Nepal Health Sector Support Programme III

(NHSSP – III)

NHSSP Quarterly Report
April to June 2018

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Nepal Health Sector Support Programme III – 2017 to 2020

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ABBREVIATIONS

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
CSD	Curative Services Division
DDR	Disaster Risk Reduction
DFID	Department for International Development
DHO	District Health Office
DUDBC	Department of Urban Development and Building Construction
eAWPB	electronic Annual Work Plan and Budget
e-GP	e-Government Procurement
EHRS	Electronic Hospital Reporting System
EOC	Emergency Obstetric Complication
EWARS	Early Warning and Reporting System
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
GBV	Gender-Based Violence
GESI	Gender Equity and Social Inclusion
GIZ	German Corporation for International Cooperation
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
IT	Information Technology
KFW	German Development Bank
LCD	Leprosy Control Department
LMD	Logistics Management Division
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MPDSR	Maternal and Perinatal Death Surveillance and Response
MSS	Minimum Service Standards
MWCSC	Ministry of Women, Children, and Senior Citizens
NDHS	Nepal Demographic Health Survey
NHEICC	National Health Education Information and Communication Centre
NHSP	Nepal Health Sector Programme
NHSS	Nepal Health Sector Strategy
NHTC	National Health Training Centre
OCMC	One-stop Crisis Management Centre
OPMCM	Office of Prime Minister and Council of Ministers
PD	Payment Deliverable
PHAMED	Public Health Administration Monitoring and Evaluation
PHC	Primary Health Centre
PHCRD	Primary Health Care Revitalisation Division
PIP	Procurement Improvement Plan
PPICD	Policy, Planning, and International Cooperation Division
PPMO	Public Procurement Management Office
Programme	The Nepal Health Sector Support Programme

RANM`	Roving Auxiliary Nurse Midwife
RDQA	Routine Data Quality Assessment
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBA	Skilled Birth Attendants
SMNH	Safe Motherhood and Neonatal Health
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
TWG	Technical Working Group
VP	Visiting Provider

CONTENTS

EXECUTIVE SUMMARY

Precis

This report is the fourth Quarterly update of the Nepal Health Sector Support Programme III covering the period from April 1st, 2018 to June 30th, 2018. The Federal Ministry of Health and Population has completed restructuring at the National level; sub-National structures are yet to be ratified by Cabinet. The deployment and nature of technical assistance to support the new incumbents and assure technical assistance relevant to the changed context is a key topic and was discussed with DFID. The *Learning Laboratory* concept is now beginning to materialise with initial field assessments completed. Innovative interventions to support nutrition are being explored. An Exit and Sustainability Plan was approved to better guide interventions. Most planned technical assistance interventions were on-time and are achieving stated result targets. Changes of key personnel in the Ministry is the most significant challenge to institutional capacity enhancement through technical assistance. Decisions on structure and organisation of the devolved sector are made by Cabinet. The Ministry is often called to provide briefs and guidance. In support, technical assistance provided various analyses, draft briefs, and other content-related interventions. Transactional assistance and functionary duties are often included in the technical assistance role. Three key points are emphasised in this report: (1) The absence of a unifying framework and comprehensive plan to guide devolution is the most significant overall risk to the sector; (2) Provincial and local government strategic approaches and delivery systems for healthcare are weak, and may weaken further, (earlier gains may well be lost); and (3) Technical responses need to be strongly founded on integrated national and sub-national capacity-enhancement and behavioural-change approaches to assure a value for money and reduce the risk of aid dependence.

The development context

The health sector is in the early stages of devolution following federalisation. Cabinet has approved the Federal Ministry of Health and Population's departmental restructuring. Uncertainty in the permanence of incumbents to key positions remains. Departmental head changes have been made more than once in the Quarter. Sub-national structures are under deliberation. Significant sector capacity-related issues are emerging at sub-national levels. District Health Office engagement in healthcare service delivery remains, but the role is becoming less clear in terms of the management and monitoring of healthcare services. Grants and fund flows to local governments for healthcare seem inconsistent; there are reports of some staff not receiving salaries. Healthcare data quality remains a concern and there is little to affirm data can be or is used in health governance. The governance, planning, management, delivery, and evaluation of healthcare services poses issues of imminent concern. Worsening health outcomes may well be a very real risk should fully functional sub-national health systems not be rapidly established.

Technical assistance

Most technical assistance personnel are located on the campuses of their respective counterparts, thus enabling ease of access. Most technical assistance is *demand-driven*. Field visits to support sub-national providers are commonplace. Technical assistance personnel are working methodically to the work plan and most activities are on-time. Mixed technical assistance approaches are being applied according to the specific need. Coordination with other DFID suppliers is evident. Working with other development partners is common if not routine. Programme planning and reporting have been reviewed and several enhancements are under development. Access by the Ministry to the Technical Assistance Response Fund has been promoted–one proposal was received, and this will be brought to DFID in the coming Quarter.

Conclusions and strategic implications

A detailed framework and work plan to support sector devolution is absent or not widely known. Provincial and local governments will require a well-planned, appropriately timed Ministerial stewardship, and skilled technical support, to attain the capacity and competencies to govern, plan, manage, deliver, and monitor health services. Without this, weakening of local health systems may become evident with subsequent worsening of health outcomes. Particularly vulnerable, will be remote localities and where those populations are suffering inadequate service currently. The extent of the gap in time, between

federalisation and the installation of appropriate national and sub-national structures and systems, will be a primary determinant of future health outcomes.

It is recommended that the Programme (1) continues working to the existing plan until the Mid-Term Review findings are known; wherefrom future technical assistance interventions may be formulated, (2) increases the emphasis on strengthening sustainability and capacity enhancement where possible, and (3) supports the Ministry to lead the sector reform, through conceptualising, designing, and advancing a framework and plan for health structures and health systems for local government and provinces to uptake.

1 INTRODUCTION

1.1 OVERVIEW

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 **1 April 2018 to 30 June 2018.**

The Programme commenced in March 2017 and is scheduled to the end of December 2020. It is the prime technical assistance component of the United Kingdom's aid to the health sector in Nepal and is aligned with Nepal's National Health Sector Strategy 2015-2020. The Programme is implemented by a consortium led by Options Consultancy Services Ltd with HERD, Oxford Policy Management, and Miyamoto. Three other DFID suppliers are actively engaged in support of the Nepal Health Sector Programme.

Long-term technical assistance (TA) personnel are deployed either by being (a) embedded within key departments of the Ministry, (b) being located on the same campus for easy access by government personnel, or based in an office in Patan. Short-term TA personnel are deployed to provide specialised inputs intermittently. Financial support is provided through funding of meetings, workshops, training events and field visits. A *Technical Assistance Response Fund* is available to support special initiatives though no funds have been drawn this past Quarter.

1.2 THE DEVELOPMENT CONTEXT

As noted in the past Quarter, there are three informal dynamics (1) meeting current population health demands, (2) meeting needs emergent from sector devolution, and (3) protecting and/or advancing gains relating to equity in access to health care. These frame the intent of technical assistance.[1] In respect of point (2), Cabinet has approved the FMOHP's departmental structures. Position reassignments have been made to match this. Though there remains uncertainty in the permeance of these assignments. At the time of writing of this report, even more key personnel changes were announced. The responsibility for the provision of healthcare has further shifted from the national government to the provincial and local governments[2]. Even greater uncertainty characterises the sector sub-nationally. District Health Offices (DHO), formally the mainstay of the system[3], remain: though changes are underway. These offices are still supporting health service delivery, but this support is uneven as provincial and local governments extend authorities to varying levels and in varying health priorities. Fund flows to local governments for health are inconsistent and there are reports of some staff not receiving salaries. Sub-national systems for planning and budgeting for health are not universally installed; many local governments lack the capacity to meet this demand[4]. Data quality could improve as could local governments application of evidence in decision-making towards effective sector management. In summation, the gap between the federalism[5] and sector devolution[6] is significant. Problems are evident, and it is expected that, without more strategically focused *health systems strengthening* type technical interventions, services will further weaken.

During this Quarter, changes of key personnel in the Ministry is the most significant challenge to institutional capacity enhancement through technical assistance. Decisions on structure and organisation of the devolved sector are made by Cabinet. The Ministry is often called to provide briefs and guidance. Much of the demand on technical assistance is content-related[7], i.e. to provide various analyses, draft briefs and other materials. In some instances, the nature of technical assistance has been a mix of transactional and functionary duties in the effort to accelerate or maintain intuitional processes. Technical assistance personnel have also reported a role of being the intuitional memory for the Ministry, as key

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[1] Though focused on maternal, neonatal and hospital quality matters.
[2] Municipal government
[3] WHO District Health Model.
[4] The inter National experience informs that local government planning and budgeting cannot be successful outside of framework of a larger integrated provincial planning model.
[5] Political decentralisation
[6] Bureaucratic decentralisation
[7] Informing and evidencing.

personnel leave, and the new incumbents take up positions. TA are alert to the risk of the aid-dependence associated with embedded and long-term engagement. Future modalities need to be carefully reconsidered to attain the best value for money in terms of technical assistance costs.

1.3 SECTOR RESPONSE AND ANALYSIS

The major focus of the FMOHP in the last Quarter has been on developing the structure and mechanisms for the sector devolution. Cabinet has approved a new structure for the FMOHP. The new structure comprises five divisions, four centres and seventeen sections in total. Three departments have been proposed, the Department of Health, the Department of Drug Administration and the Department of *Ayurveda*[8.] While the structure of the latter two departments has been approved, the Department of Health and the provincial and local government health structures are yet to be approved by the Office of Prime Minister and Council of Ministers (OPMCM). The FMOHP is defining roles and responsibilities within the new structure with an aim to execute the new structure from mid-July 2018.

Avoiding duplication of roles among divisions and centers; organising new ways of delivering the FMOHP's role; coping with frequent changes in senior leadership positions, and the timely execution of the new structures at all levels, are some of the key challenges.

Notable progress has been made in the finalisation of the Annual Work Plan and Budget (AWPB) for the fiscal year 2018/2019. This presents the programme and budget plans for the three levels of government. A consultative process was used in the development of AWPB. The use of evidence to inform decisions requires further strengthening. The FMOHP has initiated and/or planned a number of initiatives towards strengthening the sector at large: the development of health facility registry system, a web-based grievance management system, a unified coding of health facilities, minimum service standards for hospitals, an information management and monitoring and evaluation strategy, mainstreaming gender equity and social inclusion, a guideline for annual planning and budgeting, a consolidated annual procurement plan for the sector, among others. Successful management of the health sector's devolution demands strong leadership and management capacity at all levels. The FMOHP and sub-national institutions require strengthened organisational capacity in several areas but especially in leadership and management, information and communication, human resource management, procurement and supply chain management of essential medicines, the use of evidence in decision making, and in transparency and accountability. In this context, strategically placed technical assistance aligned with the devolved structures is an imperative.

A detailed framework and work plan to support sector devolution is absent (or not widely known). This needs to be significantly more developed than the *Transition Plan*[9] in current circulation. Provincial and local governments will require well-planned, appropriately timed, and skilled technical support to attain the capacity and competencies to govern, plan, manage, deliver, and monitor healthcare services. Without this, further weakening of local health systems may be anticipated. Though less evident in the immediate months, a worsening of health outcomes and an erosion of past attainments may eventuate. The most vulnerable communities such as those in remote areas or where services are already friable will be the most affected. The extent of the gap in time between federalisation and the installation of appropriate national and sub-national structures and systems will be the primary determinant of future health outcomes.

1.4 CHANGES TO THE TECHNICAL ASSISTANCE TEAM

Two structural engineers were recruited to the TA and embedded in the Department of Urban Development and Building Construction (DUDBC) – being deployed to strengthen capacity in that Department. The Procurement Specialist resigned during the 3rd week of April - a replacement is planned in the coming Quarter.

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[8] Traditional medicine

[9] Emergent from the National Annual Review held in September 2017 and the Joint Annual Review held in January - February 2018. https://docs.google.com/document/d/1KS_LDx5HEkFopvpexIJq3GurdOqS3Dm7F_wFqiH6UX8/edit?usp=sharing

1.5 RISK MANAGEMENT

There are two new risks identified in this Quarter, as reflected in the risk table: R6 (*relationship management in the context of a new structure*) under general health matrix, and R14 (*delay in tender processes*) under infrastructure matrix. Overall, the risk factors remain at the same level as the previous Quarter.

1.6 LOGICAL FRAMEWORK

The logical framework was reviewed in June 2018 with the DFID. Changes were made and logged as per Appendix 3. Changes were made to timeframes to align with the FMOHP fiscal year for the indicators that rely on government reporting systems. Coordination was undertaken with Monitoring Evaluation Operational Research [10] for alignment to the Nepal Health Sector Programme 3 Master Logical Framework. All matters with the logical framework have not been fully resolved by the end of the Quarter, though these are expected to be fully settled by July.

1.7 LEARNING LABORATORIES

Efforts to progress the Learning Laboratory or "Learning Labs" (LL) concept into concrete action are persistent. Profiling of denoted *guanpalika*[11] has commenced. Additional concepts and refinements are under current discussion and a full work plan under development.

1.8 EXIT AND SUSTAINABILITY

A plan for the Programme's exit and sustainability of interventions has been crafted and approved by DFID. This plan sets the overall strategies, thinking, and processes for enhanced sustainability of technical contributions. A *sustainability framework* is under development that will enable the examination of interventions regarding sustainability, against the results defined in the Nepal Health Sector Strategy 2015-2020. Work has begun to comply with the plan in detail including the development of *Technical Products* and *Technical Services Registries*.

1.9 TECHNICAL ASSISTANCE RESPONSE FUND

No applications were processed from the FMOHP during the reporting period and hence no expenditures were made in this Quarter. An orientation on the Technical Assistance Response Fund was made to the Head of the Policy, Planning and Inter National Cooperation (PPICD) and Director General. A request was received and will be considered in the next reporting period.

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[10] A DFID supplier.
[11] Municipalities.

