the institutionalisation and expansion of MPDSR at the provincial level

Delayed: As the MPDSR guideline was under revision in the federal context, no specific initiatives were taken during this quarter. NHSSP has continued discussion with MoHP, WHO and USAID in advocating for collaboration with the provincial Academy of Health Sciences for institutionalization and expansion of MPDSR at the provincial level.

Inputs scheduled for next quarter: At the LL sites, NHSSP will initiate collaboration with the local health academic institutions for MPDSR monitoring through a scorecard system.

Activity i5.3.4 Develop an e-learning package on MPDSR (web-based audio and visual training package) and institutionalise it

Delayed: As the MPDSR guideline was under revision in the federal context, no specific initiatives were taken during this quarter. TA has continued technical discussions with the FWD and NHTC on the eLearning materials.

Inputs scheduled for next quarter: NHSSP will work with FWD to develop MPDSR e-learning package adhering to the revised guidelines.

Activity i5.3.5 Support effective implementation of EWARS in the District Health Information System platform with a focus on the use of the data in rapid response to the emerging health needs

Ongoing: The TA has been supporting the IHIMS to hold technical consultations with the key stakeholders and to develop a consolidated plan to strengthen the existing surveillance systems, including EWARS, and build functional linkages with other systems. EWARS reporting tool has been developed in the DHIS2 platform to link with HMIS and EDCD has initiated the process of moving the EWARS reporting to the DHIS2 platform. The analytical features in the DHIS2 will allow better analysis and use of the data for more effective responses tailored to local needs.

Inputs scheduled for next quarter: NHSSP will continue working with IHIMS on the consolidated plan.

RESULT AREA: i5.4 MOHP HAS THE SKILLS AND SYSTEMS IN PLACE TO GENERATE QUALITY EVIDENCE AND USE IT FOR DECISION MAKING

Summary: Good progress has been made in this result area. 'The Health Sector M&E Guideline in Federal Context', includes the survey plan till 2030 and the SDG related priorities and this has been disseminated through the MoHP website. Policy briefs have also been developed using the routine HMIS and survey data to better understand, monitor and address equity gaps. Planning for the Nepal Health Facility Survey 2020 has been initiated with the aim of starting data collection from early January 2020 and disseminating findings by December 2020. The mid-term review of the NHSS is in progress which also includes the use of evidence. The annual work plan and budget of the next fiscal year 2019/20 and the National Health Policy 2076 have been developed with better use of evidence.

Activity i5.4.1 Support the development and implementation of a harmonised survey plan to meet the health sector's data needs

Completed: The 'Health Sector M&E in Federal Context', an M&E guideline for the three spheres of government (described in the section i5.2.1 above) includes a harmonized survey plan to meet the health sector data needs. NHSSP provided technical assistance to the MoHP in carrying out the scoping exercise for the Nepal Health Facility Survey 2020, supported jointly by USAID and DFID. The scoping exercise included consultations with programme divisions and EDPs at the federal level, Ministry of Social Development, Provincial Health Directorate, health offices, medical superintendents of hospitals and representatives of selected local governments of Gandaki Province. The suggestions mainly focussed on planning data collection schedules in recognition of seasonal influences²²; including a childbirth/delivery module for assessing the quality of intrapartum care; sharing data at provincial and local levels; encouraging better use of the data at sub national levels; costing; and developing a timeline for the survey. The field work of the survey is expected to run from January 2020 with a final report due by December 2020. NHSSP also supported MoHP to conduct a comprehensive health infrastructure assessment at the seven LL sites and the respective districts (*For details please refer to Section 6 of this report - Health Infrastructure*).

No inputs are scheduled for the next quarter

Activity i5.4.2 Analyse HMIS and national level survey data to better understand, monitor and address equity gaps (PD 20 and 53) [and assist in planning]

²² Avoiding winter season for data collection in the mountain region

Ongoing: NHSSP and MEOR are working jointly together with IHIMS and FWD to analyse the HMIS data to prepare policy briefs on family planning and safe motherhood programmes to better understand, monitor and address equity gaps. NHSSP worked with IHIMS to publish the HMIS data of the fiscal year 2017/18 through the DoHS website prior to publication of the annual report, and NHSSP also supported the IHIMS in preparation of the DoHS annual report of the fiscal year 2017/18 now published on the DoHS website (<https://dohs.gov.np/annual-report-2074-75/>). In this quarter, three activities were carried out; Analysis of HMIS data (NHSSP & MEOR); Update of HMIS data from FY 2017/18; and preparation of the DOHS Annual Report. The first two activities were continued from the previous quarter, the policy briefs (FP and Safe motherhood) and DOHS Annual Report were finalised this quarter.

Additionally, this quarter, NHSSP supported the Nepal Health Research Council (NHRC) in preparing five policy briefs for promoting use of evidence in health systems strengthening as a follow-on activity of the fifth National Summit of Health and Population Scientist in Nepal. NHSSP also provided technical inputs in conceptualizing and reviewing the drafts of the further analysis of Nepal Demographic and Health Survey 2016. The policy briefs will be disseminated late July 2019.

Inputs scheduled for next quarter: NHSSP will continue working with MEOR and IHIMS

Activity i5.4.4 Support the MoHP to improve evidence-based reviews and planning processes at different levels – concept, methods, tools, and implementation

Ongoing: This quarter NHSSP supported MoHP in reviewing the NHSS MTR draft report. (*For details please see Section 2 of this report - Health Policy and Planning*).

Quality related indicators from routine MISs, MSS and surveys were identified and their operational definitions developed. A web-based Quality Improvement Management Information System (QIMIS) is now being developed and added as a separate section to the existing dashboards in MoHP website.

The web portal 'Good practices in health sector' (www.goodpractices.mohp.gov.np) has been updated with additional information collected from various sources including AWPB of local governments. The purpose of having this portal is to compile innovative practices in the health sector and disseminate them to wider stakeholders. This is expected to be an information resource/repository as well as to provide a platform for shared learning.

NHSSP also supported MoHP in the analysis and use of data from different sources, for example, HMIS and surveys while preparing the annual work plan and budget for the 2019/20 15th periodic plan, revision of the National Health Policy, and, preparing the long-term vision paper led by the National Planning Commission (NPC).

Inputs scheduled for next quarter: NHSSP will continue working on QIMIS development

Activity i5.4.5 Support develop evidence-based programme briefs (two pages/programme) for the elected local authorities and dissemination

Ongoing: NHSSP is continuing to work with MEOR to develop policy briefs on equity analysis of DLI 12 indicators and burden of disease. The NHSSP and MEOR team are also working on a policy brief to reflect inequality in the utilisation of maternal health services based on NDHS and NHFS data.

Inputs scheduled for next Quarter. These include development of evidence/policy briefs in coordination with MEOR and programme counterparts.

Activity i5.4.6 Support partners and stakeholder engagement forums for better coordination and collaboration and informed decision-making (M&E TWG)

Ongoing: In this quarter MoHP continued with organizing the regular M&E TWG meeting held on 7th May 2019 to discuss M&E issues as below;

- Nepal Health Facility Survey scoping discussion - MoHP
- Strengthening health sector knowledge management - MoHP
- Community engagement intervention for improving service utilization in selected municipalities - MEOR
- Sharing of child mortality estimates -WHO

No inputs scheduled for the next quarter:

Activity i5.4.7 Support the development of health M&E training packages for the health workforce at different levels

Delayed: NHSSP continued the technical discussion with IHIMS, DoHS and National Health Training Centre (NHTC) to develop an M&E training package for the health workforce at different levels as a part of induction training being conducted by the NHTC. However, no concrete actions have been undertaken as NHTC staff have been unavailable until end of fiscal year.

Inputs scheduled for next quarter: NHSSP will continue to work with NHTC to initiate the process.

RESULT AREA: i5.5 THE MOHP HAS ESTABLISHED EFFECTIVE CITIZEN FEEDBACK MECHANISMS AND SYSTEMS FOR PUBLIC ENGAGEMENT IN ACCOUNTABILITY

Summary: The strategic review of social auditing will be completed in November 2019 followed by revision of the social audit guideline, developing a reporting mechanism and enhancing capacity of partner NGO's. NHSSP is also engaged with the IT Section in the MoHP for operationalizing some e-health initiatives for example, dashboards, knowledge management portal, online tool for registering and mapping of all eHealth and mHealth initiatives. In coordination with WHO, GIZ & Medic Mobile, NHSSP supported MoHP to conduct a policy discussion (held on 12th April 2019) on 'Harnessing Digital Technologies to Strengthen Health Systems' under the chairpersonship of the Hon. Deputy Prime Minister & Minister MoHP.

Activity i5.5.1 Strengthening and sustaining of social audit of health facilities - revised guidelines in the changed context, develop reporting mechanism and enhance the capacity of partner NGOs

Not scheduled: No inputs were provided in this Quarter.