2 PROGRESS IN THE QUARTER

This section highlights the progress in the reporting period by agreed activity and grouped by the Programme's result areas as described in the Inception Report. This enables cross-referencing to that document. These groups and activities have now been codified for future ease of tracking. Planned continuation of inputs, where applicable, is also noted.

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

On-time: TA assisted in the development of organisational structures, roles, and responsibilities for the FMOHP, its Departments, and Centers as approved by the Cabinet. The health organisational structures for provincial government and local government have also been finalised at the national level and currently submitted for approval.

> **Challenge:** Assuring the proper alignment of sectoral functions to the new structures and tailoring TA to support these needs may be a challenge.

Inputs are scheduled for the next Quarter.

Activity i2.1.2 Enhance capacity of Policy Planning and International Cooperation Department and respective divisions to prepare for federalism

On-time: The PPICD has developed a transition plan with clear timelines and responsibilities was approved.

Inputs are scheduled for the next Quarter.

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

On-time: TA has finalised the guideline for pharmacy registration for local governments. TA supported in preparing the *Guideline for Health Facility Operation and Management Committees,* the guideline is submitted to the FMOHP. The federalisation Implementation Unit has postponed implementing the guidelines until provincial and local government structures are approved.

Inputs are scheduled for the next Quarter.

> **Challenge:** Delay in approval of the structures will further delay the rollout of guidances for provincial and local governments.

RESULT AREA: I2.2 DISTRICTS AND DIVISIONS HAVE THE SKILLS AND SYSTEMS IN PLACE FOR EVIDENCE-BASED BOTTOM-UP PLANNING AND BUDGETING

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

On-time: Terms of reference has been developed and submitted to DFID.

Inputs are scheduled for the next Quarter.

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

On-time: TA was provided to the FMOHP in preparation of the AWPB for fiscal year 2018/19 as according to the National Planning Commission framework, the Ministry of Finance, the National Natural Resources and the Fiscal Commission. TA was provided for the planning of conditional grants for the health sector in consultation with the concerned divisions and centres. TA aided in the

development of the *Planning and Budgeting Guideline for the AWPB Preparation at the Local-leve*l. The FMOHP approved this document (the guideline has been uploaded to the FMOHP website).

Inputs are scheduled for the next Quarter.

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

Ongoing: Preparation to redefine the LL approach are now advanced.. In consultation with the concerned local governments, a template for a local health profile has been developed. Profiling is underway. Baseline assessments are being prepared. Support to formulate AWPB of selected sites is underway.

Inputs are scheduled for the next Quarter.

Challenge: Potential delay in fulfilling the staffing as per the new structures and leveling beneficiary expectations.

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

On-time: TA has been provided for the development of guidelines on budget markers for Leaving No-one Behind (LNOB) and to conduct two rounds of consultative meetings with the FMOHP and the Department of Health Services (DOHS).

Inputs are scheduled for the next Quarter: A visit to one select Province and Municipality to review their AWPB; sharing and consultation with the concerned divisions and centres and technical working group; the development and submission to the FMOHP for approval of the LNOB budget markers guidelines.

RESULT AREA: I2.3 POLICY, PLANNING AND INTERNATIONAL COOPERATION DIVISION IDENTIFIES GAPS AND DEVELOPS EVIDENCE-BASED POLICY

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

Delayed: No inputs were provided in this Quarter.

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 health sector was developed and submitted to the PPICD in 2017. Due to position changes in the government, it has not been endorsed. Key contents of the draft partnership policy were incorporated while drafting the national health policy which was submitted to the cabinet.

No inputs are scheduled for the next Quarter.

~~Activity i2.3.3 Develop recommendations on the institutional structures including roles and responsibilities manage SNS partnerships~~

Deleted: This will be included in Activity i2.3.1

No inputs are scheduled for the next Quarter.

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

On-time: TA was provided to the Curative Services Division (CSD) to develop the *Standards for Primary, Secondary and Tertiary Hospitals* along with the *Implementation Guidelines. Draft Standards for Primary, Secondary and Tertiary Hospitals* are now developed. The guidelines for the implementation of the hospital standards are under development. TA was provided to the Quality section of the Management Division to develop the *Standards for Health Post and Urban Health Centers. Draft Standards for Health Posts and Urban Health Centers* are developed.

Inputs are scheduled for the next Quarter.

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

On-time: The terms of reference for the payment deliverable[12] (PD) has been submitted to DFID and suggestions received. A meeting with the DFID is planned to level expectations.

Developing the implementation guideline for partnership in health is planned for the next Quarter.

Challenge: Challenges may include bringing other key ministries outside of health and all three levels of government on-board for private sector engagement.

Activity i2.3.6 Undertake policy stock take for the health sector and disseminate findings (PD 31)

Completed: ✓This was completed in the previous quarter. The final report is uploaded in the Programme's website, submitted and approved by the DFID.

No inputs are scheduled for the next Quarter.

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

On-time: The FMOHP has initiated the process for the formulation of the new health policy. TA plans to present the recommendation of the stocktaking report and key points of the *Draft National Health Policy* and *Draft Partnership Policy* in health, for consideration during the new health policy drafting process. The recommendation from policy stocktake and the *Draft National Health Policies* will be taken into consideration in developing the new *National Health Policy* in the next Quarter**.**

Inputs are scheduled for the next Quarter.

RESULT AREA: I2.4 FMOHP HAS CLEAR POLICIES AND STRATEGIES FOR PROMOTING EQUITABLE ACCESS TO HEALTH SERVICES

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

On-time: TA guided the revision of the draft strategy paper that is now with the FMOHP's Steering Committee for feedback and comments. It is also with National Planning Commission, Ministry of Women, Children, and Senior Citizens (MWCSC), Ministry of Federal Affairs and General Administration, Ministry of Law, Justice and Parliamentary Affairs, Ministry of Finance and OPMCM for their review and feedback. Once comments are received from sectoral ministries and the National Planning Commission, the draft will be finalised, and the approval process will be initiated. The Public Health Administration, Monitoring and Evaluation Division (PHAMED) as the lead for Gender Equity and Social Inclusion (GESI) is actively managing the process from within Government. A revised draft health sector strategy has been submitted to the FMOHP's Secretary.

Inputs are scheduled for the next Quarter: Translation of the strategy into English; Printing of the strategy after approval; and Dissemination of the strategy with a wider audience.

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[12] The primary contractual mechanism for payment to the Consortium managing the Programme. Each PD requires a term of reference agreed by DFID.

> **Challenge:** The structural changes are underway and the stretching of capacities across the health system to fit the federal structure.

Activity i2.4.2 Revise and strengthen Gender Equity and Social Inclusion institutional structures, incl. revision of guidelines in Year 2

On-time: The GESI institutional mechanism has been integrated into the revised GESI strategy. Thus, a separate guideline is not required. Establishment of the mechanism will be initiated after the approval of strategy.

Inputs are scheduled for the next Quarter: Establish the GESI institutional mechanism in selected Provinces and Municipalities.

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

Not scheduled: The policy was shared with other ministries for their feedback in the previous Quarter.

No inputs are scheduled for the next Quarter.

> **Challenge:** Risks may include revisiting the draft policy of mental health as the new government has been formed.

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

On-time: The PD42 terms of reference was submitted to DFID. TA convened a joint meeting of multi-sector stakeholders along with the Leprosy Control Division (LCD) and provided feedback to MWCSC towards finalising regulation on disability. A multisectoral steering committee led by the LCD director with representation from other divisions, sectoral ministries, relevant ministries and National Federation of the Disabled has been formed to oversee the development of the *national guideline.*

Inputs are scheduled for the next Quarter: Organise the Steering Committee meeting and develop a roadmap for the guidelines development including formation of the multisectoral technical working group.

Activity i2.4.5 Revise Social Service Unit Guideline

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter: Revision and printing of social service unit operational guidelines.

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

Not scheduled: This activity has been postponed until December 2018 by MWCSC, in consultation with the FMOHP.

No inputs are scheduled for the next Quarter. Note: Standard Operating Procedures for integrated guidelines for services to GBV survivors will be developed in 2019 once the guidelines approved from Cabinet.

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

Not scheduled: No inputs were provided in this Quarter.

No inputs are scheduled for the next Quarter. Note: Reviews will be organised in 2019.

Activity i2.4.8 Capacity enhancement of Gender Equity and Social Inclusion focal persons and key influencers from the federal Ministry of Health and Department of Health Services on Gender Equity and Social Inclusion and Leave No-one Behind aspects

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter: An orientation on revised GESI strategy to key officials of the FMOHP and DOHS and Ministry of Social Development of Provinces is planned.

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

Activity i2.5.1 Support strengthening and institutionalisation of Health Sector Partnership Forum
On-time: TA developed a concept note for the Health Sector Partnership Forum and shared this with the PPICD. Preparations for a *Partnership Forum* was discussed with the FMOHP.

Inputs are scheduled for the next Quarter.

Challenge: Changes in FMOHP key officials may present challenges.

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

On-time: The Joint Coordination Meeting was organised on the 2nd of May to share implementation progress, the AWPB preparation process, and the key points of note in the AWPB. A follow-up meeting between external development partners and the FMOHP was organised on the 15th of June for post-budget discussions.

Inputs are scheduled for the next Quarter.

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

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter.

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

On-time: Terms of reference was drafted by external development partners and feedback was provided.

Inputs are scheduled for the next Quarter.

I3.1 DOHS INCREASES COVERAGE OF UNDERSERVED POPULATIONS

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

Site selection and the establishment of services as per AWPB, and mentoring

On time: TA provided support including facilitating planning workshops to establish new Comprehensive Emergency Obstetric Neonatal Care (CEONC) services at Gukuleswor Hospital. Two remote areas were selected and included in the Family Health Division's (FHD) AWPB.

Inputs are scheduled for next Quarter. Planned for feasibility assessment in two sites.

Challenge: Criteria are not being followed.

Improving reporting, monitoring and response mechanisms

On time: TA monitored and reported to FHD directors on the functionality of all CEONC sites using HMIS data and the problems reported from service sites. Continuity of caesarean section services in the 83 established sites are the highest since 2010. There are five non-functioning CEONC sites in three districts (Jajarkot, Sarlahi, and Tanahu) of the 72 districts with established sites. TA provided support including facilitating the planning workshops to establish new CEONC services (one site), on-site visits to newly established sites (two sites) and poor to functioning sites (nine sites) during this period.

Inputs are scheduled for next Quarter. Continued monitoring and exploration for developing a sustainable monitoring system linking with existing MIS.

Challenge: Budgets are not being released in a timely way from District Public Health Offices to hospitals. Trained personnel are lured to the private sector once skilled. A multi-year employment policy is absent. A policy brief to address these issues may assist.

Continuation of the caesarean section study and implementation of recommendations

On time: TA organised a one-hour session on *Rising Caesarean Section Rates in Nepal – A Public Health Concern at* the Nepal Society of Obstetricians and Gynaecologists Conference on 8th June 2018.

Inputs are scheduled for next Quarter. Plan for the inclusion of introduction of Robson criteria in Aama implementation guideline and introduction in selected hospitals.

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

Deleted: The selection and upgrading of strategically located sites to deliver Basic Emergency Obstetric and Neonatal Care have been discontinued. TA will facilitate the planning and implementation of local health plans in selected remote councils. (i.3.1.13)

No inputs are scheduled for the next Quarter.

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

On time: The Primary Health Care Revitalisation Division (PHCRD) recruited an organisation to conduct the assessment. TA provided inputs to the methodology and the study. A report is pending.

Inputs are scheduled for next Quarter.

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

BBC Media Action m-Health

On-time: The contract between the British Broadcasting Commission (BBC) Media Action and Options Consulting Services Ltd is completed and signed. TA provided orientation on the innovation to the new FHD director.

Inputs are scheduled for the next Quarter.

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

As reported in an earlier quarterly report, this activity is planned and budgeted under FHD AWPD in 2017/17 in 30 *gaunpalikas* (15 districts).

On-time: TA provided guidance to 10 rural municipalities in five districts (two in each district) to conduct post-natal care micro-planning meetings via telephone, explaining how to follow the implementation guideline. The post-natal care checklist and guideline was also sent. Checklists are being used by service providers during post-natal care home visits to check-up on the mother and newborn's health in the 3rd and 7th day of delivery. TA followed up the implementation status in 10 gaunpalikas,

out of which, five (50%) had developed their plan and programme implementation (post-natal care home visit) was in place.

Inputs are scheduled for next Quarter.

Challenge: The Public Health Nurse was the focal person in the Safe Motherhood and Neonatal Health (SMNH) Programme but in the federalised context, this will be the Health Coordinators who are appointed in municipalities. They had no capacity to conduct the post-natal care micro-planning process.

i3.1.5 Support the FHD/CHD/PHCRD and District Health Office to improve access to Reproductive, Maternal, Newborn, Child and Adolescent Health and Family Planning services in remote areas building on Remote Areas Maternal and Newborn Health Project approach

On-time: TA was provided to three rural municipalities in two earthquake-affected districts during their annual planning and budgeting, focusing on service delivery and access to basic health care services with a special emphasis on reaching unreached populations. A three-day workshop was facilitated on: the identification of gaps using data; mapping of health services delivery sites and distance traveled by the community to these service sites; identification and prioritisation of needs; and planning and budgeting based on evidence within Nepal. The local health AWPB were developed by all wards and gaunpalikas, pending approval by the Municipal Assembly for the financial years 2075/2076. Because of the post-natal care micro-planning meeting, Paribartan (Duikholi) Rural Municipality of the Rolpa district developed a plan to provide Female Health Community Volunteer (FCHV) basic training. TA was provided by sending an FCHV trainer who ensured the quality of training, conducted the first phase of basic training, thus enhancing the capacity of 24 FCHVs.

Inputs are scheduled for next Quarter: Continue to follow-up in 4 *gaunpalikas*. TA will follow up on approval of the budget and implementation of their plan and will be presented as a case study.

Implement social mobilisation and behaviour change approaches with local non-government organisations

Due to the changing context of federalism, the TA will focus on strengthening FCHVs instead of working with local non-government organisations.

Inputs are scheduled for next Quarter.

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

On-time: Most municipalities mobilised Visiting Providers (VPs) and Roving Auxiliary Nurse Midwives (RANMs). VPs were deployed in 15/20 Districts (35/60 *gaunpalikas*) RANMs in 20/20 districts (38/40 *gaunpalikas*). TA is monitoring these activities by phone. This programme will continue until the end of the fiscal year (mid-July 2019). Supported by TA, all (five districts) completed the implementation of the *family planning-extended programme of immunisation* integration activities in their districts.

Inputs are scheduled for next Quarter: Facilitation to the Provincial and local government for Visiting Providers and RANM recruitment, respectively.

Supporting capacity and skills enhancement of Visiting Providers and Roving Auxiliary Nurse Midwives in remote districts

On-time: TA conducted telephone follow-up but no direct support or capacity enhancement for VPs and RANMs.

No inputs are scheduled for the next Quarter.

i3.1.7 Support the FHD to expand the provision of comprehensive Voluntary Surgical Contraception

On-time: Districts have conducted comprehensive voluntary surgical camps services. Comprehensive voluntary surgical camps services are slowly replacing the traditional and seasonal practice of conducting mobile/outreach voluntary surgical camps services. TA contacted and interacted with DHOs and district Family Planning Supervisors and Officers by telephone or during field visits and took stock of programme progress.

Inputs are scheduled for next Quarter.

i3.1.8 Develop a digital platform for social change targeting adolescents

Review of ASRH pack and GBV IEC materials from GESI perspectives

Completed: ✓ TA reviewed and revised the GBV pack considering the new changes and revised GESI strategy during this Quarter, upon the request of the National Health Education Information and Communication Centre (NHEICC). The revised pack was shared with NHEICC for their feedback. The revised GBV pack will contribute to addressing the gaps that persist at different levels in terms of advocacy materials related to GBV; One-stop Crisis Management Centres (OCMC); and information on free health services in the Nepali language.

Inputs are scheduled for next Quarter. Presentation of revised GBV pack to NHEICC and other divisions across DOHS.

i3.1.9 Support to the FMOHP for improving delivery of nutrition interventions

Opportunities to strengthen nutrition within the Programme in Nepal - Scoping Analysis

On-time: With the support of the nutrition specialist from Options United Kingdom, several recommendations were made for policy, strategy and implementation levels. This included engaging in strategic discussions about the implementation of the MSNP II, supporting local government in evidence-based planning and implementation of nutrition programmes, supporting the establishment of information systems for routine data collection to ensure quality nutrition data is used for decision-making and prioritisation, and strengthening the integration of maternal nutrition into key health programmes, including community-based approaches. An innovation *Testing a local nutrition surveillance system to better identify households at risk, including children with moderate acute malnutrition,* has been identified for further discussion and testing at two LL sites.

Inputs are scheduled for next Quarter.

i3.1.10 Strengthening and scaling up of One-stop Crisis Management Centres

Completed: ✓ Seven new OCMCs were established during the Quarter with support from NHSSP. TA advocated with the FMOHP to disburse the OCMC budgets. for FMOHP and to resolve the problems that OCMCs faced. Municipalities were reluctant to transfer budgets. This impacted staff motivation, the functionality, and quality of services provided, and raised concerns for the future.

The OCMCs status report was prepared and shared with the OPMCM and the MWCSC during the quarterly review organised by OPMCM.

To address the capacity gaps, sessions were delivered on the OCMC concept and operational guidelines to 16 participants undergoing a six-months-long counseling training from five OCMCs, seven safe homes and four counseling centers in coordination with the United Nations Population Fund and the Centre for Victims of Torture. Orientation on GBV clinical protocol was completed in four hospitals. About 125 health staff were oriented.

Inputs are scheduled for next Quarter: Development of Implementation Guidelines based on revised OCMC guidelines; scoping for the establishment of new OCMCs.

Challenge: Key standing challenges include multisectoral cooperation and collaboration to ensure integrated *one-door* services to GBV survivors, the timely hiring of staff nurses for OCMCs on contract and regular holding of meetings of OCMC district coordination committee, given the changed context.

The revision of *OCMC Operational Guidelines* with the clear roles and responsibilities of multi-sectoral stakeholders and mentoring will, to some extent, support to improve the coordination aspects for the harmonisation of services through *one-door*.

Support the strengthening of OCMCs through mentoring/monitoring and multisectoral sharing/consultation

On-going: Site visits for coaching/mentoring and monitoring in seven OCMCs and meetings with district-level multi-sectoral stakeholders to review the progress, challenges, and achievements for the strengthening of OCMCs was conducted. At the Federal level, a coordination meeting was held with external development partners and Nepal Police during this Quarter. This quarterly meeting was held to develop the future roadmap concerning the OCMC strengthening.

Inputs are scheduled for next Quarter: Mentoring and follow-up support to select OCMC hospitals where GBV clinical protocol has been rolled out; update the status of all 45 OCMCs including reporting for the dashboard.

i3.1.11 Rolling out the GBV clinical protocol

Completed: ✓ Orientation on GBV clinical protocol completed in four hospitals. TA was provided for the development of presentation slides and facilitated over two days of the sessions. About 125 health staff were oriented.

Inputs are scheduled for next Quarter: Review from a distance to understand the effectiveness of the orientation in responding to the needs of survivors by the hospital system.

i3.1.12 Rolling out the GBV Standard Operating Procedures

Completed: ✓ With a goal to improve clinical care and integrated quality treatment and services to GBV survivors and prepare competent trainers, TA initiated and completed a training of trainers (TOT) session entitled *Health Response to GBV*. Following the TOT, TA facilitated on-the-job training was conducted in all three training sites by the trainers (who received TOT) in their respective sites for medical officers and paramedics. TA facilitated on-the-job training in Koshi and Lumbini. The rollout of the GBV clinical protocol at the hospitals has greatly enhanced the understanding of service providers on GBV and responding to survivors, as reported during the annual review. Following the TOT and on-the-job training, Koshi zonal hospital reported that the inter-departmental coordination and response within the hospital has been quite effective. Significant numbers of survivors have been identified by the outpatient and emergency departments and are referred to OCMC. This shows the increased response within the hospital system to identify survivors and address their needs. During this Quarter, 65 GBV survivors received services from the OCMC of Koshi zonal hospital. Sustaining the trainers of GBV clinical protocol at the site will support quality service delivery and response to GBV survivors and those at risk of violence.

Inputs are scheduled for next Quarter: Process documentation of establishing GBV clinical protocol training sites in three referral hospitals; follow-up and monitoring at training sites; development of PD report on the establishment of training sites.

Supporting the rollout of the protocol (and Standard Operating Procedures once approved)

Not scheduled: The Standard Operating Procedures will be developed in 2019 once the Integrated Guidelines for Services to GBV Survivors are approved from the Cabinet. The rollout process will take place after that.

i3.1.13 Scaling up Social Service Units

Completed: ✓ Seven new Social Service Units (SSUs) were established this Quarter. The SSUs are clearly improving the access of poor and disadvantaged people to health services - a core aim of the Nepal Health Sector Strategy (2015–2020). In Western Regional Hospital, Pokhara, the SSU has been serving about 125 target group patients (who receive free or subsidised care and services) and facilitating about 300 clients on social health insurance per day. On average, the hospital has 1,200 OPD patients per day

and the SSU is reaching about 35% of this total. This can be regarded as a success of SSU. Within this fiscal year (July 2017 – July 2018) 47% of poor, five percent disabled and four percent helpless received free care services from 16 old SSUs. Site visits for coaching/mentoring and monitoring in six SSUs and meetings with NGO partners to review the progress, challenges, and achievements for the strengthening of SSUs was conducted during this Quarter.

Inputs are scheduled for next Quarter: Mentoring and follow support to select new SSUs; update the status of all 31 SSUs including reporting for the dashboard.

Support for the capacity enhancement of SSUs through mentoring/monitoring and online reporting

On-going: Consultations were held with hospital management committees and local government to coordinate for reaching the unreached and for resource mobilisation of the sites visited. A status report of SSUs was prepared and shared with PHAMED. Newly established SSUs require training on *inspirational volunteerism and humanitarian approach* to more effectively facilitated.

Inputs are scheduled for next Quarter: Scope for capacity building for five new hospitals.

i3.1.14 Capacity building to put LNOB into practice

Completed: ✓ Orientation was provided on GESI and LNOB to stakeholders in the Ministry of Social Development of Karnali Province and Province No 1. Similarly, orientation was provided to the staffs of Biratnagar Metropolis, Nepalgunj Sub-Metropolis, Sandhaikharka Municipality and Tamghas Municipality. Since there have been changes at all levels, continuous orientation on the GESI framework and targeted interventions (OCMC, SSU, disability and mental health) are required to build capacity and to raise the awareness of stakeholders at all levels.

Inputs are scheduled for next Quarter: Orientation to public health stakeholders on GESI and LNOB in two provinces and two municipalities.

I3.2 RESTORATION OF SERVICE DELIVERY IN EARTHQUAKE-AFFECTED AREAS

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

Delayed: The National Health Training Centre (NHTC) and LCD conducted a consultative meeting with key stakeholders to identify appropriate physiotherapy skills for the training of paramedics and nurses. A further meeting is delayed to the beginning of the new fiscal year due to high workload of NHTC during the last few months of the fiscal year.

Inputs are scheduled for next Quarter. In the July-September Quarter, the NHTC plans to call a one-day workshop to prioritise and finalise key physiotherapy skills and TA will contract out an organisation to develop a curriculum and test in three districts as agreed by the TWG of LCD and NHTC.

i3.2.2 Support the institutionalisation of mental health services

Completed: ✓ TA assisted with the development of the training manual based on the Standard Treatment Protocol for Prescribers and the Reference Manual. The training manual is the first of its kind developed by FMOHP to ensure that trainers and co-trainers feel skilled and confident in their ability to train health-care providers to assess and manage priority mental, neurological and substance use disorders. It can also be used for TOT. The aim is to generate future trainers and co-trainers who can ultimately be mobilised for the training of medical officers and Primary Health Centre (PHC) workers at the local level . The training manual will be printed in both English and Nepali languages by July. The rollout of the manual has been planned by PHCRD to take place in seven provinces in the coming fiscal year.

Inputs are scheduled for next Quarter.

~~i3.2.3 Strengthen the capacity of District Health Offices and HFOMC in two earthquake-affected districts~~

Discontinued: This activity is combined with the remote areas activity under support to the FMOHP and DHO to improve access to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) and family planning services. (i3.1.5)

No inputs are scheduled for the next Quarter.

I3.3 THE FMOHP/DOHS HAS EFFECTIVE STRATEGIES TO MANAGE THE HIGH DEMAND (OF MNH SERVICES) AT REFERRAL CENTRES

i3.3.1 Free emergency referral for obstetric complications

On-time: The Programme provided referral funds to the CEONC sites through Bhimeshwor, Jiri and Manthali Municipalities in Dolakha and Ramechhap, respectively. A total of 33 cases were referred from birthing centres to CEONCs in Dolakha and Ramechhap districts (22 in Charikot PHC, three in Jiri hospital, and eight in Manthali PHC). This support came to an end on 16th July 2018.

Delayed: The plan to assess this free referral has been delayed due to concerns about the proposed methodology. The revised methodology was submitted to DFID on the 16th of July.

Inputs are scheduled for next Quarter.

i3.3.2 Support the FMOHP/DUDBC to upgrade infrastructure for maternity services at referral hospitals

Bharatpur metropolitan city and the hospital are interested in developing a birthing unit at the hospital. Follow up and planning with the FMOHP and municipality will be provided by TA.

Inputs are scheduled for next Quarter.

i3.3.3 Support the implementation and refinement of the Aama programme

TA supported the FHD in reviewing and revising the Aama Programme prototype guideline for *gaunpalikas,* incorporating updates from the budget speech and evidence from requirement analysis and programme implementation experiences.

Inputs are scheduled for next Quarter.

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

On-time: To bridge the capacity gap this Quarter, TA has: 1) updated the budget sheet for the planning of the Aama Programme in the upcoming fiscal year that was prepared based on the sufficiency exercise from last Quarter, 2) supported the understanding of the requirement analysis methodology, including a selection of study *gaunpalikas* and health facilities, updating the tools and conducting training. A monitoring visit was also conducted to quality assure their work, 3) found additional budget sources for the doubled transport incentive in the Redbook. (the current additional allocation had a deficit of NPR 40 million which was communicated to FMOHP and Ministry of Finance), 4) developed a TOR for a data analyst to conduct further analysis of the Nepal Demographic Health Survey (NDHS).

Inputs are scheduled for next Quarter.

I3.4 CONTINUOUS QUALITY IMPROVEMENT INSTITUTIONALISED

i3.4.1 Support the DoHS to expand implementation of Minimum Service Standards and modular HQIP

On-time: A technical working group (TWG) was formed under the leadership of CSD and with technical assistance provided by the World Health Organisation (WHO), Nick Simons Institute and the Programme. It was agreed to divide the Minimum Service Standard (MSS) into three sections namely; Governance and Management, Clinical Service Management and Hospital Support Service Management. A template was developed by the TWG and inputs received from clinical and managerial subject experts on MSS. Following the inputs from the subject experts, a workshop was organised with experts, key officials from FMOHP, DOHS, and Centers to discuss and further refine the standards. Following the workshop, several meetings of the TWG were organised to refine the MSS for hospitals. The draft MSS was also consulted with health councils, associations, and professional societies. The TWG further worked to incorporate the feedback and develop the final version of the MSS for primary, secondary and tertiary hospitals.

Inputs are scheduled for next Quarter: It is expected to have final tools and guideline in the next Quarter.