Activity i5.5.2 Support the development and operationalisation of smart health initiatives, including grievance management system for transparency and accountability

Ongoing: NHSSP together with WHO, GIZ and Medic Mobile provided technical assistance to MoHP to develop the National e-health Guideline and finalizing the e-health Roadmap in line with the National e-health Strategy. MoHP is updating the health facility registry in coordination with the provincial health directorates. NHSSP is also engaged with the IT

Section in the MoHP for operationalizing some e-health initiatives such as dashboards and knowledge management portal.

NHSSP also contributed to conceptualizing an online tool for registering and mapping all eHealth and mHealth initiatives in Nepal which will enable sharing good practices in digital health technology across all spheres of government, and, sharing data and helping build interoperability between digital health systems. MoHP has initiated the process of developing this tool with its own resources.

Inputs scheduled for next quarter: Continue supporting local governments in the LL sites to update and use the health facility registry and dashboards for evidence-based monitoring and decision-making.

Activity i5.5.3 Establish and operationalise policy advocacy forums through the development of the approach and tools

Ongoing: NHSSP in coordination with WHO, GIZ, Medic Mobile supported MoHP to conduct a policy discussion on 'Harnessing Digital Technologies to Strengthen Health Systems' on 12 April 2019 under the chairpersonship of the Hon. Deputy Prime Minister & Minister MoHP. The discussions fed into the preparations of the National eHealth Guideline and the eHealth Roadmap (**See i5.2.7**). As suggested by the DPM and Minister MoHP, MoHP has prioritized and initiated the process of developing an online OPD registration, finalizing the health workforce registry and improving the IT infrastructure within MoHP complex which includes reactivating dashboards, updating the MoHP website and improving the Internet and Intranet.

Other activities

1. Continued regular monthly meetings between NHSSP and MEOR, monthly meeting minutes have been shared with DFID.
2. Supported MoHP in the review of 40 years of Primary Health Care implementation at country level (WHO; Alma-Ata Declaration September 1978).
3. Supported the MoHP and DFID in analysis of the DLI indicators and in revising them for the changed context.
4. Supported the development of an M&E framework for the SMNH roadmap

6. HEALTH INFRASTRUCTURE

HEALTH INFRASTRUCTURE KPA 1: POLICY ENVIRONMENT

17.1.1 Produce post-2015 Earthquake Performance Appraisal Report (PD 13)

Completed: Achieved in Quarter 3, Year One.

NHSSP has continued to provide support to MoHP Health Emergency and Disaster Management Unit (HEDMU) as part of the coordinated effort of all the stakeholders (the overall process is managed by WHO and led by MoHP) for the health cluster to perform better during emergencies. In line with the Health Sector Emergency Preparedness and Disaster Response Plan Workshop (organised in January 2019), NHSSP supported HEDMU in the preparation of comprehensive training guidelines on health sector disaster preparedness and response plan.

In coordination with other NHSSP work streams, the HI team developed and finalised an assessment tool which supports the analysis of the level of disaster preparedness and response planning of each of the health facilities within the Learning Lab districts. Based on the tool, the HI team completed the assessment in 5 Districts with learning lab sites and are progressing in the sixth learning lab site district. Both the 6th & 7th remaining Districts with learning lab sites are expected to be completed by the end of August 2019.

The collected data from the completed assessments are under analysis and will be completed in the next quarter. The results of the analysis will set the baseline information for the required interventions at the HF level regarding disaster preparedness and response. The analysis, once disseminated, will enable respective municipalities, concerned authorities and other stakeholders to identify current needs and gaps to support appropriate interventions.

Inputs scheduled for the next Quarter: The training guidelines on health sector disaster preparedness and response plan has been planned for publication. NHSSP will also be contributing technically and financially for the publication in coordination with other EDPs.

Challenge: The changes in functions and relationships under the new federal dispensation may impact on the approach to mainstreaming DRR across the different spheres. This situation will be monitored closely, and if necessary, adjustments will be made to the implementation modality. The adverse weather conditions may also affect the planned assessment remaining in two districts for which a contingency plan, using HIIS, is being prepared to analyse alternative routes, locations, and clusters.

17.1.2 Upgrade HIIS to integrate functionality recommendations

On time: As per Quarterly Report January – March 2019.

As reported in the last quarter, the Federal government decided there should be a health facility in each local ward (although this was a Manifesto commitment from the previous year, implementation of the decision was only implemented at the start of this year). Despite NHHSP technical advisers making the case that a blanket approach should not be applied, the federal government decided to adhere to its decision. Events organised involving local stakeholders has resulted in some resentment being reported from local representatives and officials who have advised that some of them did not require this kind of facility. Local authorities stated that this was a top-down approach to planning, rather than a bottom-up approach which reflects need-based analysis. As a result of this being reported by the local authorities, during the interaction programme, and verified using the satellite imagery using HIIS, it was observed that some facilities granted a budget for development were in close proximity to existing health facilities. In a reported case of Balirampur health post, the new location for the construction of the health facility was actually within 50 meters of the existing one.

To support the argument and provide evidence, digital maps have been developed for identifying the distance between the nearest existing and proposed location of health facility development using the ward level GIS-based features, this has been circulated to the stakeholders along with the ward level health facility availability report for dissemination. The maps show that almost 1446 wards without any health facilities, out of the total 2472 delineated earlier, has an existing health post within its catchment area (2 km radius in hills and 3 km radius in Terai).

In the last quarter, the government had also decided to develop one 15-bed hospital in each local authority (as above manifesto commitment) and announced that all Primary Health Care Centres which were constructed previously (as per government standard designs supported by NHSSP) were to be converted into 15-bed hospitals. The HI team strongly argued (based on HIIS information) against this stating that they may end up having more than one hospital in the same local authority, while many of the municipalities with smaller catchment populations would not require a 15-bed Hospital. Convinced by the argument, the Department of Urban Development and Building Construction has now communicated with all of its Project Implementation Units to carry out a proper Needs Assessment of the PHCCs developed earlier in order to identify the rationale and required level of intervention required.

Inputs scheduled for the next Quarter. The HI team will continue to promote the use of HIIS for rational planning and evidence-based decision-making through the following activities:

- Continual and regular update of HIIS drawing on primary and secondary sources of information.
- Support the assessment and its completion of health facilities in districts with learning lab sites.
- Delineation of the most effective clusters of health facilities and identifying the most efficient routes, using HIIS for supporting the ongoing assessment.
- Verification of data being received from the health facilities in districts with learning lab sites and feedback to the enumerators for improvement.
- Updating of HIIS based on compiled verified data.
- Data analysis and report preparation of health facility assessment

Challenge: Planners in different government spheres persist in making irrational decisions on health infrastructure development. The HI team seeks to address this through continuous dissemination of information and the promotion of the value of evidence-based planning through events and interactions across all three spheres of government.

17.1.3 Transfer HIIS to MoHP, support the institutionalisation of the tool and enhance capacity in its use

On-time: The HI team continues to build the capacity of MoHP, DOHS, and DUDBC officials to use the HIIS for HI planning and development of health infrastructure. Government counterparts have been working alongside the HI team in different planning and interaction programs enabling full understanding of usage and implementation aspects of HIIS.

The use of HIIS in planning purposes and its dissemination at federal, provincial and local governments has been a regular ongoing process. Local level government counterparts have been informed about the data inventory and operations during the interaction programmes while explaining about the procedures of development and the deployment of guidelines regarding health facility development (Nepal Health Infrastructure Development Standards - NHIDS 2017). The HI has been continuously advocating for rational HI planning using HIIS evidence and information. “Categorisation of health facilities” a volume to the NHIDS 2017 delineated using HIIS has been a useful tool at all levels of government as a basic guideline for development and upgrading of the health facilities. Additionally, local governments have

been allotted budget to develop primary hospitals in line with this document. The information in the HIIS inventory has been used to help the representatives of local governments to assimilate the categorized status levels of health facilities in their jurisdiction, thus rationalizing the local level health facility development plans. The online web-based HIIS portal has been configured to enable each local authority to access the information on health facilities under their jurisdiction. HIIS user account credentials for each local authority and province along with GIS-based data packages are being developed. System usage training is in agenda for discussions.

Inputs scheduled for the next Quarter: Initiate a gap and readiness analysis of MoHP's capacity to take full ownership of HIIS and develop a timeline and implementation plan in coordination with the evidence and accountability team in line with the e-health strategy. The analysis will also ascertain the implementation feasibility and technical skill intervention required.

Challenge: Staff adjustment of the officials in all levels of government and in health facilities has not yet been finalised, this makes the gap analysis and the internalisation process of HIIS difficult. In order to mitigate this risk, the team will continue the dissemination on the use of HIIS at the different levels of Government and also produce evidences supporting the rationale planning and decision-making process in order to create its demand.

7.1.4 Revision of the Nepal National Building Code (NNBC) in relation to retrofitting, electrical standards, Heating, Ventilation and Air Conditioning (HVAC), and sanitary design.