On-time: A hospital quality improvement workshop was completed at eight (100%) hospitals in this Quarter as per the plan. The hospital quality improvement committee was formed based on the *National Quality Improvement Guideline.* The workshop enhanced the capacity of the committee to conduct quarterly self-assessments; develop action plans; and implement actions for quality improvement of MNH services. Out of 14 existing Hospital Quality Improvement (HQIP) implemented facilities due for conducting self-assessment, 12 (86%) completed four monthly self-assessments and follow up actions to improve the quality of services. Five nurses at the provincial level received capacity enhancement on HQIP during this Quarter. Discussions were had with the MSS development team and FHD on whether CEONC hospitals need a separate HQIP assessment after conducting MSS. This will continue in the next Quarter. Capacity strengthening of provincial health coordinators and concerned officials on the quality improvement process is crucial.

Inputs are scheduled for next Quarter.

Delayed: Quality dash-board: Pending TA for the possibility of integration into the existing reporting system.

Inputs are scheduled for next Quarter.

i3.4.2 Support the FHD to scale up on-site mentoring of Skilled Birth Attendants

On-time: The FHD has scaled up the Skilled Birth Attendants (SBA) onsite coaching programme in 31 districts in the financial year 2017/2018. Capacity building of district coach/mentors and delivery service providers on quality improvement process (emergency obstetric complication management, infection prevention and quality improvement at birthing centres (BC) and basic emergency obstetric centres (BEONC) are of concern. Seven mentor/coaches from four new coaching districts (planned in this Quarter) enhanced their coaching capacity and confidence levels at their hospitals under the supervision and monitoring of the SBA trainer from TA. From follow-up of districts where Skilled Birth Attendants clinical mentors were developed, clinical coach/mentors provided on-site coaching to 76 MNH service providers (Nurses, ANMs, and SBAs) on selected emergency obstetric complications (EOC) management services and Infection Prevention. The Quality Improvement Process (QIP) was in place at 13 BC and BEONC service sites after training of QIP was delivered by district mentors to the health facility operation management committee. Expansion and follow-up will continue in the next Quarter based on FHD's AWPB.

Inputs are scheduled for next Quarter.

i3.4.3Support the expansion of the scope of strategic birthing centres as CCEs for RMNCAH services

Deleted

No inputs are scheduled for the next Quarter.

i3.4.4 Support revision of the standard treatment guidelines/protocols and roll out of the updated guidelines

Delayed: Waiting for the TOR approval from DFID and finalisation of the Basic Health Services Package.

Inputs are scheduled for next Quarter.

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

On-time: Under clinical mentoring and QIP at hospitals and BC/BEONCs, infection prevention and whole site sanitation and waste management were included. A total of 12 hospitals (with CEONC) and 13 BC/BEONC conducted self-assessments and planning for improving the quality of care.

Inputs are scheduled for next Quarter.

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

On-time: TA conducted a rapid assessment of three referral hospitals (Koshi Zonal hospital, Bharatpur hospital and Pokhara academy of health sciences) by using the quality improvement tools (maternal-neonatal health, family planning, and training). The findings of this assessment were used for two reasons; first, for developing hospital action plans and second, for providing feedback to the TWG for MSS tools. The Nepali translation of the revised NHTC's training management guidelines is in progress.

Inputs are scheduled for next Quarter.

I3.5 SUPPORT FHD AND CHD IN PLANNING, BUDGETING AND MONITORING OF RMNCAH AND NUTRITION PROGRAMMES

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

On-time: The FHD developed the AWPB and program implementation guideline for local level and provincial level government for financial year 2018/2019, with TA. The focus on SMNH was related to human resources CEONC fund, ANM, and SN; BC equipment purchasing; referral for EOC; Skilled Birth Attendants on-site coaching/mentoring; Aama Programme implementation; post-natal care micro-planning; and all family planning interventions.

Inputs are scheduled for next Quarter. Planning with FHD for technical assistance will be carried out in July-August 2018.

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

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for next Quarter, including activities planned under LL sites. Implementation will start in Q5 with OCAT and Q6 with service delivery improvement planning with local government.

Organisational capacity assessment, using OCAT, following consultations with FMOHP and implementation of prioritised findings

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for next Quarter.

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

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for next Quarter.

RESULT AREA: I4.1 EAWPB SYSTEM BEING USED BY THE FEDERAL MINISTRY OF HEALTH AND POPULATION SPENDING UNITS FOR TIMELY RELEASE OF THE BUDGET

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

On-time: An orientation for planning officials from the FMOHP and DOHS on AWBP was completed. The e-AWPB is now uploaded to TABUCS and FMOHP can see the budget analysis in their dash-board. Provincial and local government budgets are not yet able to be captured as the authorisation rests with these governments.

Inputs are scheduled for the next Quarter.

Activity i4.1.2 FMOHP Budget analysis report with policy note produced by HRFMD using eAWPB (PD 50)

On-time: A review of the Redbook and preliminary analysis of the FMOHP budget was conducted and shared with development partners. The budget analysis framework, process, and templates were finalised. Consultants were recruited who: have experience with tracking the previous year's expenditure, are familiar with the budget process; and are experienced in understanding the linkages between policy and budget . The tracking of expenditure, budget and validation process is ongoing. A topic for a Policy Note has emerged from the analysis. A chapter on spending against the NHSS indicators will be featured as part of this Budget Analysis report. TA will also try to capture sample budget allocation practices at the provincial and local government.

Inputs are scheduled for the next Quarter.

Activity i4.1.3 Revise eAWPB to include 766 (TBC) spending units and prepare a framework for eAWPB

Completed: ✓All levels of government can use the eAWPB as part of their planning. Currently, we are not able to capture provincial and local budgets due to a change in the chart of account. This requires technical support to endorse the changes from the FMOHP, provide information technology (IT) solutions and support to upload budgets to TABUCS.

No inputs are scheduled for the next Quarter.

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

On-time: TA reviewed the previous business plan document. A draft framework was prepared to suit the changing structure of DOHS and the FMOHP. A draft framework is available. If resources are available, this can be rolled out to provincial and local governments. This may need a re-design to capture the upcoming change at the FMOHP/DOHS structure.

Inputs are scheduled for the next Quarter.

Activity i4.1.5 Requirement analysis of Aama programme in eAWPB

On-time: There is a requirement to capture the Aama budget by spending units. A framework for this has been developed and now included in TABUCS. The FMOHP can now obtain a monthly report accordingly by spending unit. There remains a need to make further improvements to capture the incentives at the local level and additional transport incentives announced in the last budget speech.

Inputs are scheduled for the next Quarter.

Activity i4.1.6 Package evidence into advocacy materials

On-time: TA supported the development of the Annual Financial Plan.

Inputs are scheduled for the next Quarter.

RESULT AREA: ACTIVITY I4.2 TABUCS IS OPERATIONAL IN ALL FMOHP SPENDING UNITS, INCL. THE DUDBC

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

On-time: TA has identified NHSS indicators that can be linked to the FMOHP and its entities' annual budgets. A framework was prepared to map NHSS indicators to the annual budget for federal, provincial and local governments. Consultants have started working on the mapping and writing of the code sequence for TABUCS. NHSS indicators are now captured through TABUCS. The FMOHP management personnel can access this information using the dashboard. Mapping will capture information on FMOHP's health budget allocation spread across three levels of government. It will not, however, capture information on additional allocations for health from provincial and local governments. The Ministry of Finance may demand the addition of the SDG indicators.

Inputs are scheduled for the next Quarter.

Challenges: The Programme has no resource to address this currently.

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

On-time: This process is ongoing. Data collection is in progress.

Inputs are scheduled for the next Quarter.

Challenges: Full data collection requires additional personnel and time.

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

On-time: All updates have been made. As a result, the National Reconstructions Authority, Ministry of Urban Development are using TABUCS. Revisions may be necessary to address the upcoming changes in the structure of the FMOHP and for the federal context.

Inputs are scheduled for the next Quarter.

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

On-time: A support contract is effective until August 2018. The FMOHP has included a budget allocation to recruit IT engineers to sustain this task. Saipal Technologies may need to continue their support until new IT engineers are trained.

Inputs are scheduled for the next Quarter.

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

On-time: This is an on-going process. STTA have made user required adaptations. The DUDBC can now prepare a progress report using TABUCS. This can be accessed by the FMOHP management. Upcoming changes in the DUDBC may require further changes in TABUCS.

Inputs are scheduled for the next Quarter.

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

On-time: This is an on-going process. This financial year, NPR 6 billion was allocated to the DUDBC. This allocation has increased work at the DUDBC. Expenditure is expected to increase significantly. This will require minor modifications, such as adding the types of expenditure into TABCUS. A training manual that has now been uploaded to the system can be used by personnel

Inputs are scheduled for the next Quarter.

Challenges: Staff transfer is an issue in terms of institutional knowledge.

Activity i4.2.7 TABUCS monitoring and monthly expenditure reporting

On-time: This is an on-going process. The expenditure data from TABUCS are being used in every meeting of the public financial management committee. This also reports on cash advances that may help DFID and other development partners to make the suggestions to reduce the same.

Inputs are scheduled for the next Quarter.

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

Not scheduled: No inputs were provided in this Quarter.

Further inputs are planned for the 4th Quarter.

Activity i4.2.9 Support the annual production of Financial Monitoring Report using TABUCS (PD 27)

On-time: This is an on-going process. A new format for the Financial Monitoring Report has been developed and endorsed by the FMOHP. However, full expenditure data may not be available. TA will work with the Financial General Comptroller Office (FCGO) to address this challenge.

Inputs are scheduled for the next Quarter.

Activity i4.2.10 Support FMOHP with the further development of TABUCS to capture the Nepal Public Sector Accounting Standards report

Delayed: Full expenditure data is not available. This could be a good initiative for provincial and local governments.

No inputs are scheduled for the next Quarter.

Challenges: This requires additional personnel and budget.

Activity i4.2.11 Requirement analysis of Aama program in TABUCS (one of SD team core areas)

Completed: ✓

No inputs are scheduled for the next Quarter.

Activity i4.2.12 Share the features of TABUCS with other governments

Completed: ✓ The National Reconstruction Authority, the Ministry of Urban Development and several other ministries in Provincial Government are now using TABUCS. The National Reconstruction Authority is in the process of accessing (from the FCGO) an e-payment system in TABUCS. If the FCGO accepts this request, there will be a significant reduction in preparation time for payments, as well as improved governance. This needs additional personnel and budget which will enable the FMOHP's spending units to practice e-payment.

Inputs are scheduled for the next Quarter.

RESULT AREA: ACTIVITY I4.3 REVISE, IMPLEMENT, AND MONITOR THE FMIP

Activity i4.3.1 Update internal control guidelines

Completed: ✓ A draft report is being prepared, and it is in the endorsement process at the FMOHP.

No inputs are scheduled for the next Quarter.

Challenges: Printing may be delayed due to a late endorsement decision by the FMOHP.

~~Activity i4.3.2 Discuss with the DFID whether a PETS is more useful and appropriate than a PER~~

Deleted: DFID has advised that PETS will be carried out by the World Bank.

No inputs are scheduled for the next Quarter.

~~Activity i4.3.3 Conduct PER~~

Deleted: DFID has advised that PER will be carried out by the World Bank.

No inputs are scheduled for the next Quarter.

Activity i4.3.4 Finalise, print and disseminate the FMIP

Completed: ✓ The first version of the Financial Management Improvement Plan has been prepared, uploaded and disseminated.

Inputs are scheduled for the next Quarter.

Activity i4.3.5 Support monitoring of the FMIP in collaboration with the Public Finance Management and Audit committees

On-time: The minutes of the Public Finance Management and Audit Committee are regularly shared with the concerned development partners.

Inputs are scheduled for the next Quarter.

Activity i4.3.6 Update the training manual on Public Finance Management and finalise by a workshop, printing

On-time: The development of the training manual revision is in progress.

This will be completed in the next Quarter.

Activity i4.3.7 Build the capacity of FMOHP and DOHS officers in core Public Finance Management functions

On-time: The FMOHP and the DOHS have conducted Public Finance Management workshops in five places covering all provinces.

Inputs are scheduled for the next Quarter.

Activity i4.3.8 Support the process of institutionalising the internal audit function through IAIP and internal audit status report (PD 43)

On-time: Entry forms have been developed in TABUCS to capture the records from spending units and to monitor internal audit functions.

Inputs are scheduled for the next Quarter.

Challenges: There is a risk that the collection of internal audit reports from all spending units may not be fully completed. Additional resources are required to support this.

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

Delayed: TA has provided a series of updates on Public Finance Management and procurement in development partners' meetings.

Inputs are scheduled for the next Quarter.

Activity i4.3.10 Support to the Public Finance Management & Audit committee

Delayed: See Challenges below.

Inputs are scheduled for the next Quarter.

Challenges: There is an issue of delayed meetings due to unavailability of concerned members.

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

On-time: A workshop has been conducted to inform the FMOHP on the Performance-Based Grant Agreement.

Inputs are scheduled for the next Quarter.

Activity i4.3.12 Review and revise the current Performance-Based Grant Agreement Framework

Completed: ✓A refined framework for the Performance-Based Grant Agreement (PBGA)was prepared which will be discussed in the PBGA learning café with stakeholders, including the FMOHP.

No inputs are scheduled for the next Quarter.

Challenges: A lack of an institutional home for the Performance-Based Grant Agreement might undermine its implementation. After the upcoming structural changes, TA may need to provide additional support.

Activity i4.3.13 Redesign Performance-Based Grant Agreement for hospitals

Not scheduled: Based on the discussions focused on the revision of the Performance-Based Grant Agreement format, the contract agreements with selected non-government hospitals are to be redesigned.

Inputs are scheduled for the next Quarter. TA will take this agenda in the next Public Finance Management Committee meeting.

Activity i4.3.14 Policy discussion on Performance-Based Grant Agreement for Hospitals in federal structure

Not scheduled:

No inputs are scheduled for the next Quarter.

Activity i4.3.15 Expansion of Performance-Based Grant Agreement in selected hospitals

Not scheduled:

No inputs are scheduled for the next Quarter.

Activity i4.3.16 Contribution to the learning laboratories

Not scheduled:

No inputs are scheduled for the next Quarter.

Activity i4.3.17 Develop performance monitoring framework and support its implementation

Not scheduled:

Inputs are scheduled for the next Quarter.

Activity i4.3.18 Performance-Based Grant Agreement training (preparation of manual)

Not scheduled:

No inputs are scheduled for the next Quarter.

Activity i4.3.19 Discuss with the best performing governments and provider on Performance-Based Grant Agreement modality

Not scheduled:

No inputs are scheduled for the next Quarter.

Activity i4.3.20 Initiate Performance-Based Grant Agreement learning group

On-time: A learning meeting is being organised on a basis of *as when required*. The Performance-Based Grant Agreement receiving agencies, the FMOHP and TA will participate in the meeting. The agenda addresses the evolving grant management issues.

Inputs are scheduled for the next Quarter.

RESULT AREA: ACTIVITY I4.4 LOGISTICS MANAGEMENT DIVISION IS IMPLEMENTING STANDARDISED PROCUREMENT PROCESSES

Activity i4.4.1 Re-assess and build on the operations and management survey and disseminate findings

Delayed: There is a risk that this may not happen due to changes in the LMD structure.

No inputs are scheduled for the next Quarter.

Revise Standard Operating Procedures and obtain endorsement by DOHS

Completed: ✓ Standard Operating Procedures have been distributed to the provincial and local government.

Not inputs are scheduled for the next Quarter.

Preparation of Standard Operating Procedures for Post Delivery Inspection and Quality Assurance

On-time: The TOR for STTA is being prepared. The Programme is expecting the FMOHP to endorse the Standard Operating Procedures.

Inputs are scheduled for the next Quarter.

Review Draft Standard Bidding Document of FA and support its endorsement by the Public Procurement Monitoring Office

Delayed: Several meetings have been conducted with the Public Procurement Monitoring Office (PPMO). The Standard Bidding Document (SBD) preparation committee at the PPMO is working on finalising the SBD.

Inputs are scheduled for the next Quarter.

LMD capacity building on standardised procurement processes

On-time: Exposure visits and coaching activities were aimed at developing the capacity of LMD staff members. Due to the potential changes in the LMD's organisational structure, the TA were not able to plan the exposure visits. However, the TA has started the process of procurement clinics at LMD. A total of 30 clinics have been implemented in this Quarter. TA assures the participation of LMD personnel in diagnosing the issue and providing a solution to the clients.

Inputs are scheduled for the next Quarter.

Challenges: The restructuring of LMD is a risk to this intervention.

Activity i4.4.2 Revise and update the Procurement Improvement Plan

Completed: ✓ An update on the implementation of the Procurement Improvement Plan (PIP) was given at the Consolidated Annual Procurement Plan (CAPP) Monitoring Committee meeting, which was held in this Quarter. Implementation of the PIP by the FMOHP and its departments has been successful.

Not continued next Quarter.

Establishment and regular meeting of the Consolidated Annual Procurement Plan Monitoring Committee

On-time: The third CAPP Monitoring Committee meeting was organised.

Inputs are scheduled for the next Quarter.

Activity i4.4.3 e-CAPP preparation using Standard Operating Procedures and the establishment of CAPP Monitoring Committee

On-time: The terms of reference for the e-CAPP has been developed and shared with LMD. The selection process of an IT provider has been initiated.

Inputs are scheduled for the next Quarter.

e-CAPP designed, tested, provide training and implement
On-time: The consultant selection process is in process. e-CAPP has been designed and tested, and training provided.

CAPP produced within the agreed time frame

Completed: ✓The CAPP report was submitted to DFID as a Payment Deliverable (PD). A comprehensive CAPP at the FMOHP, integrating the APPs of 30 procuring entities for the financial year 2018-2019 was prepared based on their AWPB, posted on the Line Ministry Budgetary Information System.

No inputs are scheduled for the next Quarter.

Review of the Public Procurement Act and Public Procurement Regulation for Health Sector Procurement in coordination with PPMO

On-time: Suggestions have been provided to PPMO for special amendments required in the Public Procurement Act and the Public Procurement Regulation for the health sector. The Senior Public Procurement Advisor made a presentation at a high-level forum, in the presence of Ministers and the PPMO Secretary. The forum was organised by the Law Commission of Nepal.

No inputs are scheduled for the next Quarter.

Challenge: There is a challenge to make the Public Procurement Act and Public Procurement Regulation health sector friendly.

Preparation of standard bidding documents for the Procurement of Health Sector Goods

Delayed: The standard bidding document for the procurement of Health Sector Goods was prepared and submitted to the PPMO. The approval from the PPMO is delayed due to the transfer of their Secretary. TA needs to engage the FMOHP's Secretary with PPMO to get their consent.

Inputs are scheduled for the next Quarter.

Capacity building on Procurement System in federal, provincial and local government

On-time: The Standard Operating Procedures for the standardisation of drug procurement has been developed with the involvement of the Department of Health Services staff. This has been printed as a *Handbook of Procurement and Supply Chain for provincial and local governments* and was sent to all the Local Governments and health institutions in April 2018.

Inputs are scheduled for the next Quarter.

Challenge: Effective implementation and monitoring remain a risk.

RESULT AREA: ACTIVITY I4.5 LMD SPECIFICATION BANK IS USED SYSTEMATICALLY FOR THE PROCUREMENT OF DRUGS AND EQUIPMENT

Activity i4.5.1 Develop coding of specification bank and orientate all DOHS divisions on their use

Completed: ✓This has been achieved and TSB is now used by the concerned personnel.

No inputs are scheduled for the next Quarter.

Activity i4.5.2 Specification bank updated by LMD in consultation with development partners

Delayed: Please see Challenges below:

Inputs are scheduled for the next Quarter.

> **Challenges:** There is a lack of Biomedical Engineers in the Logistic Management Division (LMD) to enable this.

RESULT AREA: ACTIVITY I4.6 PPMO ELECTRONIC PROCUREMENT PORTAL IS USED BY LMD FOR AN EXPANDED RANGE OF PROCUREMENT FUNCTIONS

~~Activity i4.6.1 Support PPMO on changes needed on e-GP for health sector procurement~~

Deleted. The PPMO is currently undergoing organisational restructuring. The change in the current Electronic Procurement Portal (e-GP) is not a current priority for the PPMO. In this context, LMD has agreed to delete this activity.

No inputs are scheduled for the next Quarter.

Activity i4.6.2 Develop guidelines to support the use of e-procurement at local levels

On-time: TA has prepared e-GP guidelines for the health sector to support local government. The effective dissemination of the guidelines, implementation, and monitoring are potential issues or risks to monitor.

Inputs are scheduled for the next Quarter.

Activity i4.6.3 Adapt e-GP to be used for handling of grievances

On-time: A separate grievance handling mechanism is being adapted in LMD for the health sector. A contract has been forged by LMD with an IT company, and prototype demonstration of the system has been completed.

Inputs are scheduled for the next Quarter.

> **Challenges:** The PPMO has not been able to complete this module in e-GP so far.

Activity i4.6.4 Adapt e-GP to support e-payments

Not scheduled: The Financial Comptroller General's Office is piloting e-payments in three spending units. TA expects that a scale-up may be initiated in financial year 2018/19. After that, TA will include this in TABUCS.

No inputs are scheduled for the next Quarter.

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

Activity i5.1.1 Support the development of RQDA tools for different levels and their rollout (PD 33)

On-time: The web-based Routine Data Quality Assessment System (RDQA) tool developed in the previous Quarter was tested in Bagheswori Health Post in Nuwakot district. The application has since been refined based on the lessons learned and feedback received from the health workers and programme managers. An e-learning package that includes an introductory video, users' manual (an audio-visual tutorial), implementation guideline, *Frequently Asked Questions*, and other resources related to RDQA have been developed. The RDQA tool with the complete set of e-learning package has been updated incorporating feedback from the users, managers and other stakeholders. The package is hosted on the FMOHP website.

Inputs are scheduled for the next Quarter.

Challenges: Use of e-learning package to initiate RDQA on their own depends on the computer literacy of health workers and managers, infrastructure (computer and internet at the facility), behaviour and most importantly, the shift in the practice of providing training for any new initiatives.

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

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter as part of the Learning Labs (LL).

RESULT AREA: *ACTIVITY I5.***2 FMOHP HAS AN INTEGRATED AND EFFICIENT HEALTH INFORMATION SYSTEMS (HIS) AND HAS THE SKILLS AND SYSTEMS TO MANAGE DATA EFFECTIVELY**

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

Completed: ✓

No inputs are scheduled for the next Quarter.

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

On-time: TA has developed and shared a concept note to PHAMED to initiate electronic reporting of the Health Management Information System (HMIS) from local governments from August 2018 -the beginning of next fiscal year - when there will be no district structure (in the current form). The concept note proposes to mobilise the existing resource pool (personnel and financial resource) within districts to enable local governments to take on this responsibility. The FMOHP, through the DOHS, has circulated a guideline to the districts for the same. TA are identifying the specific sector needs of the LL sites.

Inputs are scheduled for the next Quarter. The activities identified this Quarter will be implemented at the selected LL sites in the next Quarter.

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

On-time: Currently, patient-based data in health facilities are recorded on a paper-based system which is prone to errors and cannot be readily analysed, used and shared for decision making. PHAMED, the FMOHP officials, and TA visited Nuwakot District Hospital to observe the Electronic Health Record System (EHRS) being implemented by GIZ to understand the challenges and basic requirements for implementation and operation. TA will prepare a concept note to develop the EHRS modules for primary hospitals/primary health care centres and health posts. Using lessons from the implementation of EHRS in the country, TA will design and implement a similar system in selected LL sites. The design of EHRS modules is a payment deliverable for November 2018.

Inputs are scheduled for the next Quarter**.**

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

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the LL sites next year.

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

On-time: TA initiated a concept for the development of a mechanism to monitor the number of health facilities and local governments using electronic reporting and displaying progress on a dashboard that is hosted on the FMOHP website. The web application is under development.

TA reviewed and provided feedback to the HMIS e-learning modules for the orientation of health workers, statisticians, computer operators and programme managers . TA initiated the sharing of these e-learning materials through the FMOHP website so that local governments and health facilities personnel can benefit.

Under federalism, whereby health facilities are managed by local governments from the next fiscal year onwards, the FMOHP priority will be to initiate electronic reporting of HMIS from local government and gradually expand e-reporting to the health facility.

Inputs are scheduled for the next Quarter.

Activity i5.2.6 Support the development of an OCMC software and update the SSU software

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter.

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

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter.

RESULT AREA: i5.3 FMOHP HAS ROBUST SURVEILLANCE SYSTEMS IN PLACE TO ENSURE TIMELY AND APPROPRIATE RESPONSE TO EMERGING HEALTH NEEDS

Activity i5.3.1 Support the strengthening and expansion of MPDSR in hospitals and communities

On-time: TA provided inputs to the provincial review plans prepared by the FHD. A concept note was also developed (see Activity i5.3.3). TA reviewed the current web-based Maternal Perinatal Death Surveillance Report (MPDSR) data collection tool and provided feedback. Inputs focused on identifying and addressing errors in variable definitions, user-interface, and inconsistent back-end data. Advice was provided on the terms of reference developed by the FHD for the repair of the system.

Inputs are scheduled for the next Quarter.

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

On-time: A policy brief was developed to improve maternal death reporting, including advice on screening questions in the notification form itself and on the use of a mobile phone application for notification. This will save time, ease the process, help with the collection, processing, analysis, and use of the information. The brief was shared with government officials and during the provincial annual review of MPDSR programme. Endorsement of the concept by the FMOHP is pending.

Inputs are 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

On-time: TA has developed a policy brief highlighting the need for a process of engaging health academic institutions in each province to lead the implementation, strengthening and expansion of MPDSR within the province. The brief has been shared with key officials from the FMOHP. The FMOHP will need to craft a memorandum of understanding with the academic institutions and focus its function on regulation and ensuring quality. This concept was shared during the provincial review meetings (see Activity i5.3.1).

Inputs are scheduled for the next Quarter.

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

Not scheduled: No inputs were provided in this Quarter.

Inputs planned for next year.

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

The Programme is requesting that this activity is removed: Early Warning and Reporting System (EWARS) has already been customised in the *District Health Information System 2* platform. The weekly EWARS bulletin has been standardised and Epidemiology and Disease Control Division (EDCD) is regularly developing and disseminating the weekly bulletin to stakeholders. EWARS is institutionalised in the EDCD. Currently, Programme support is demand-based, focusing on establishing and operating the data management system during a disaster. Any specific input to the system will be reported as and when, appropriate.

No inputs are scheduled for the next Quarter.

RESULT AREA: I5.4 FMOHP HAS THE SKILLS AND SYSTEMS IN PLACE TO GENERATE QUALITY EVIDENCE AND USE IT FOR DECISION MAKING

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

On-time: In collaboration with MEOR, TA drafted a guideline on *Health Sector M&E in the federal context*. This guideline defines the health sector M&E functions of the local, province and federal government; specifies the way forward and roles of different entities in meeting the data gaps with specific reference to the NHSS Results Framework and Sustainable Development Goals - Goal 3. TA conducted a detailed exercise on indicator mapping to identify gaps in data, the source of data, action required to meet the data gap, the agency responsible for data and levels from which indicators are to be reported. The output of this exercise and the output of Activity i5.2.1 above constitutes the key contents of the guideline. Programme advisors reviewed the sections prepared by MEOR and provided feedback. The FMOHP is reviewing the draft guideline. It will be finalised by August 2018. TA with MEOR discussed the contents of the draft document with the DFID Health Advisor with specific reference to its scope and alignment with the federal context. The DFID review and input has been instrumental in shaping this document in its current form. The final guideline will be translated into the Nepali language for the benefit of local governments.

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 & 53) [and assist in planning]

On-time: Dashboard: The dashboard to monitor major health indicators including the NHSS Reporting Framework and health-related SDG indicators has been developed and published on the FMOHP website (PD 20) http://mohp.gov.np/content/statistics. The dashboard uses data from the Nepal Demographic and Health Surveys, Nepal Health Facility Survey and HMIS. It will help to monitor the indicators (and aid decision making) from an equity perspective, with regards to geography, socio-economic and demographic characteristics of the population. TA are working with the HMIS Section to develop a system to track the use of this dashboard by local authorities.