As per previous Quarterly Report (Jan–Mar 2019), the development of new training modules and handbooks for electrical services, water supply and sanitary services, HVAC and waste management were initiated, draft handbooks have now been completed. Feedback is being collected from the HI team members, DUDBC officials and other experts and the review process is expected to be completed by August and submitted for peer review by an expert panel which will include experts from MOHP, DoHS, and DUDBC.

Inputs scheduled for next Quarter: Formation of expert panel, review and finalisation of the handbook by end of September.

Challenge: The development and endorsement of the modules and handbooks may be delayed if not given due attention by DUDBC. The HI team will engage closely with DUDBC officials to expedite the process as necessary.

7.1.5 Nepal earthquake retrofitting and rehabilitation standards produced and adopted (PD 21)

Completed: Although completed, there is continuing progress towards this result.

Continuous engagement with RAN for the development of standards has progressed and it has been agreed that RAN will coordinate and support NHSSP for the development of seismic vulnerability assessment standards in close coordination and under the leadership of DUDBC. The draft content of the standards was completed and submitted to DUDBC in April 2019 and is now under review by DUDBC and other experts. The approval of the draft has been delayed due to different schools of thought between different participating experts. The introduction of the new seismic design code NNBC 105 is soon going to be endorsed by DUDBC, based on which, the submitted contents may have to be revised and resubmitted again to DUDBC for approval. NHSSP is coordinating with the concerned members to streamline the ongoing process and reach an agreement.

Inputs scheduled for next Quarter: Continuously follow up with DUDBC and the retrofitting alliance to conclude the draft code contents.

17.1.6 Development of the Climate Change and Health infrastructure framework (PD 22)

Completed: As initiated during the last quarter for application of Climate Change and Health Infrastructure framework during the upgrading of provincial health facilities in Karnali Province, the HI team has completed the assessment of all the district hospitals within the province. The Climate Change and Health Infrastructure framework forms a key component in the application of multi-hazard resilience and has been used by the HI team as part of the health facility assessment in seven Learning Lab Districts (*see 17.1.1*).

17.1.7 Support the development of implementation plan for Infrastructure Capital Investment Policy (PD 89), and Preparation of framework for the development of supporting tools for effective implementation of the categorisation of health facilities (PD 46)

On-time: In line with this objective, the HI team conducted the following orientation events.

Technically supported for the orientation of NHIDS as per the objective to build capacity of provincial and local governments to adopt the NHIDS, and design and implement integrated health infrastructure development plans to Province 2. The orientation programme was organized and financed by the Ministry of Social Development (MoSD) and held in Bardibas. Two groups of participants attended separately on 13th and 14th of June 2019. The first group had participation from 17 different Municipalities and the second group had participation from 12 different Municipalities. Altogether 29 municipalities from Province 2 were covered. Participants included local representatives and officials, the Mayor, Deputy Mayor, Chief of Health Section and Chief Executive Administrator from each municipality. Honourable State Minister Mr. Abhiram Sharma, Ministry of Social Development, Province 2 addressed the participants during the occasion.

Inputs scheduled for next Quarter. A similar event has been requested by Province 5, date to be confirmed. The orientation programme for the remaining Municipalities (both rural and urban) in Province 2 has been planned for next quarter.

Challenge: The demand for orientation is high and requires intensive interaction and widespread dissemination across provincial and local government spheres. The HI team will continue to redirect efforts and support from federal to provincial and local level to meet this demand.

17.1.8 Revise existing Health Infrastructure Design Standards and upgrade Guidelines to ensure equity by bringing them in line with LNOB good practice and orient infrastructure stakeholders on these

On-time: Standards are in place and are being used.

During this quarter, preparation of alternative Standard design for Primary Hospital B1, B2 and B3 type designs were completed to address some of the requirements to be added in the present standards (based on different spatial context).

Inputs scheduled for next Quarter. The HI team will carry out orientations on GESI/LNOB issues in the tender process for retrofitting the two Priority Hospitals. The event was originally planned for this quarter but was postponed due to delays in the tendering process. DUDBC officials, construction professionals and contractors will all attend separate events before the contracts for the retrofitting projects are awarded.

A study has also been planned to be initiated in August for assessing the existing situation of radiation protection in health facilities, based on which, standard requirements and construction details for safety and protection will be developed and added to the existing standards.

17.1.9 Implementation Plan for Health Infrastructure Development, upgrading, repair and maintenance (PD 68)

Completed: This comprehensive document is being further developed based on information provided on existing scenarios and status of the health infrastructure development, land issues (suitability and ownership), upgrading and repair and maintenance at different local levels, based on feedback collected during interaction with local authorities.

The document intends to strengthen federal direction and guidance to sub-national governments on health infrastructure. It will bring together the issues, standards and recommendations of PD 46 Categorisation of Health Facilities and PD 89 Capital Investment Policy and add to the repair and maintenance focus of PD68.

Inputs scheduled for next quarter. Preparation of final draft document intended for end of April 2019 has been postponed to the next quarter since additional issues and feedback are still being received from local authorities in the different provinces. Feedback from learning lab districts will also be very important for the finalisation of the document.

HEALTH INFRASTRUCTURE KPA 2: CAPACITY ENHANCEMENT

17.2.1 Ongoing capacity development support to the MoHP/DUDBC, including capacity assessment, including the formation of a Capacity Enhancement Committee.

The following capacity development support activities were carried out by the HI team in the current quarter.

Support in technical Monitoring of Reconstruction Project to MoHP

As part of ongoing support for the reconstruction effort of MHoP, the HI team provided technical support for the following;

- Technical verification of construction health posts (Majhipheda Health Post by Terre's De Hommes (TDH) in Kavre; Saipu Health Post in Ramechhap.
- Review of consultant service procurement documents of FC recovery project phase II funded by KFW.
- Development of specifications cost estimates for the procurement of equipment for newly reconstructed buildings of Paropakar Maternity and Women's Hospital and Bir Hospital.
- Organisation of the inauguration programme of both the Hospitals for July 2019.

Support at Province and Municipal Level

Preparation of designs (architectural, structural, electrical and sanitary) and cost estimates of Jajarkot Hospital IN Karnali Province have been completed in conjunction with DUDBC. The process has been useful in the capacity building of DUDBC staff in designing of Hospitals using passive solar approach and also for standard hospitals in a terraced land. The HI team also supported DUDBC in preparing BOQ for the project resulting in the tender notice for this being published on 18th June 2019. This design process and technique, as applied by the HI team, can be replicated by DUDBC in other similar contexts for future Hospital design work. Support was provided to the following;

- The Ministry of Social Development, Karnali Province for the completion of the bidding process for the procurement of equipment and civil works for the secondary level hospital in Surkhet. NHSSP also supported the Provincial Government for the e-procurement process engaging DUDBC PIU in the process as part of capacity development enhancement effort.
- Bishnu Budhanilkantha Municipality for design of City Hospital. This has been useful in building the capacity of private sector professionals hired by the Municipality for

designing hospitals in a terraced land using the standard designs developed by NHSSP. Based on the concept and architectural design, supported by HI team, the private sector professionals are now developing the detailed drawings and necessary documents for project implementation.

Engineering assessment of 11 Hospitals (Dolpa, Rukum, Salyan, Dailekh, Dullu, Humla, Province hospital Surkhet, Mehelkuna, Jajarkot, Mugu, Kalikot) within Karnali province was completed. Based on the assessment results, the HI team plans to support the province in developing short, medium and long-term infrastructure development plans for Karnali Pradesh, initiating a planned integrated approach to health infrastructure planning. It is expected this approach will be adopted for other provinces using a planned integrated infrastructure development approach. This is a joint initiative with the USAID funded project 'Strengthening Systems for Better Health' (SSBH). SSBH is supporting the assessment of HR and service delivery in these Hospitals. A joint report will be submitted to the Ministry of Social Development, Karnali Province next quarter.

Support at the Federal Level

On the request of MOHP, the HI team has prepared a master plan and initial project report for the design of Ram Raja Prasad Singh Academy of Health Science. A detailed ToR for a project report (DPR) is being prepared. The ToR will serve as an established model for the preparation of DPR for the establishment of other academic Hospitals. NHSSP is also supporting the gap analysis and preparation of a master plan for Gajendra Narayan Singh Hospital in Rajbiraj, Saptari. The field survey has already been completed for this.

7.2.5 Health Infrastructure Policy Development Training Programme Implementation Y3

Completed: Approved by DFID (PD 88) and conducted on 27-28 May 2019,

7.2.7 Policy Development Training Impact Evaluation (PD 61)

Completed: Conducted in April 2019. The report has been submitted and approved by DFID.

7.2.9 DUDBC technical skill training design and conducted Y3

Completed: The skills training event on retrofitting design of masonry buildings was successfully completed in March 2019.

No Inputs are scheduled for the next quarter.

7.2.10 Technical Skills Training Impact Evaluation (PD 39)

Completed: This activity was achieved during the last Quarter Year Two.

No inputs are scheduled for the next Quarter.

7.2.11 Technical Skills Training Impact Evaluation (PD 69)

Completed: The technical Skills Training Impact Evaluation (PD 69) was conducted in May 2019. The report was submitted to DFID and approved.

No Inputs are scheduled for the next quarter

7.2.12 Feasibility Study and Recommendations for Establishment of Mentoring Support (PD 54)

On-time: The assignment has been completed and approved by DFID.

No inputs are scheduled for the next Quarter.

17.2.14 Skills Development Training for contractors and professionals designed and implemented Y3

Inputs scheduled for next Quarter. The training will be conducted as soon as the main retrofitting Tender is published. Training contents and design will be developed by July in close coordination with DUDBC.

17.2.15 Design & Roll-out of Roadshows & Information Sessions in Priority Districts (PD 47)

On-time: This activity was achieved during the last year.

No Inputs are scheduled for the next Quarter.

17.2.12 Design & Roll-out of Roadshows & Information Sessions in Priority Districts (PD 73)

On time: The ToR has been sent to DFID for approval and the contents have been updated from the previous roadshow programme. The second round of roadshows will highlight on decanting strategy for retrofitting, electrical design, water supply and sanitary design, HVAC, hospital waste management, sewage treatment plant (STP), effluent treatment plant (ETP), disaster risk management plan and repair and maintenance of Health facilities.

Inputs scheduled for next Quarter: The event will be held in August, date to be confirmed in consultation with the priority Districts.

HEALTH INFRASTRUCTURE KPA 3: RETROFITTING AND REHABILITATION

17.3.5 Design of retrofit works (structural / non-structural) with the DUDBC (PD 29)

On-time: The design was completed and submitted to DUDBC and DFID in Year One.

The modified retrofitting designs incorporating comments of the international monitoring and verification team contracted by DFID (M & V team) were reviewed jointly with DUDBC engineers. Final dissemination of the retrofitting designs tendering and construction process as well as the monitoring and supervision plan of the priority hospitals was organised during this quarter on 3rd May 2019. The event was hosted by DUDBC with support from the HI team. All concerned stakeholders and experts were present. As an ongoing capacity enhancement support, NHSSP team are engaging with DUDBC engineers as required, for refining retrofitting designs and detailing construction/demolition plans including cost estimates and the tender process.

DUDBC has approved the decanting block designs and have submitted these to the Hospital Management and respective municipalities (Pokhara Metropolitan City and Bhaktapur Municipality) for building construction permits. Bhaktapur Municipality has already provided construction permission for decanting blocks and for the use of public land for decanting space.

DUDBC/FPIU has published tender notices for both the decanting blocks in Pokhara and Bhaktapur. The tender document has been reviewed by the HI team and feedback has been provided for necessary amendments.

A feasibility study on a decentralised waste-water treatment system (DEWATS) for both hospitals has been completed. This is the first time this kind of study has been initiated for

waste-water management through DUDBC. Results of the feasibility survey will be available shortly.

The activity schedule, re-routing plan during construction works, site management plan and demolition plan for the retrofitting works at Western Regional Hospital have been updated following discussion with hospital authorities. The revised activity schedule and demolition plans have been presented to the hospital management in Pokhara.

Inputs scheduled for the next Quarter. Capacity enhancement of DUDBC staff to continue working together on drawings and design modifications. Design of a Decentralised Waste Water Treatment System (DEWATS) in both Hospitals.

i7.3.7 Preparation of final drawings

Completed: completed during last quarter

No inputs are scheduled for the next Quarter

i7.3.8 Production of Bills of Quantities

Completed: completed during last quarter

No inputs are scheduled for the next Quarter

i7.3.9 Tender process and contractor mobilisation (PD 40)

Partially completed: Tender notice has been published for construction of decanting blocks for both the hospitals. DUDBC has planned the tender notice publication for the main retrofitting work for the next quarter. It will be published as soon as their officials complete the internal review and approval process.

Inputs scheduled for next Quarter. Publishing of tender for main retrofitting works

i7.3.10 Priority Hospitals Work Implementation and Supervision, completion of the first phase (PD 55)

Not scheduled. No inputs were provided in this Quarter.

No inputs are scheduled for the next Quarter.

i7.3.12 Engagement of FMOHP/DUDBC people in design and tendering

The NHSSP team, DUDBC health building unit, DUDBC-PIU (Province 3) and DUDBC-PIU (Gandaki Province) completed the joint review of designs, estimates and bidding documents for decanting blocks of the two priority hospitals. Inputs are scheduled for the next Quarter. Support will be provided for joint review of designs, estimates and bidding documents for main retrofitting blocks.

7 CONCLUSIONS

This report reflects the effectiveness of TA support provided by NHSSP over the last 3 months. This has been both an exciting and challenging time for the team with most of the work being dominated by the NHSP3 Reshape/Extension proposal (submitted to DFID on 19th June 2019). A new team leader joined the team in May 2019 and has already undertaken field visits to Province 1 and to both retrofitting hospitals in Pokhara Metropolitan City and Bhaktapur Municipality respectively. A series of meetings have also been held with key Government officials and EDP's. Progress and outputs of the team have already improved, and, the team continue to work well together collaboratively. All PD's have been submitted to DFID and approved and NHSSP continues to have excellent working relationships with external partners and key stakeholders. This is evident in the partnership working and collaboration between NHSSP and USAID, WHO, GIZ and MEOR.

Implementation of Federalism continues to progress slowly. Although MOHP is now addressing key issues including the lack of coordination and systems between the three spheres of government, a number of challenges still remain (for example, under execution of provincial and local budgets, recruitment issues, staff readjustment and shortages). This quarter also saw the GoN undertaking enactment of the Civil Servants Adjustment Act (2075). This has caused great unrest with more than 12,000 grievances being lodged against the list published by the Ministry, this is having an impact on service delivery and will need to be monitored closely. Additionally, a number of personnel within senior leadership positions within MOHP and other government bodies were replaced, and this has also led to some delays in programme implementation, for example, in the delayed signing off of the Safe Motherhood Roadmap.

To conclude on a positive note, the team have also had notable successes, these include (but are not exhaustive to);

- Implementation of the OCAT and MSS was completed for all LL sites at municipal level and for RDQA at health facility level. Knowledge of the gaps identified helped greatly in the AWPB process and HSS Officers worked closely with local governments in the development of this for FY 2019/2020. Municipal allocation is expected to increase in each of the sites as a result of this.
- NHSSP continued its efforts with MOHP & DUDBC resulting in DUDBC/FPIU finally publishing tender notices for both the decanting blocks in Pokhara and Bhaktapur Hospitals, work will start on these next quarter. Support was also extended to provincial and local governments resulting in infrastructure sensitization workshops being held in Provinces 2,3,4 & 6.
- NHSSP continued supporting MOHP to scale up OCMC in all 55 sites. Medico-legal training was provided in all 7 Provinces (150 Drs participated), GBV workshops for survivors were held and GBV training was provided to all Palika Mayor & Deputy Mayors in Chitwan districts resulting in a commitment to allocate 5.5 million NPR to support GBV survivors.

The coming months will bring not only new challenges for the team but also new opportunities and with a new team leader in place and a strong team, NHSSP remains in a confident position to continue providing timely and appropriate support as and when required.

ANNEX 1 INTERNATIONAL STTA INPUTS IN FIRST QUARTER (APRIL – JUNE 2019)

S. N.	Name	Date	Purpose
1	Alison Dembo Rath	30 March – 11 April	NHSSP Reshaping and management support to NHSSP senior team
2	Clare Cummings	11 – 26 April	Review of partnership guidelines
3	Shanti Mahendra	24 April – 3 May & 9 - 15 June	Support to service delivery and evidence and accountability workstreams
4	Deborah Thomas	1 – 30 June	Support GESI team to develop GBV case study
5	Steve Topham	25 April – 18 May	Technical assistance to infrastructure team. Supporting NHSSP reshaping.
6	Rachel Grellier	26 April – 6 May	Support TL/DTL and workstream leads with technical needs including finalisation of quarterly report and PDs.
7	Mark O' Donnell	6 - 25 May	Internal audit and TABUCS review
8	Natasha Mesko	April - May	SMNH roadmap review
9	Dr. Geeta Rana	March - June	Development of Standard Treatment Protocol for service providers to provide basic health care services
10	Peter Drury	March - June	eHealth expert – inputs into development of national eHealth guidelines
11	Tony Bondurant	25 May – 19 June	Induction of Team Leader, support in reshaping proposal.