Inputs are scheduled for the next Quarter.

Analysis of the equity gaps in health service utilisation

On-time: TA is preparing a report analysing the equity gaps in the utilisation of health services, using data from NDHS. This is a Payment Deliverable (PD 53) and **will be completed by August 2018.**

Inputs are scheduled for the next Quarter.

SMNH Roadmap

On-time: TA provided data to establish the evidence for the development of the *Safe Motherhood and Neonatal Health Roadmap* and wrote the terms of reference for data analysis/evidence generation on identified data gaps for its development.

Inputs are scheduled for the next Quarter.

~~Activity i5.4.3 Support the development of a survey plan to meet the health sector data needs with a focus on NHSS RF & IP, SDGs & disbursement-linked indicators and its implementation~~

Deleted. This is addressed in Activity i5.4.1. The M&E Guideline explained in Activity i5.4.1 above includes a Survey plan.

No inputs are scheduled for the next Quarter.

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

On-time: TA with the National Health Training Centre (NHTC) developed a framework and the tools for collating evidence, to support local governments' . These tools are incorporated in the '*Health Orientation Package*' developed by NHTC and the '*Local Level Planning Guideline*' developed by the FMOHP. This package has been rolled out to provincial and local governments.

HMIS series data were analysed as a part of the health profile of the LL sites. At the request of Pokhara Metropolitan City - one of the LL sites - training was provided to data collectors on health facility assessment.

Quality Improvement Management Information System (QIMIS): TA is developing the QIMIS that draws quality-related data from HMIS, NDHS, and NHFS and presented the outputs on the Dashboard hosted on the FMOHP website (http://mohp.gov.np/content/statistics). This is expected to help programme managers to monitor the quality of care indicators.

TA worked with the FMOHP to develop the recording and reporting tools and the M&E plan, as a part of the Minimum Service Standards for hospitals and health posts.

TA finalised the protocol for assessment of free inter-facility referral services (BCONC to CEONC) in the Dolakha and Ramechhap districts. A study design and a tentative budget for this task were developed.

Inputs are scheduled for the next Quarter.

Activity i5.4.5 Support develop evidence-based program briefs (2 pager/program) for the elected local authorities and dissemination

On-time: A policy brief based on an analysis of caste disaggregates from the NDHS 2016 data was completed and three more commenced on client satisfaction on antenatal care services; caesarean section service utilisation; and strengthening and expansion of MPDSR. These policy briefs will be translated into the Nepali language for the benefit of local governments and a larger audience.

Inputs are scheduled for the next Quarter.

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

On-time: TA facilitated a development partner M&E TWG meeting to discuss the *Big Asks* in M&E in the current transition phase, and to suggest a better way of harmonising the Government and development partner efforts in addressing issues.

Inputs are 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

Not scheduled: No inputs were provided in this Quarter.

Inputs planned for next year.

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

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.

Planned for next year.

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

On-time: TA reviewed the technical and implementation aspects of the unified coding of health facility, health facility registry, grievance management system, and file tracking system being developed by the FMOHP. TA contributed to consultation meetings and the development of an orientation package to roll out these initiatives. TA collected the policies, strategies, guidelines, protocols and survey reports produced by different entities within the FMOHP to facilitate the *Knowledge Management Portal* being developed. All these e-health initiatives will be finalised and implemented by the end of July 2018.

Inputs are scheduled for the next Quarter.

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

On-time: A concept note has been developed to initiate a policy forum with the objective of promoting evidence-based dialogue on key policy areas in the health sector. It promotes a series of evidence-based discussions with expected outputs to be disseminated in the form of policy briefs. The concept note has been shared with the FMOHP.

Inputs are scheduled for the next Quarter.

Activity i5.5.4 Support citizen engagement forums at central and provincial levels to jointly monitor performance and feed the decision-making processes

Delete. This activity is covered by Activity i5.5.1 and Activity i5.5.3.

No inputs are scheduled for the next Quarter.

HEALTH INFRASTRUCTURE KPA 1: POLICY ENVIRONMENT

i7.1.1 Produce post-2015 Earthquake Performance Appraisal Report (PD 13)

Completed: ✓Achieved in Quarter 3, Year One. This report provides an overview of disaster risk reduction (DDR) activities and policies in the FMOHP, to improve and enhance the coordination mechanism for DDR governance in the changed context of federalism. It has been planned to integrate the activities with the LL sites as a pilot. A concept note has been prepared to mainstream the DRR in the health sector for all levels of government as per the new DRM Act 2017. An EQ appraisal report and its findings towards mainstreaming DRR in the health sector were presented by TA representing the FMOHP at the *International Conference of DRR Risk to Resilience* conducted by NSET during this Quarter.

A study on DRR governance status in the health sector in proposed LL areas has been planned for the next Quarter.

Challenge: There is a risk that the federal dispensation induced changes that may impact on the concept of mainstreaming DRR at the different levels. In such cases, adjustments will be required in the proposed implementation modality.

i7.1.2 Upgrade HIIS to integrate functionality recommendations

On time: An online Health Infrastructure Information System (HIIS) has been developed and is being updated. The URL has been created and further updates are ongoing. The URL is 5.9.167.97:8000. Digitisation and the update of feature information in the HIIS geo-database have been further achieved and is an ongoing activity. The data from Damage Assessment carried out during TRP has been updated into the system and further data availed from different official sources on infrastructure are being updated. It is envisaged the system will be the integrated source of health infrastructure information, which will become a major planning tool to support planners and policymakers in strengthening the health infrastructure development planning and implementation at all levels of governance, bringing about more rationalisation and transparency in the health infrastructure investments. The HIIS has been very useful in the development of annual plans for health facility development and upgrading for the FMOHP, the DOHS, and the DUDBC. This also has been recently used for extracting the list of potential health facilities for retrofitting in case the surplus money allocated in Financial Aid is agreed to be used for further expansion of retrofitting activity in Nepal. The system was also useful in preparing a detailed report and maps for a selection of health facilities for reconstruction and recovery work being implemented by FMOHP. The system was also useful in identifying different health facilities that are at risk to a different kind of disaster for one of the PDs on climate change and health infrastructure

framework. submitted to DFID in the Quarter Four of Year One. The system needs more updating since we are expecting more federal dispensation induced changes in the health infrastructure structure.

Inputs are scheduled for the next Quarter.

Challenge: The system depends on data collected in 2008 and information from secondary sources for many of the attributes for 47 Districts in the system. It does not fully cover the information on the physical status of about 3,900 sub-health posts which were under the jurisdiction of the local government until 2011. In 2011, these SHPs were declared as health posts and came under the jurisdiction of the FMOHP. This may skew the accuracy in the analysis of data sometimes. To improve the data in the system, a detailed infrastructure assessment of health facilities in the remaining 47 districts has been proposed by the Management Division, the DOHS, and the FMOHP.

i7.1.3 Transfer HIIS to FMHOP, support the institutionalisation of the tool and enhance capacity in its use

On-time: Government staff from the DOHS are from time-to-time working in hand with the infrastructure team in planning for different health infrastructure -related analysis using HIIS and thus getting them acquainted with the tool. In the past, training and orientation programmes have also been organised to enhance the capacity of the FMOHP and the DUDBC staff in using HIIS. Activities have been planned under KPA1 to roll out the HIIS in the provinces and selected local government units. The know-how on how to use the HIIS will be transferred to the provinces and local governments so that they can update the information on health infrastructure in their provinces or municipalities themselves. A virtual private server has been maintained by TA at present for the HIIS in the absence of a well-maintained data centre at the FMOHP.

Inputs are scheduled for the next Quarter.

Challenge: Implementation of e-health information system strategy by the government so that HIIS has a home in the Ministry and is owned by the Ministry. Human resources working at FMOHP especially at Policy Planning and Monitoring Division and at the Management Division will be trained in the use of HIIS. A temporary home for HIIS will be developed at Management Division, which can later be transferred into the e-health unit at the FMOHP.

i7.1.4 Revision of the NNBC in relation to retrofitting, electrical standards, HVAC, and sanitary design.

On time: Regarding this activity, when discussed with the DUDBC officials, it was advised that this activity sentence should be rephrased as TA are not authorised officials or agencies to change the code. We can only provide TA to them to modify, update or develop these codes. Accordingly, it is suggested that the sentence is rephrased as *Technical assistance to the DUDBC to revise, update and develop as appropriate the NNBC in relation to retrofitting, electrical standards, Heating, ventilation, and air conditioning (HVAC) and sanitary design.* So far, case studies and reviews have been made on existing HVAC standards and practices. Dialogue with the DUDBC in this regard has been initiated with a positive response. To set good HVAC practices and support in the development of guidelines, HVAC design has been incorporated in retrofitting of two priority hospitals.

Inputs are scheduled for the next Quarter.

Challenge: The lengthy endorsement process and the limited availability of the DUDBC officials at required times to expedite the process.

i7.1.5 Nepal earthquake retrofitting, and rehabilitation standards produced and adopted (PD 21)

Completed: ✓The PD was achieved during Quarter Four, Year One. Initially, the standard was produced as guidelines, which during a high-level workshop was recommended by the participants to be developed as standards for Nepal. This will become a guiding document for retrofitting. A working

committee has been formed under the leadership of the DUDBC and a detailed plan of action is being prepared for taking the initiation forward. A workshop was conducted earlier in the first year of the Programme to collect the comments, suggestions, and recommendations for developing standards. The workshop was attended by all the concerned government authorities in Nepal, national and international experts. A working calendar for support from an international expert from Miyamoto has been prepared during the last Quarter for continuing and completing the standard development work, in close coordination with the Senior Earthquake Resilience Adviser.

Inputs are scheduled for the next Quarter.

i7.1.6 Development of the Climate Change and Health infrastructure framework (PD 22)

Completed: ✓Achieved in Quarter Four, Year One.

Inputs are scheduled for the next Quarter.

i7.1.7 Support the development of the Infrastructure Capital Investment Policy, including facility prioritisation and selection (PD 46)

On-time: Since the work demanded by the PD was already completed in the previous year, now it is requested that the terms of references be rephrased to address the implementation of the document. Both the terms of references are under revision and will be submitted as a PD for August 2018.

Inputs are scheduled for the next Quarter.

i7.1.8 Revise existing Health Infrastructure Design Standards and upgrading Guidelines to ensure equity by bringing them in line with LNOB good practice and orient infrastructure stakeholders on these

On-time: The final draft document for GESI/LNOB compliance in health infrastructure development has been prepared and has been provided to the Ministry of Urban Development for review. The document has been much appreciated by the DUDBC. The GESI/LNOB related issues have been incorporated in tender documents for retrofitting of two priority hospitals this reporting Quarter and have been sent to the DUDBC for discussion.

Inputs are scheduled for the next Quarter.

HEALTH INFRASTRUCTURE KPA 2: CAPACITY ENHANCEMENT

i7.2.1 Ongoing capacity development support to FMHOP/the DUDBC, including capacity assessment, including the formation of a Capacity Enhancement Committee

On-time: At the request from Management Division and DUDBC, TA visited the construction site of Mid-Western Regional Hospital at Surkhet (proposed to tertiary level as per the Facility Prioritisation approved by the FMHOP) and provided on-site instructions for resolving the issues, which had arisen on-site due to the complicated level of land contours. Further assistance was also provided for the revision of architectural, structural, electrical and sanitary design and drawings for the construction. The project is worth more than NPR 600 million in total. The work is progressing well and is well ahead of the agreed schedule signed with the contractor by the DUDBC. The investment is funded through the pool fund.

TA also supported the FMOHP to monitor progress and resolve construction-related issues in Bir Hospital and Paropakar Maternity and Women's Hospital.

TA also assisted the FMOHP and KFW in reviewing the design and drawings of five different hospitals under reconstruction. All these hospitals were heavily damaged during an earthquake in 2015. The review helps in building the capacity of the designers working for KFW to understand the local context and design, as per the standards and guidelines developed for health facility construction.

On the request of the PPICD, TA was provided to PCU for the evaluation of bids for eight health facilities planned for reconstruction. All these health facilities were destroyed by the 2015 earthquake. This helps PCU staff to build their capacity to interpret the provisions in the acts and norms, enabling to work independently in future in a similar context or resolve similar issues.

TA was provided to the local community at Manthali for the completion of a project funded and directly executed by TA in Ramechhap for construction of the operating theatre, diagnostic area, and the OCMC in Manthali Hospital.

TA also coordinated with Bhaktapur Municipality several times to resolve the issue of a land dispute at Bhaktapur Hospital. During the visit, the request was also made to Municipality officials to coordinate with communities (Guthi) that own the open space next to the Hospital, for their temporary use for the decanting of Hospital services. This sets an example for the DUDBC on the importance and necessity of coordinating with local government for all kinds of constructions.

TA was provided to the District Public Health Office Kathmandu in finalising the contract for Budanilkantha City Hospital and the signing of the contract, in line with provisions in the procurement acts and regulation. The project authority has been transferred to local government for implementation during the Quarter.

Inputs are scheduled for the next Quarter.

i7.2.2 Training Needs Analysis (TNA) for FMOHP and Staff (PD)

Completed: ✓The PD was achieved in Quarter Three of Year One. It is an on-going process; more needs may be added in the future depending on the situational requirement.

Inputs are scheduled for the next Quarter.

Challenges: Overwhelming requests for training can come from the government due to changing scenarios in the federal context.

i7.2.3 Health Infrastructure Policy Development Training Programme Implementation Y1 (PD)

Completed: ✓PD approved by DFID and payment already made during the last Quarter of 2017.