ANNEX 2 PAYMENT DELIVERABLES APPROVED IN THIS QUARTER

Area	Milestone No	Description of Milestone	DFID approval date
HPP	49.2	Guidelines for partnership in health sector	11-Jun-19
SD	59.1	Progress report on the implementation of the Physiotherapy Task-shifting Innovation	07-May-19
RHITA 2	61	Policy Development Training Impact Evaluation	13-May-19
Management	62	Quarterly report 7 Jan – March 2019	04-Jun-19
PPFM	63	MoH internal audit status report produced by HRFMD, including progress on response time to audit queries	05-July-19
PPFM	64	Web based grievance redressal mechanism in use by LMD	03-July-19
RHITA 2	69	Technical Skills Training Impact Evaluation	07-Jun-19
RHITA 1	88	Policy Development Training updated and implemented	07-Jun-19

ANNEX 3 LOGFRAME UPDATE: YEAR 3 (2018/19 - 16 JULY 2018 - 15 JULY 2019)

The table below summarizes the progress update of the NHSSP Log Frame indicators against the year 3 (2018/19) milestones. There are no milestones set for one (OC1.1) of the three outcome indicators; and two (OP4.6 and OP6.4) of the 25 output indicators for year 3. The progress presented in the table below is based on the data extracted from the routine MISs at the end of the fiscal year, (June 2019). It takes approximately 2-3 months after completion of the fiscal year to get complete data in the national database so there will be some updates on these figures when the data gets completed reported.

Code	Indicator	Source of data	Year 3 (2018/19)		Remarks
			Milestone	Achievement	
Outcome indicators					
OC1.1	% of newly constructed health facility buildings adhered to environmental shocks and natural disaster resilience (structural and functional) criteria	DUDBC report	No milestone	Not applicable	Will be updated next year.
OC2.1	% point reduction in gap between the average SBA delivery of the bottom 10 and top 10 districts	HMIS	5	14	Average of top 10 districts: 71.3% Average of bottom 10 districts: 12.8% This year: Difference: 58.5% Last year: Difference: 67.8% Note: This is based on the data extracted from HMIS on 21 July 2019. Data entry is not completed yet so the reported figure will go up when data entry gets completed.
OC3.1	% of allocated health budget expended at central, provincial and local levels	TABUCS, FMIS	Federal: 87	77	Federal: Initial budget: NRs 34.08 Million Net budget: NRs 29.33 Million Expenditure: NRs 22.6 Million (77% of net budget) Note: This is based on the data extracted from LMBIS on 22 July 2019. Data entry is not completed yet so the expenditure will go up when data entry gets completed. This will result in higher % of expenditure. There is no mechanism to track the % of allocated health budget expended at provincial and local levels.
Output indicators					
OP1.1	% of local governments adhering to guidelines on health structure in federal context (defined in terms of the sanctioned posts of health staff at local government/Palika)	MoHP report	50	Staff placement is in progress	Federal government has defined the health structure of all 753 local governments and based on this, the staff adjustment/placement process is in progress.
OP1.2	Number of priority health policies, strategies and guidelines endorsed by MoHP	Policies, Strategies, Guidelines	1. National Health Policy 2. Health section in the national '15 th Periodic Plan 2076/77-2080/81) 3. National eHealth Guideline 4. Public Private Partnership Guideline	7	1. National Health Policy 2076 2. Health section in the national '15 th Periodic Plan 2076/77-2080/81) 3. National eHealth Guideline, 2076 4. Public Private Partnership Guideline 2076 5. Gender Responsive Budgeting Guideline for the Health Sector, 2076 6. Health Sector Gender Equality and Social Inclusion Strategy, 2076 7. National Guidelines for Disability Inclusive Health Services, 2076
OP1.3	% of public hospitals implementing the minimum service standards bi-annually (in learning labs sites)	NHSSP reports	50	50	Total public hospitals in 7 LL sites: 6 Hospitals implementing MSS: 3
OP1.4	% of MoHP entities met actions recommended from OCAT as per the plan	OCAT progress report, NHSSP	100	100	NHTC is the MoHP entity at the federal level that implemented OCA in Nov 2018. OCA has also been implemented in 6 LL sites.
	<i>[Note: The NHSP3 LF revised for Annual Review by MEOR has replaced this indicator with: % of LL established with completed OCAT score and action plan. Y3 milestone: 70; Y4 and Y5: 100].</i>		70	86	<i>Of the seven LL sites, OCA has been implemented in six sites. In Kharpunath, Humla, Province 6, SSBH/USAID has done a separate capacity assessment exercise.</i>
OP1.5	% of agreed actions in Joint Consultative Meeting (JCM) completed timely	JCM report	100	75	JCM is planned in August 2019: Action points of the last JCM: 1. Pharmaceutical laboratory inspection report (DDA): Not done 2. TA mapping (EDP): USAID has initiated the process 3. Finalization of BHCS package (MoHP): MoHP has submitted the final version to

Code	Indicator	Source of data	Year 3 (2018/19)		Remarks
			Milestone	Achievement	
					other line ministries for their review and feedback. 4. JAR 2017/18 (MoHP): Done
OP2.1	% of MoHP spending units conducting internal audit in line with the internal audit improvement plan (IAIP)	MoHP report	30	99	Out of 315 SUs 312 have conducted IA in line with IAIP. FY 2018/19 status is the IA of FY 2017/18.
OP2.2	Number of MoHP officials trained on a) Revised eAWPB; b) Updated TABUCS	Health sector eAWPB Training completion report	a) 150 b) 150	a) 47 b) 47	The MoHP spending units have been reduced to 47 in the federal context. 47 programme officials of these 47 units have been trained on the revised eAWPB and TABUCS.
OP2.3	% of MoHP spending units having no Recorded Audit Observations	OAG annual report	34	41	Out of 313 spending units 131 had no recorded audit observations. Of the 315 SUs, BPKIHS and Trauma Centre did not do Final Audit. Final audit of FY 2017/18 is done in FY 2018/19.
OP3.1	% of procurement contracts awarded against Consolidated Annual Procurement Plan (CAPP)	LMD Record on CAPP	60	94.5	Total number of procurement contracts: 73 Contracts awarded against CAPP: 69
OP3.2	% procurement tender completed adhering with specification bank for, a) Free drugs; b) Essential equipment	LMD Report	a) 90 b) 85	a) Health commodities: 100 b) Essential equipment: 100	Free drugs were not procured by MD this year. Instead of this the WB has changed the definition of DLI as Health Commodities. List of essential equipment is not yet finalized by MoHP. As per MD there are currently 1109 specifications of medical equipment in the TSB. All of them are essential depending on the use by the HIs. As per the WB the equipment procured by MD are counted as essential equipment for DLI. Total number of procurement tenders: a) Health commodities: 14 b) Essential equipment: 8
OP3.3	% of responses among the cases registered in procurement clinic	LMD report	60	100	Total number of cases registered in the clinic: 26 Cases responded: 26
OP4.1	Number of public CEONC sites with functional caesarean section service	HMIS	80	61	Of the total 84 CEONC sites, 61 sites reported to HMIS in the last three months (March/April, April/May, May/June 2019). Note: This is based on the data extracted from HMIS on 21 July 2019. Data entry is not completed yet so the reported figure will go up when data entry gets completed.
OP4.2	Number of current users of: (Disaggregated by provinces and ecological region) a) IUCD and Implant b) IUCD c) Implant	HMIS	a) 604,365 b) 197,055 c) 407,310	a) 385,888 b) 106,330 c) 279,558	Note: This is based on the data extracted from HMIS on 21 July 2019. Data entry is not completed yet so the reported figure will go up when data entry gets completed.
OP4.3	Number of people served by One Stop Crisis Management Centres (OCMC)	OCMC reports	5,160	7575	Total OCMCs established as of Jun 2019: 55 Note: This is based on the data received by end of June 2019. Data entry is not completed yet so the reported figure will go up when data entry gets completed.
OP4.4	Number of women benefited from Aama programme (disaggregated by ecological region and Province)	HMIS	293,850	244,146	Note: This update is based on the data extracted from HMIS on 21 July 2019. Data entry is not completed yet so the reported figure will go up when data entry gets completed.
OP4.5	Number of SBA trained using revised SBA training manual on nutrition	Training completion report, FHD and NHTC	400	Development of SBA training manual delayed	Delay in approval for revision of SBA strategy, training strategy and manual
OP4.6	Number of innovative interventions evaluated and disseminated	Evaluation report	No milestone	Not applicable	
OP5.1	% of local governments in the learning lab sites using equity monitoring dashboards based on HMIS data	HMIS	50	100	All seven learning lab sites have used the HMIS dashboard and also done online reporting of HMIS.
OP5.2	% of government health facilities achieving benchmark on RDQA in LL sites	RDQA/NHSSP report	15	49	First instance of the RDQA is completed in all 45 public health facilities in five of the seven LL sites. Of these 45 facilities, 49% of them have met the benchmark on system assessment (2.5 - 3).
OP5.3	Number of assessments conducted on priority programme areas and results shared with stakeholders	Assessment reports	2	2 in progress	In progress: 1. Health facility assessment in districts with LL sites 2. mHealth assessment

Code	Indicator	Source of data	Year 3 (2018/19)		Remarks
			Milestone	Achievement	
OP5.4	Number of policy briefs produced based on MoHP priorities and shared to inform policy [Knowledge products]	Policy briefs	5	5+3	1. Hand in hand in health care: Partnership management 2. Stock take of health information management and M&E in the Constitution, Acts, Regulations, Policies, Strategies and Cabinet Decisions 3. Organizational capacity assessment and its utilization in Nepal 4. Visiting service providers in family planning 5. Improving quality of HMIS data through web-based RDQA In progress: 6. Socioeconomic inequalities in institutional deliveries 7. Use of HMIS data in reviews and planning 8. Web portal of Good practices in health (goodpractices.mohp.gov.np)
OP6.1	Number of health infrastructure related policies endorsed by MoHP	Policies and standards endorsed by MoHP	Health sector infrastructure development, upgrade and maintenance	1	Implementation plan for health sector infrastructure development, upgrade and maintenance (PD 68) has been prepared. Repair and maintenance part of this plan document has been finalized and agreed by the TWG. Regarding the issues on health facility development and upgrade NHSSP is building the case from different provincial level orientation programme which is under discussion with MoHP.
OP6.2	Number of people trained in policy development and technical skills related to resilient design, construction and maintenance: a) Government staff; b) Construction workers	Training completion reports	a) GoN staff: 90 b) Const. workers: 50	a) GoN staff: 508 b) Const. workers:	
OP6.3	% of new government health facilities designed adhering to hazard resilience criteria (structural and functional)	Signed contracts, payment reports and completion certificates	100	100	Total health facilities designed: 34 Health facilities designed adhering to hazard resilience criteria: 34 Note: This year DUDC was authorized to design 14 projects. On top of this, design of 20 health facilities was completed adhering to hazard resilience criteria.
OP6.4	Number of health facilities/hospitals retrofitted or rehabilitated with support from DFID's earmarked Financial Aid	Verification report and the tender launch document Standards and retrofitting completion certificate from MoHP	Independent verification complete and responded too; decant tender launched	Independent verification has been completed incorporating the feedback from the reviewers, and decant tender launched	

ANNEX 4 VALUE FOR MONEY (APRIL 2019 – JUNE 2019)

Value for Money (VfM) for the DFID programmes is about maximising the impact of each pound sterling spent to improve poor people's lives. DFID's VfM framework is guided by four key principles as summarised below:

- **Economy:** Buying inputs of the required quality at the lowest cost. This requires careful selection while balancing cost and quality;
- **Efficiency:** Producing outputs of the required quality at the lowest cost;
- **Effectiveness:** How well outputs produce outcomes; and
- **Equity:** Development needs to be fair.

Detailed below are the indicators NHSSP has committed to reporting on a Quarterly basis.

VfM results: Economy

Indicator 1: Average unit cost of short-term TA daily fees, disaggregated by national and international

The average unit cost for Short Term Technical Assistance (STTA) for this reporting period is £564 for international TA and £175 for national TA. The average unit cost of both international and national STTA is below the programme benchmark of £611 and £224, respectively. Likewise, the actuals to date unit cost for both international (£555) and national (£157) STTA is also below the benchmark.

International STTA	Actuals to date (March 2017 - June 2019)	Average unit cost to date (March 2017– June 2019)	Current Quarter (April 2019 – June 2019)	Average unit cost (April 2019 – June 2019)
Days	717	£ 555	151	£ 564
Income (GBP)	£ 397,561		£ 85,019	
National STTA	Actuals to date (March 2017 – June 2019)	Average unit cost to date (March 2017 – June 2019)	Current Quarter (April 2019 – June 2019)	Average unit cost (GBP), (April 2019 – June 2019)
Days	1,723	£ 157	219	£ 175
Income (GBP)	£ 270,919		£ 38,419	

Indicator 2: % of total STTA days that are national (versus international)

The use of both national (41%) and international (59%) STTA in this quarter compared well with our programme indicators. The use of international STTA has been considerably increased since the last quarter. The ISTTAs provided technical support on the following key areas: TABUCS and internal audit review, development of national eHealth guideline (PD 66) and guideline for partnership development (PD 59.1). Similarly, national consultants provided technical support for the SMNH roadmap, STP and the design works related with hospitals. The use of international

STTA will increase in the coming quarter as the programme is expecting specialised inputs from experts on the following key areas: Aama review, social audit review, and NMS update.

Short Term Technical Assistance Type	In client contract budget*		Actuals to date (March 2017 – June 2019)		Current Quarter (April – June 2019)	
	Days	%	Days	%	Days	%
International TA	2,291	44%	717	29%	151	41%
National TA	2,942	56%	1723	71%	219	59%
TOTAL	5,233	100%	2440	100%	370	100%

Indicator 4: % of total expenditure on administration and management is within acceptable benchmark range and decreases over lifetime of the programme

In this reporting period, 18 percent of the budget was spent on administration and management which exactly matches with that of the programme benchmark. The key drivers are office running and office support staff's costs which are regular expenditures.

Category of admin / mgmt. expense:	Client budget		Actuals to date (March 2017 – June 2019)		Current Quarter (April 2019– June 2019)	
	GBP	%	GBP	%	GBP	%
Office running costs (rent, suppliers, media, etc)	88,550	2%	87,860	6%	12,548	5%
Equipment	26,063	1%	35,457	2%	738	0%
Vehicle purchase	120,000	3%	52,875	4%		0%
Bank and legal charges	13,110	0%	2,975	0%	275	0%
Office Set up and maintenance	29,090	1%	39,292	3%	1,970	1%
Office Support Staff	383,318	9%	171,367	12%	18,256	7%

Vehicle Running cost and Insurance	73,998	2%	25,963	2%	5,284	2%
Audit and other Professional Charges	16,000	0%	23,732	2%	6,691	3%
Sub-total admin / management	750,129	18%	439,521	30%	45,761	18%
Sub-total programme expenses	3,385,899	82%	1,027,105	70%	209,59	82%
Total	4,136,028	100%	1,466,625	100%	255.35	100%

VfM results: Efficiency

Indicator (I5): Unit cost (per participant, per day) of capacity enhancement training (disaggregated by level e.g. National and local)

During this Quarter, six sessions of capacity enhancement trainings were conducted to 201 participants. At the national level, four training sessions were conducted to reach 139 participants and at the local level two training sessions were conducted to 62 participants. The average cost per participant per day incurred for national-level training and local level is £38 and £10 respectively, both well below the benchmark cost. The trainings conducted at national level were on health infrastructure policy development, annual work plan and budgeting and nursing and midwifery strategic planning. At the local level, trainings were conducted at Bhaktapur and Dadeldhura on organisational capacity assessments.

Level of Training*	Cost per participant/day Benchmark**	Actuals to date (Jan 2018 – June 2019)***			Current Quarter (April 2019 – June 2019)		
		No. of capacity enhancement training conducted	No. of Participants	Average Cost Per Participant/Day (GBP)	No. of capacity enhancement training conducted	No. of Participants	Average Cost Per Participant/Day
National	£ 62	21	755	£ 37.5	4	139	£ 38
Local	£ 39	14	974	£ 15.5	2	62	£ 10

* The level has been reduced to two: National and Local, the district has been embedded into local

** The benchmark was set at the initiation of NHSSP (reference for cost taken from NHSP 2 and TRP programmes)

*** The data for this indicator was collected from Jan 2018 onwards.

VfM results: Effectiveness

Indicator 8: Government approval rate of technical assistance deliverables as % of milestones submitted and reviewed by DFID to date

To date, the programme has submitted 65 PDs; 64 PDs have been approved by the Government of Nepal and signed off by DFID.

	Payment Deliverables (March 2017 – June 2019)
Total technical deliverables throughout NHSSP3	110
PDs submitted to date	65
PDs approved to date	64
Ratio %	98%

ANNEX 5 CASE STUDY

VfM case study: Survivor perspectives on the nature, risks and response to gender-based violence in Nepal and the implications for One Stop Crisis Management Centres

A. Introduction

Gender based violence (GBV) includes violence against women and girls as well as men and boys. In Nepal, as universally, women and girls are the primary targets of GBV. Gender inequality and social norms that condone violence against women and girls and persons that break gender norms underpin GBV.

This case study presents the experiences of GBV survivors and victims²³. It offers insight into the nature of violence, and the risks and responses to GBV in Nepal. The stories were shared by survivors, their guardian or primary provider and were collected from OCMC focals of hospital based One Stop Crisis Management Centres (OCMC)²⁴. This case study complements studies that have looked at the response to GBV from the supply side²⁵. The survivor stories place the violence they experienced in the context of their lives, their use of OCMCs and other GBV services, and their life thereafter. It provides a user perspective to the government's multisectoral response of which OCMCs are a part, and evidence to support the continuing quality improvement of OCMCs and the responsiveness of the state to GBV.

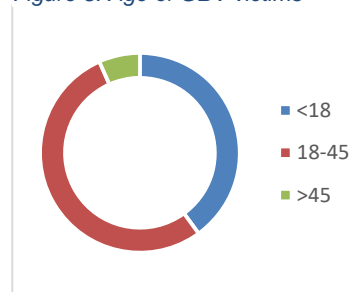
Gender based violence was defined by the United Nations Declaration on the Elimination of Violence Against Women (1993) as "any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life".