No inputs are scheduled for the next Quarter.

i7.2.4 Health Infrastructure Policy Development Training Programme Implementation Y2

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter.

i7.2.5 Policy Development Training Impact Evaluation (PD 38)

Completed: ✓During the Quarter, an impact evaluation of the health infrastructure policy development was conducted. A term of reference was developed, and a call was made for the interested and capable organisation for the assessment. A selection was made, a contract awarded, evaluation completed, and a report submitted by the consultants. This report has been submitted to DFID (one of the PDs this Quarter). This was approved. The impact evaluation has suggested improvement in certain areas in the policy training which will be incorporated or revised in the contents of the next training. One of the major changes recommended by the assessment is that federalism is to be addressed in the next training. Overall, the result of the impact evaluation shows the positive impact of training conducted. *The report has been disseminated through Options internal newsletter and is on the NHSSP website.*

No inputs are scheduled for the next Quarter.

i7.2.6 the DUDBC technical skill training design and conducted Y2 (PD 34)

Completed: ✓As identified and prioritised by the training needs analysis an orientation training on retrofitting and tender process was conducted for the DUDBC officials and a training completion report submitted to DFID as a PD34. The skills development training on multi-hazard resilient health infrastructure planning, designing, health infrastructure standard design and guidelines, tender document preparation, and electronic governance portal was provided to the DUDBC officials from different division offices. This was targeted at developing their capacity to enhance their knowledge in the design of multi-hazard resilient health infrastructures, retrofitting project management, adapting to standard designs and guidelines and preparing tender documents and using e-GP for tendering. The DUDBC is adopting a similar approach as disseminated during the workshop for their other retrofitting projects. The DUDBC divisional offices have started using e-GP at their workplace in different divisional offices.

Inputs are scheduled for the next Quarter.

i7.2.8 Technical Skills Training Impact Evaluation (PD 39)

Completed: ✓The result of an impact evaluation study shows the positive impact of training conducted for the DUDBC staff members in different divisional offices of the DUDBC. A structured interview tool was developed by the consultant (third party) for the assessment and the DUDBC officials were interviewed.

No inputs are scheduled for the next Quarter.

i7.2.9 Establishment of Mentoring / Support Help-line (if found as required) (PD 54)

On-time: A terms of reference has been prepared and submitted to DFID. It was agreed to in a meeting with DFID to make some changes.

Inputs are scheduled for the next Quarter.

i7.2.10 Skills Development Training for contractors and professionals designed and implemented

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter.

i7.2.11 The DUDBC Technical Skill Training programme implementation Y2

Not scheduled: No inputs were provided in this Quarter.

Inputs are scheduled for the next Quarter.

i7.2.12 Design & Roll-out of Roadshows & Information Sessions in Priority Districts (PD 47)

On-time: A terms of reference has been prepared and submitted to DFID.

Inputs are scheduled for the next Quarter.

~~i7.2.13 Annual Impact Review: assess the impact and effectiveness of capacity programme activities developed, implemented and adopted in Year One.~~

Delete. This is redundant with the assessments mentioned above.

No inputs are scheduled for the next Quarter.

HEALTH INFRASTRUCTURE KPA 3: RETROFITTING AND REHABILITATION

i7.3.1 Strengthening Seismic, Rehabilitation and Retrofitting Standards and orientation on the standards, incl. report with recommendations (PD 16)

Completed: ✓Achieved in year one Quarter 3.

No inputs are scheduled for the next Quarter.

i7.3.2 Identification and Selection of Priority Hospitals (PD 15)

Completed: ✓Achieved in Quarter 1 year one.

No inputs are scheduled for the next Quarter.

i7.3.3 Geotechnical site survey, structural element test, production of drawings, detailed condition assessment

Completed: ✓Geotechnical investigations, structural element tests using non-destructive and destructive tests and detailed condition assessment have been conducted. All these investigations were carried out together with the DUDBC engineers, which have enabled them to understand the requirements for analysis for preparing retrofitting designs. All the test reports have been incorporated in the design parameters.

No inputs are scheduled for the next Quarter.

i7.3.4 On-site training to FMOHP and DUDBC technical staffs on seismic assessment of the hospitals buildings

Completed: ✓On-site training to the FMOHP and the DUDBC technical staff on seismic assessment of the priority hospitals has been completed.

No inputs are scheduled for the next Quarter.

i7.3.5 Design of retrofit works (structural / non-structural) with the DUDBC (PD 29)

On-time: The design has been completed and submitted to both the DUDBC and to DFID. The design report of retrofitting work was prepared during the Quarter. Further verification tests have been done as demanded by reviewers and to boost the confidence of the designers and the DUDBC officials, alternative models have also been prepared for comparison. More details are being produced. A value for money analysis has been done, and a document has been prepared on the retrofitting design during the Quarter. The document is being finalised. Capacity enhancement of the DUDBC staff is on-going with consultation meetings, presentation of retrofitting design, with the DUDBC, working in hand with the DUDBC engineers on retrofitting design of the hospitals, peer review by renowned experts and feedback in joint forums, and field verifications with peer reviewers.

Inputs are scheduled for the next Quarter.

i7.3.6 Training on retrofitting design and tendering, and sharing of the design and measures (PD 35)

Completed: ✓Achieved in Q1 2018.

No inputs are scheduled for the next Quarter.

i7.3.7 Preparation of final drawings

All the required sets of architectural, structural, sanitary, electrical drawings with cost estimates have been submitted to the DUDBC for tendering. The design has been presented to both the priority hospitals and agreed with the hospital management committee.

No inputs are scheduled for the next Quarter.

i7.3.8 Production of Bills of Quantities

Completed: ✓A bill of quantity has been prepared for the main three packages for both the hospitals. Norms for rate analysis for retrofitting works has been prepared, presented and under revision as according to the suggestions received from the DUDBC and other concerned officials from different line agencies. The DUDBC has agreed to endorse the norms for the rate analysis. A workshop with broad participation from different concerned government agencies was organised by the DUDBC with assistance from TA where the newly developed norms and rate analysis for retrofitting were presented.

No inputs are scheduled for the next Quarter.

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

Delayed: This PD had to be postponed due to the request for the review process to be completed by an external international consultant for all the structural designs. The expected timeframe for completion of this PD will now be November 2018. During this Quarter all the required documents and processes for calling the tender was completed. The amendment of an official budget line specifying the name of the priority Hospitals and the tendering packages in the AWPB is in progress. The *disbursement-linked indicator* dates, amount, indicators, and the *means of verification* for completion of phase wise completion were also prepared and submitted to DFID. Environmental management and safety plan for workers were prepared and incorporated in the tender document. The estimated work schedule and labor schedule has been prepared and is under discussion with the DUDBC. The tender documents prepared have been submitted to oversight agency (Crown agents) for review and comments as received are being incorporated in the document. Service procurement related tender document and process were presented to the DUDBC during this Quarter and feedbacks and comments received and accordingly adjusted.

Inputs are scheduled for the next Quarter.

Challenge: A delay in the review and a slow move for the budget adjustment may delay the tendering process. TA is working to mitigate that risk through continuous follow-up. Due to the delays, the disbursement-linked indicators timelines will also be affected now.

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.

i7.3.11 Tatopani Health Post Retention wall construction

Completed: ✓A work completion certificate has been issued to the contractor and payment has been made. The project has been completed and the health post already functioning. The six-month defect liability period is complete.

No inputs are scheduled for the next Quarter.

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

Delayed: Two structural engineers have been recruited and embedded in the DUDBC to support the DUDBC and engage them in retrofitting design. A demonstration of the splint and bandage method in one of the walls of Pokhara hospital was conducted and participated by the DUDBC engineers. The DUDBC team are working in hand with the TA on all the aspects and are fully engaged in the process. A working committee for each type of work has also been established and is functioning.

Inputs are scheduled for the next Quarter.

EMERGENT OR UNPLANNED TECHNICAL ASSISTANCE

Other TA included:

- TA was provided to a TWG led by CSD and members were general administration, nursing administrator, Human Resources Division of FMOHP and key supporting partners (Nick Simons Institute, WHO, the Programme). The TWG drafted a deployment strategy for scholarships for medical graduates including specialists as a part of the FMOHP Human Resources for Health (HRH) strategy. During this reporting period, the TWG submitted the final draft implementation guidelines on a deployment strategy to FMOHP for their approval. It is expected that FMOHP will use this guideline to deploy specialised doctors with scholarships to the CEONC sites, according to the hospital needs.
- Inputs were provided to develop detailed job descriptions and roles and responsibilities of HRH working at primary hospitals (50 bedded and below), existing PHCs, health posts, urban health centres and Ayurvedic clinics. During last fiscal year, these health facilities were handed over to the local government; therefore, it is expected that this document will be used by the local government to monitor the performance of HRH working in these health facilities. The job descriptions are linked to MSS and basic health care services.
- TA participated and provided inputs on (1) NHTC's TWG initiative to revise/update family planning clinical training packages, (2) ASRH strategy finalisation workshop, and (3) post-partum family planning management guideline workshops. TA also contributed to knowledge sharing by disseminating relevant research articles to government and supporting partners, reviewing draft journal articles as a peer reviewer; and by answering technical updates by phone on request.
- Accompanied and coordinated the Joint TSV with FHD, DFID, UNFPA on FHD and supporting partner family planning program activities to Kailali, Dadelhura, Baitadi, and Darchula districts, 19-24 May 2018.
- Participated in the DFID - Blue sky thinking workshop: The GESI team facilitated a blue sky thinking workshop upon the request of DFID's Social Development Advisor. Reviewed the workshop report and finalised. The workshop contributed to identifying strategic interventions on gender-based violence as per the changed context including the role and scope of different actors.
- Contributed to a DFID led focused group discussion on *Sexual Exploitation, Abuse, and Harassment*: GESI team participated and facilitated a session in the focused group discussion organised by DFID on sexual exploitation, abuse and harassment and GBV in working place. Contributed to finalise the report for the meeting.
- Facilitated an orientation programme entitled *Promotion of citizen engagement and grievances handling* organised by PHCRD: Delivered session on *Addressing the voice and concerns: Participation of poor, vulnerable and excluded in health service delivery*.
- Orientated a women-led organization working on disability issues upon the request of Leprosy Control Division: Delivered session on GESI, GBV, SSU, OCMC and policy provision on disability.
- Organised and accompanied a field trip for a journalist from AFP for Aama case stories http://www.dailymail.co.uk/wires/afp/article-5961345/Free-bus-rides-driving-safer-births-Nepali-women.htm.
- Provided information to a journalist from BBC Reel for Aama case story.
- Hired a TA to facilitate and lead a review of SMNH programmes for SMNH roadmap development. A series of group meetings took place to review from the quality of care, availability and readiness of CEONC/BEONC/BC, Family planning, Access and use of MNH/SAS, and community-based interventions. All groups meeting organised on 16th May 2018 to present and discuss review findings.
- Reviewed and provided technical inputs to operational research plan of MEOR on *Increasing responsiveness to the birth preparedness package among marginalised women in Mahottari district, Nepal*.
- Supported and facilitated MPDSR review meeting at Butwal for Province 4 and 5.
- Organised and accompanied DFID mission chief and health advisors trip to Province 5.

3 CONCLUSIONS

Three key points are emphasised in this report: (1) The absence of a unifying framework and comprehensive plan to guide *devolution* is the most significant overall risk to the sector; (2) Provincial and local government strategic approaches and delivery systems for healthcare are weak, and may weaken further, (earlier gains may well be lost); and (3) Technical responses need to be strongly founded on integrated national and sub-national capacity-enhancement and behavioural-change approaches to assure value for money and reduce the risk of aid dependence.

Building capacity *at all levels of government* will be a core requirement in assuring health systems foundations are in place. The international experience in devolutions informs us that focal area for technical support include (1) strengthening national stewardship of devolution, (2) strengthening local governance of healthcare, (3) strengthening human resources management and developing workforce incentives, and (4) developing and installing workable healthcare delivery systems adapted to local needs. However, a detailed framework and work plan to support sector devolution is absent (or not widely known). Provincial and local governments will require a well-planned, appropriately timed Ministerial stewardship, and skilled technical support, to attain the capacity and competencies to govern, plan, manage, deliver, and monitor health services. Without this, weakening of local health systems may become evident with subsequent worsening of health outcomes. Particularly vulnerable, will be remote localities and where those populations are suffering inadequate service currently. The extent of the gap in time, between federalisation and the installation of appropriate national and sub-national structures and systems, will be a primary determinant of future health outcomes.

It is recommended that TA 1) continue working on the existing plan until the Mid-Term Review findings are known; wherefrom future technical assistance interventions may be formulated, 2) increase the emphasis on strengthening sustainability and capacity enhancement where possible, and 3) support the Ministry to lead the sector reform, through conceptualising, designing, and advancing a framework and plan for health structures and health systems for local government and provinces to uptake.