B. Who, what, where?

This case study draws from a sample of 45 cases of GBV collected from 26 OCMCs between 2017 and 2019²⁶. There are currently 44 OCMCs in the country and the 26 selected are in the Hill and Terai areas. The sample is not representative of GBV cases in the country as most incidence of GBV goes unreported and most victims do not seek help. The case stories do however provide insight into the characteristics of victims that use OCMCs, their perpetrators, and the nature and type of violence experienced.

Who: All but one case involved violence against women and girls; the victims ranged in age from a baby to 70 years. Six survivors were aged ten and under, most of the victims had experienced violence repeatedly and had not shared their experiences with anyone. Women typically only visited hospital after a violent episode or were taken to hospital in critical condition. Even after coming to hospital, most of them hid domestic violence as the cause of their injuries for fear of being stigmatized by society or their family.

Figure 3: Age of GBV victims



What: Thirty cases involved rape and three attempted rape. This included the rape of children as young as five, rape of a woman aged 70, reoccurring rape of girls by fathers and grandfathers, marital rape and group rape. Many in the sample experienced rape as well as other forms of sexual and physical violence. The sample included the abandonment of a newborn baby, a woman

²³ One woman did not survive the injuries inflicted upon her by her husband and died after 54 days in intensive care.

²⁴ OCMCs provide a comprehensive range of services for survivors of GBV, including health care, psycho-social counselling, access to safe homes, legal protection, personal security, rehabilitation and vocational skills training. Because of the multi-faceted needs of GBV survivors, OCMCs act as secretariats, coordinating with multi-sectoral partners to ensure services are provided.

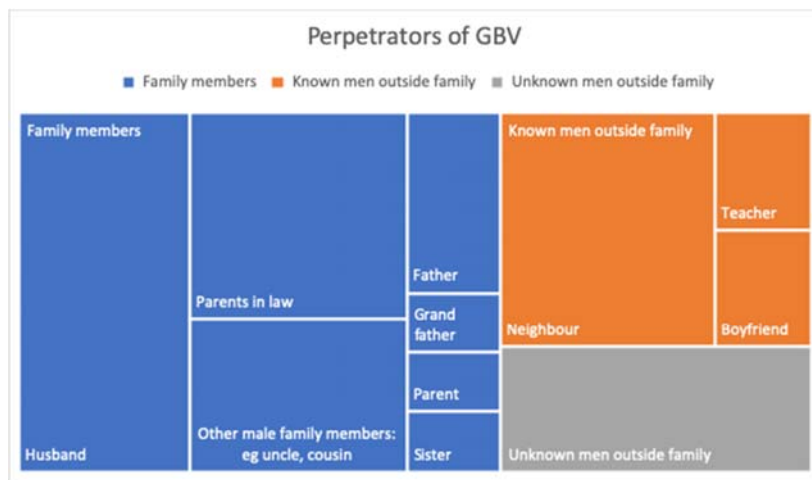
²⁵ Nepal Health Sector Support Programme III. February 2019. Improving hospitals' responses to survivors of Gender-Based Violence in Nepal.

²⁶ Twenty five of the cases were collected through interviews with the survivor in 2019.

accused and assaulted for alleged witchcraft, and the chaining and deprivation of a woman with intellectual disabilities.

Where: GBV took place in private and public spaces. The home was by far the most common place, but survivors were also violated in school, walking home from school, while grazing cattle and abducted and taken to jungle areas.

Perpetrators: As other studies in Nepal have shown, women are at greatest risk of violence from people who are closest to them, particularly husbands and intimate partners. The children in this collection of GBV stories were violated by family members (7) and non-family persons (11). Across the 45 cases, the most common perpetrator of violence was the woman’s husband, followed by neighbours/men in the village and then parents-in-law (mother and/or father-in-law). Violence in the home was often inflicted on an individual by multiple persons for example the husband and parents-in-law. Perpetrators include other male family members such as uncles and cousins. In seven cases the perpetrator was a stranger or unknown and in two, it was the girl’s teacher.



C. Risk factors

International studies of violence against women and children find shared risk factors including gender inequality and discrimination, marital conflict, family disintegration and the presence of non-biological father figures in the home²⁷. The risk factors that stand out from survivor reports in Nepal mirror such findings and include the absence or death of biological parents and adoption by extended family, absent husbands working away from home, early marriage and women’s lack of citizenship status.

Case #12: a girl of 16 whose mother died when she was young was living with her uncle and his family. Her father had given her away when he remarried. Her uncle repeatedly raped her and threatened to kill her if she told anyone. She became pregnant but no one suspected anything until she went into labour. She delivered at home. During delivery her aunt scolded her for being characterless and having an illegitimate child. After delivery, she shared that the uncle was the perpetrator. After interrogation the uncle admitted his crime and has been sentenced to 20 years in prison.

²⁷ Guedes A. et al. Bridging the gaps: a global review of intersections of violence against women and violence against children. *Global Health Action* 2016, 9: 31516 - <http://dx.doi.org/10.3402/gha.v9.31516>

The most common risk factor was being a person with intellectual disabilities or mental health condition. Globally, girls and young women with disabilities face up to ten times more GBV than those without disability²⁸. While the evidence base on the intersection between GBV and disability in Nepal is limited, this study captures examples of the extra vulnerability of women and girls with disabilities to GBV.

D. How social norms and gender inequality condone GBV

Analysis of the case stories shows how social norms perpetuate gender inequality and women's powerlessness, and act to condone male violence against women and girls. Gender unequal attitudes, values and beliefs put women and girls at risk of violence and impact decisions on whether to speak out about experiences of GBV, seek help, and pursue justice.

The shame and stigma of GBV for the individual and family is a major reason why GBV remains invisible, victims can end up being blamed for the violence, and constrained or denied help or justice. In cases of GBV where women and girls are living with impairment the shame is further amplified.

Case #10: a 13 year old girl was raped and became pregnant. The girl kept silent on what had happened to her and it was only when her teacher noticed her growing belly that the mother took her to the hospital. After the girl was found to be pregnant at the OCMC, her mother refused to take her home in fear of the response from her elder brother and the loss of social prestige. The girl was provided shelter in a safe house run by a NGO and is where she and the baby remain. Her family have not visited the survivor due to their sense of shame and have prevented a police case being filed.

Case #4: a 21 year old woman with intellectual disabilities, who is a deaf person and unable to speak was raped by an unknown person. When the pregnancy was detected at the OCMC, the parents did not want to take her back to the village due to the "hateful discrimination" against the woman and the stigma they would face. The woman stayed at the safe home until delivery. The baby died and after multiple family counselling sessions the parents agreed to take the woman home. No case was filed to investigate who the perpetrator was.

Case #19: a 17 year old girl studying, living and working away from her family was rescued from an attempted rape by a man she encountered at her workplace. Both the girl and the perpetrator were questioned by the police. The girl and her family decided not to press charges. She said, "since I had already earned so much shame on my name, I did not want to prolong it by filing a case against him. The hotel uncle also suggested that it would be bad for my reputation if I filed a case against him - I would have to go through so many hurdles in court. I therefore decided to reconcile (milapatra)".

In many of the cases of domestic violence, men use sexual and physical violence to assert their control over women, and sometimes the denial of rights too. Women are often seen as the property of the family. The dominant beliefs of the subservience of the wife to their husbands and parents-in-law can trap women into a culture of violence in the home.

Case #11: a 25 year old woman separated from her abusive husband but he continued to harass her. One day he tricked her into meeting him and he took her to the jungle on his motorbike where two of his friends raped her. The woman continues to live in a safe house and has filed a case against the husband and his two friends.

Case #30: a 27 year old married woman with three children who lived with her husband in a joint family set up experienced repeated sexual, physical and emotional abuse from her husband. She says, "he refuses to register our marriage and also refuses to make my citizenship. He has also denied registering the birth of our children in the respective ward."

Case #18: a 25 year old woman, married to a man in the army was emotionally and physically abused by her husband and his parents. The husband who was away from the joint family home insisted she give up her teaching job as he thought it gave her freedom to roam around with other men.

²⁸ UNFPA. 2018. Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realising Sexual and Reproductive Health and Rights. https://www.unfpa.org/sites/default/files/pub-pdf/Final_Global_Study_English_3_Oct.pdf

Case #15: a 36 year old married woman experienced sexual and physical abuse from her husband and physical and emotional abuse by her in-laws. Her in-laws beat her and asked their son to leave her and marry another woman to give him a son. She complained to the police twice about the abuse before the incident of physical assault and broken ribs that brought her to the OCMC. On those two prior occasions the police spoke to the husband and asked her to reconcile.

Case #28: a 24 year old woman married a man 16 years older than her when she was very young. He started physically abusing her after their first child was born. She was also threatened by her father in law "my father-in-law would come at night to my bed whenever my husband was not around... it happened two-three times... I did not let him touch me and had fights with him." She complained to her mother-in-law and husband but they did not believe her and blamed her for insulting her father-in-law. The woman and husband moved into a separate home and his abuse continued. One evening he beat her with an iron pot and she was taken to emergency at hospital and thereafter transferred to OCMC.

E. Help seeking: the added value of OCMCs

Many of the GBV survivors/victims were taken to hospital after a violent episode and were transferred within the hospital from emergency department, others arrived at the OCMC via police or the Women's Development Office. All 45 received medical services from the OCMC/hospital. Survivor counselling was provided by the OCMC in 39 cases and counselling of family members in 15. OCMCs are the only point of counselling in the district health service. In some cases, survivor stories suggest that the counselling service helped women move forward.

Case #3: a 24 year old woman suffering from post-traumatic stress disorder after her husband died and her mother-in-law took their child attempted suicide and was treated at the OCMC. She received medical care, psycho-social counselling and information on her legal rights. Her mental health has now improved and she is considering filing a case to gain custody of her child.

The OCMC coordinated with other service providers (police, Women and Child Office, NGOs, courts) in 43 cases, and often times OCMC staff were pivotal in leveraging resources and assistance to safeguard survivors and manage complex situations, going far beyond their medical care and counselling responsibility. For example, helping women to arrange schooling for their children, raising funds to cover immediate costs and organising livelihood support for the medium term. The level of effort provided by OCMCs was particularly intense in cases which involved women and girls with disabilities where finding an agency to provide a safe home and rehabilitation was difficult and complex cases required Case Management Committee and District Coordination Committee meetings and decisions to protect the special needs of survivors.

Case #27: a woman in her mid-20s with mental health problems was living on the street and began a relationship with a man who also had mental health problems. She became pregnant and was brought to the OCMC when she went into labour. She delivered at the OCMC and stayed there for a week post delivery because she had no home to return to. The OCMC invested time in finding an agency to provide a safe home to the mother and baby and mental health care. Funds from the OCMC referral fund were used to transport the mother and baby to KOSHISH an NGO where they stayed for six months. In the meantime, the father received mental health care. The municipality and local organisations provided funds to build the family a home; OCMC and other organisations collected funds for basic living utensils, and OCMC provided funds for poultry. The family moved into their home and are running a small poultry farm.

Case #30: OCMC staff provided multiple counselling sessions to the wife and counselled her husband to register the marriage and citizenship of his wife; which he did. OCMC also accompanied the wife to register her children at school and met with the headmaster. Both schools provided scholarships to the children.

F. What happened next for survivors

The pathway for survivors after the incident that brought them in contact with the OCMC is varied. In seven cases perpetrators are in prison and another 11 cases have been filed with the police. In the majority of cases, no police case is lodged. Even in cases of child rape, some families have decided not to lodge a case in part because of perceived family shame and perception of many hurdles in court (as per case #19 above).

Case #44: a 17 year old girl with intellectual disabilities was raped by a boy in the village. Her mother knew what happened but did not intervene. The mother decided not to file a case because as she said it will harm their social status and they will not be able live in the village due to the social stigma attached to it.

The safety of the survivor is the number one concern of providers and in many instances, survivors are referred to safe houses run by Women Development Office where they can stay for up to 45 days or to facilities run by NGOs where they may stay longer²⁹. Staying at a safe house is a temporary though important immediate response and the survivor generally returns to the family home thereafter. This is the case even when the conditions that fuelled domestic violence have not changed. In some cases, violence reoccurs but the options available to women to leave the violent home are very limited.

Case #29: a 30 year old married woman who was married at 13 and has four children experienced regular physical abuse from her husband after he came home drunk. After the incident that brought her to the OCMC with serious injuries she went to stay with her sister. A few days later, her husband came begging her to return home. He promised never to hurt her again. She returned. But, after some days he started the same routine again. She said she stays with him as she has nowhere else to go. She believes that if she leaves him it will be difficult for her children. She refused to file a case against her husband even after repeated counselling sessions and offer of help.

In a small number of cases survivors of intimate partner violence have been able to break the cycle of violence with support from NGOs that have provided skill development training and helped women start small businesses to become financially independent or in the case of one woman, the Medical Superintendent of the hospital gave her a job.

G. Conclusion

Survivor stories present a chilling picture of the abuse women and girls in Nepal face trapped by social norms and gender inequality which condones male violence and the authority of in-laws to control women. OCMCs are a critical structure in the response to GBV providing essential medical care and counselling and performing an important coordination response. However, community awareness of OCMCs is low, survivors rarely come direct to them and OCMC staff are hospital based. While recognising the contribution OCMCs are making to the lives of GBV survivors, the case stories shared here reflect the magnitude of the challenge.

Tackling GBV in Nepal will require multisectoral and sustained commitment by government at all levels. The main responsibility for the health sector is to provide supportive care to GBV survivors and this will require continued strengthening of health staff capacities and expansion of service availability. The UKAid-funded Nepal Health Sector Support Programme (NHSSP) is working with the Nepal Ministry of Health and Population to:

- Scale up hospital based OCMCs across the country to provide the hub of the multisectoral GBV response.
- Extend the response to GBV down the health chain so that health staff at primary level have the capacity to provide first line supportive care and referral up to OCMCs for comprehensive services.
- Work with local governments to:

²⁹ Safe houses are run by a variety of NGOs with support from Ministry of Women, Children and Senior Citizen, Sub-National Governments and development partners.

- Prevent GBV through public health campaigns that mobilise the health and social development workforce in each municipality, community leaders, women's and men's community groups and activists.
- Establish district GBV rehabilitation funds to support survivors recover from GBV and establish economically independent lives that are free of violence for themselves and their children.

ANNEX 6 RISK MATRIX

GHTA RISK MATRIX												
Risk No	Risk	Gross Risk		Risk Factor RAG rated	Current controls	Net Risk		Risk Factor RAG rated	Net Risk Acceptable?	Additional controls / planned actions	Assigned manager / timescale	Actions
		Likelihood	Impact			Likelihood	Impact					
	Contextual											
R3	Changes in UK Government leads to reduced commitment to aid budget, including budget for NHSSP 3 Extension.	Low	Medium			Low	Medium		Yes	Maintain close contact and regular communication with DFID advisors in Nepal and the UK to understand any implications to NHSSP extension planning.	Team Leader and Options Director of Programmes	Tolerate
	Political											
R4	Anticipated consultation meetings with the Government of Nepal may yield a different set of priorities or approaches at federal and sub-national levels, than those presented in the Extension proposal.	Medium	High			Medium	Medium			NHSSP will maintain close communication with DFID Advisors regarding government consultations, especially should they lead to unanticipated variances in approach.	Team Leader	Tolerate
	Safeguarding											
R16	Harm, abuse and exploitation of children and vulnerable adults (includes sexual harassment and exploitation)	Low	Medium		NHSSP takes a zero-tolerance approach to the abuse and exploitation of children and vulnerable adults. NHSSP, led by Options has systems in place to document, monitor and report on the implementation of its safeguarding policy. NHSSP adopts child and vulnerable adult safeguarding recruitment procedures for the selection of staff. NHSSP conducts due diligence on all new partners and conducts regular due diligence checks on existing partners to ensure compliance with Options' and DFID's Code of Conduct.	Low	Low		Yes	NHSSP staff will undergo additional safeguarding training. Options' Child and Vulnerable Adult Safeguarding Policy will be rolled out to NHSSP staff. Updates to partner contracts will include compliance with DFID's latest Supply Partner Code of Conduct.	Team Leader and Options' Safeguarding Lead (Director of Programmes)	Treat
RHITA RISK MATRIX												
Risk No	Risk	Gross Risk		Risk Factor RAG rated	Current controls	Net Risk		Risk Factor RAG rated	Net Risk Acceptable?	Additional controls / planned actions	Assigned manager / timescale	Actions
		Likelihood	Impact			Likelihood	Impact					
	Financial											
R15	Disagreements over land allocations at Bhaktapur Hospital may cause delays in the retrofitting work	Medium	High		NHSSP team will seek to promote resolution between the principal parties	Medium	Medium		Yes	NHSSP will work with Bhaktapur municipality to settle disputes	Lead Infrastructure Adviser	Tolerate

									between parties.		
	Safeguarding										
R16	Harm, abuse and exploitation of children and vulnerable adults (includes sexual harassment and exploitation)	Low	Medium		NHSSP takes a zero-tolerance approach to the abuse and exploitation of children and vulnerable adults. NHSSP, led by Options has systems in place to document, monitor and report on the implementation of its safeguarding policy. NHSSP adopts child and vulnerable adult safeguarding recruitment procedures for the selection of staff. NHSSP conducts due diligence on all new partners and conducts regular due diligence checks on existing partners to ensure compliance with Options' and DFID's Code of Conduct.	Low	Low	Yes	NHSSP staff will undergo additional safeguarding training. Options' Child and Vulnerable Adult Safeguarding Policy will be rolled out to NHSSP staff. Updates to partner contracts will include compliance with DFID's latest Supply Partner Code of Conduct.	Team Leader and Options' Safeguarding Lead (Director of Programmes)	Treat