Appendices

APPENDIX 1 UPDATE OF LOG FRAME

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME (March 2016- December 2020)									
OUTCOME 1	**Outcome Indicator 1.1**		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	**Assumptions**	**Remarks**
Health system is more resilient to environmental shocks and natural disasters	% of new health facility buildings completed on time and adhering to environmental shocks and natural disaster resilience (structural and functional) criteria	**Planned**	Not applicable	No milestone planned	No milestone planned	No milestone planned	100	100	Revised standards are timely endorsed by FMoHP.	Baseline value is not applicable as the environmental shocks and natural disaster resilience criteria are not revised for new health facilities. For Milestone Y1 & Y2 the existing criteria have been considered.
		Achieved			Revised standards are endorsed by mop.					
			Source							
			DUDBC report							
OUTCOME 2	**Outcome Indicator 2.1**		**Baseline Value (Mid July 2015 -Mid July 2016)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	Regular availability of SBAs at all BCs, BEONCs and CEONCs	Y1 - Y2: HMIS does not report data by local government so districts are monitored. From Y3 HMIS will generate data by local governments so from Y3 onwards local governments will be monitored
Equitable utilization of quality health services	% point reduction in gap between the average SBA delivery (disaggregated by Province)	**Planned**	Not applicable	No milestone planned	5	No milestone planned	No milestone planned	No milestone planned		Baseline 2015/16: Average % of highest 10 districts: 90.8
	2.1.a) % point reduction in gap between the average SBA delivery of the bottom 10 and top 10 districts (for MY1, MY2)	**Achieved**		1.3	Annual data will be available by October 2018					Average % of lowest 10 districts: 18.4 Percentage difference: 72.3
			Source							
			HMIS							
	2.1.b) % point reduction in gap between the average SBA delivery of the bottom 10% and top 10% of local government (for MY3, MY4)	**Planned**	Not applicable	No milestone planned	No milestone planned	Establish baseline for Local Governments	5	No milestone planned		
		Achieved								

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			Source								
			HMIS								
OUTCOME 3	**Outcome Indicator 3.1**		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**		For Province and Local Government, baseline and targets will be set at the end of FY 2017/18	Baseline data for Central level accessed from TABUCS on 10 Aug 2017
Improved governance and accountability of the health sector at the three levels of government that leaves no one behind	% of allocated health budget expended at central, provincial and local levels										
	3.1a) Federal government	**Planned**	83.1	No milestone planned	85	87	88	No milestone planned			
		Achieved		93.9	Annual data will be available by October 2018						
			Source								
			AWPB, TABUCS, FMR								
	3.1b) Provincial government	**Planned**	Not applicable	No milestone planned	No milestone planned	TBC	TBC by year 2	No milestone planned			
		Achieved		Not applicable	Not applicable						
			Source								
			AWPB, TABUCS, FMR								
	3.1c) Local government	**Planned**	Not applicable	No milestone planned	No milestone planned	TBC	TBC by year 2	No milestone planned			
		Achieved		Not applicable	Not applicable						
			Source								
			AWPB, TABUCS, FMR								
INPUTS (£)	**DFID (£)**		**Govt (£)**		**Other (£)**		**Total (£)**	**DFID SHARE (%)**			
INPUTS (HR)	**DFID (FTEs)**										

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OUTPUT 1	Output Indicator 1.1		Baseline Value (Mid July 2016-Mid July 2017)	Milestone Y1 (Mid July 2016- Mid July 2017)	Milestone Y2 (Mid July 2017-Mid July 2018)	Milestone Y3 (Mid July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target(Mid July 2020-Dec 2020)	Assumptions	
Evidence based policies and guidelines developed in the federal context endorsed by the respective authorities in FMoHP	% of local governments adhering to guidelines on health structure in federal context	**Planned**	Not applicable	No milestone planned	No milestone planned	50	75	No milestone planned	Health structures in federal context will be defined in year 1	
		Achieved		Not applicable	FMoHP has submitted the proposed health structures in federal context to the Ministry of Federal Affairs and General Administration for endorsement in May 2018. This is expected to be finalised by July 2018.					
		Source								
		FMoHP report on organization restructuring in federal context								

	Output Indicator 1.2		Baseline Value (July 2015 - July 2016)	Milestone Y1 (1 July 2016- 30 June 2017)	Milestone Y2 (1 July 2017-30 June 2018)	Milestone Y3 (1 July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)		
	Number of priority health policies, strategies and guidelines endorsed by FMOHP									
	1.2a) Policies	**Planned**	FMoHP priorities set for Year 1 & 2	1 (Partnership in Health)	1 (AMR)	To be determined based on FMoHP priority	To be determined based on FMoHP priority	To be determined based on FMoHP priority		

	Achieved		1 (Policy on Partnership in Health drafted. The partnership issues are included in the revised National Health Policy)	1 AMR is included in the revised National Health Policy (draft) developed with NHSSP support.				
	Source							
	FMoHP endorsed policies, strategies and guidelines							
1.2b) Strategies	**Planned**	FMoHP priorities set for Year 2	No milestone planned	1 (GESI)	To be determined based on FMoHP priority	To be determined based on FMoHP priority	To be determined based on FMoHP priority	
	Achieved		Not applicable	1 Health Sector GESI Strategy developed and submitted to FMoHP with NHSSP support				
	Source							
	FMoHP endorsed policies, strategies and guidelines							
1.2c) Guidelines	**Planned**	FMoHP priorities set for Year 2	No milestone planned	1 (National Standard Treatment Guideline)	To be determined based on FMoHP priority	To be determined based on FMoHP priority	To be determined based on FMoHP priority	

	Achieved		Not applicable	5 Development of NSTG is awaiting finalisation of Basic Health Package. 1. Guideline for handover of health facilities to the local governments developed and executed. 2. Health Sector AWPB Preparation Guideline for Local Level 3. SoP of Procurement Management Facilitation Handbook for Local Level; 4. Electronic Government Procurement Handbook for Local Level. 5. Health infrastructure design and construction guidelines (Volume 2 of NHIDS 2017)					

Source
FMoHP endorsed policies, strategies and guidelines

Output Indicator 1.3		**Baseline (Mid July 2015-Mid July 2016)**	**Milestone 1 (1 July 2016- 30 June 2017)**	**Milestone 2 (1 July 2017-30 June 2018)**	**Milestone 3 (1 July 2018-June 2019)**	**Milestone 4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	Minimum service standards for primary hospitals will be updated in line with the standards of IIDP 2017 in year	Year 2: The new structure of facilities is not implemented yet.
% of public hospitals implementing the	**Planned**	Not applicable	No milestone planned	No milestone planned	50	70	100		

		Baseline	Milestone 1	Milestone 2	Milestone 3	Milestone 4	Target		
minimum service standards bi-annually in learning lab sites	**Achieved**		Revision of minimum service standards of primary hospitals in progress.	MSS revised for primary hospitals; and MSS developed for secondary and tertiary level hospitals				1.	
	Source								
	Updated Minimum Standards for primary hospitals, NHSSP periodic progress reports								
Output Indicator 1.4		**Baseline (Mid July 2015-Mid July 2016)**	**Milestone 1 (1 July 2016- 30 June 2017)**	**Milestone 2 (1 July 2017-30 June 2018)**	**Milestone 3 (1 July 2018-Mid July 2019)**	**Milestone 4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	OCAT will be designed, adopted and the first round of assessment completed in year 2.	
% of FMoHP entities met actions recommended from OCAT as per the plan	**Planned**	Not applicable	No milestone planned	No milestone planned	100	100	100		
	Achieved			The NHSSP is exploring suitable tools and the process of OCAT used in other countries for adaptation in the local context. This will be shared with the FMoHP once the health structures are finalised in the federal context.					
	Source								
	OCAT progress report, NHSSP periodic progress reports								
Output Indicator 1.5		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**		
% of agreed actions in Joint Consultative Meeting (JCM) completed timely	**Planned**	JCM action monitoring mechanism does not exist	No milestone planned	100	100	100	100		

		Achieved		Not applicable	100					

IMPACT WEIGHTING (%)		**Source**	**RISK RATING**
		JCM note for record	

INPUTS (£)	**DFID (£)**		**Govt (£)**		**Other (£)**		**Total (£)**	**DFID SHARE (%)**

INPUTS (HR)	**DFID (FTEs)**	

OUTPUT 2	**Output Indicator 2.1**			**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	**Assumptions**
Financial management capacity strengthened by supporting the development, implementation and monitoring of Financial Management Improvement Plan (FMIP)	% of FMoHP spending units conducting internal audit in line with the internal audit improvement plan (IAIP)		**Planned**	IAIP does not exist	Milestone not planned	Milestone not planned	30	50	No milestone planned	IAIP will be finalised and implemented in year 1.
			Achieved			FMoHP has finalised IAIP and sent to FCHGO. Implementation monitored by PFM committee				
			Source							
			OAG Annual Report							

	Output Indicator 2.2			**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	Revised eAWPB and TABUCS are in line with the upcoming legal and system frameworks.	Baseline: Current eAWPB is not fully used and needs to be updated to include planning at local, provincial and federal level.
	Number of FMoHP officials trained on									eAWPB and TABUCS will be revised/ updated in year 1	Removed the target of 2.2a (training on e-AWPB) from 2018 onward. Since we have developed eAWPB as an integral part of TABUCS we will provide 'one training' which is included in 2.2b
	2.2a) Revised eAWPB		**Planned**	Not applicable	No milestone planned	100	150	200	No milestone planned		
			Achieved		Not applicable	109				The figures in	

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			Baseline Value (Mid July 2016-Mid July 2017)	Milestone Y1 (Mid July 2016-Mid July 2017)	Milestone Y2 (Mid July 2017-Mid July 2018)	Milestone Y3 (Mid July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)		
		Source							milestones and targets are cumulative.	(updated TABUCS). This shows that systems are now integrated and integrated training to the accountants and planners are planned.
		Health sector eAWPB, Training completion report								
	2.2b) Updated TABUCS	**Planned**	Not applicable	No milestone planned	100	150	200	No milestone planned		
		Achieved		156	126					
		Source								
		Health sector eAWPB, Training completion report								
	Output Indicator 2.3		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**		
	% of FMoHP spending units having no Recorded Audit Observations	**Planned**	30	No milestone planned	32	34	37	No milestone planned		
		Achieved		19.1 (Of the total 307 FMoHP spending units, 59 units reported to have no recorded audit observations)	The audit reports that show the 'Recorded Audit Observations' will be available by April 2019.					
IMPACT WEIGHTING (%)		**Source**							**RISK RATING**	
		OAG Annual Report								

INPUTS (£)	DFID (£)		Govt (£)		Other (£)		Total (£)	DFID SHARE (%)	
INPUTS (HR)	DFID (FTEs)								

OUTPUT 3	**Output Indicator 3.1**		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	**Assumptions**

Procurement capacity enhanced by implementing Procurement Improvement Plan (PIP) that results in improved procurement of drugs, medical supplies and equipment that are of good quality	% of procurement contracts awarded against Consolidated Annual Procurement Plan (CAPP)										The decrease in % is due to dropping of many procurement packages in 2017-18. That is resulted due to many items including equipment were added in CAPP of 2016-17 at the end of third Quarter (February-March), the contracts of which were awarded around June-July. Therefore, the CAPP of 2017-18 carried the payment liability of previous CAPP. That is also reason of no equipment procured in 2017-18 (OP 3.2b).
		Planned	48	No milestone planned	50	60	70	No milestone planned		
		Achieved		60 (Out of 176 procurement contracts in CAPP, a total of 106 contracts were signed as of mid-July 2017)	56.78					
		Source								
		LMD Record on CAPP (Baseline taken from NHSS 2015-20, RF)								
	Output Indicator 3.2		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	Timely monitoring of progress by PFM and CAPP monitoring committees.	
	% procurement tender completed adhering with specification bank for									
	3.2a) Free drugs	**Planned**	Standard specification bank is in the process of revision	No milestone planned	85	90	95	No milestone planned		
		Achieved		FMoHP has endorsed and published the standard specification for 105 free essential drugs.	100					
		Source								
		LMD Report on procurement of free drugs and essential equipment, Specification Bank								
	3.2b) Essential equipment	**Planned**	Standard specification bank revised	No milestone planned	75	85	90	No milestone planned		

			Baseline Value (Mid July 2016-Mid July 2017)	Milestone Y1 (Mid July 2016-Mid July 2017)	Milestone Y2 (Mid July 2017-Mid July 2018)	Milestone Y3 (Mid July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)		
		Achieved		DoHS has initiated the process of revising the standard specification for 1088 medical equipment.	No essential equipment procured					
		Source								
		LMD Report on procurement of free drugs and essential equipment, Specification Bank								
	Output Indicator 3.3		Baseline Value (Mid July 2016-Mid July 2017)	Milestone Y1 (Mid July 2016-Mid July 2017)	Milestone Y2 (Mid July 2017-Mid July 2018)	Milestone Y3 (Mid July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	Procurement clinic will be established in Year 1.	
	% of responses among the cases registered in procurement clinic	Planned	NA	No milestone planned	50	60	70	No milestone planned		
		Achieved		Procurement clinic has been established at LMD, DoHS.	100				**RISK RATING**	
		Source								
		LMD report on procurement clinic								

INPUTS (£)	DFID (£)		Govt (£)		Other (£)		Total (£)	DFID SHARE (%)		

INPUTS (HR)	DFID (FTEs)									

	Output Indicator 4.1		Baseline Value (Mid July 2016-Mid July 2017)	Milestone Y1 (Mid July 2016-Mid July 2017)	Milestone Y2 (Mid July 2017-Mid July 2018)	Milestone Y3 (Mid July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	**Assumptions**	
OUTPUT 4										
FMoHP expands access to RMNCAH and nutrition services, especially to underserved groups	Number of public CEONC sites with functional caesarean section service	Planned	75	No milestone planned	78	81	84	No milestone planned	The figures in milestones and targets are cumulative.	
		Achieved		63	Annual data will be available by October 2018					

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		Source							
		HMIS							

Output Indicator 4.2		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**		
Number of current users of: (Disaggregated by provinces and ecological region)									
4.2a) IUCD and Implant	**Planned**	420,715	No milestone planned	516,998	604,365	679,979	No milestone planned		
	Achieved		463,195	Annual data will be available by October 2018					
	Source								
	HMIS								
4.2b) IUCD	**Planned**	169,299	No milestone planned	183,533	197,055	209,901	No milestone planned		
	Achieved		175,593	Annual data available by October 2018					
	Source								
	HMIS								
4.2c) Implant	**Planned**	251,416	No milestone planned	333,466	407,310	470,078	No milestone planned		
	Achieved		287,602	Annual data will be available by October 2018					
	Source								
	HMIS								
Output Indicator 4.3		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**		OCMC Status update report published on March 2018' shows that 8958 people were served by OCMC from October 2013 to mid-July

		Baseline Value	Milestone Y1	Milestone Y2 (Mid July 2017-Mid July 2018)	Milestone Y3	Milestone Y4	Target		
	Number of people served by One Stop Crisis Management Centres (OCMC)	**Planned**	3,480	No milestone planned	4,320	5,160	5,760	No milestone planned		2017. Annual disaggregation is not available in the system. Now the system has been established to generate the yearly data.
		Achieved			Annual data will be available by August 2018					
	Source									
	OCMC reports									

Output Indicator 4.4		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	
Number of women benefited from Aama programme (disaggregated by ecological region and Province)	**Planned**	315,355	No milestone planned	321,356	327,355	333,355	No milestone planned	
	Achieved		291,711	Annual data will be available by October 2018				
Source								
FHD record, HMIS, TABUCS								

Output Indicator 4.5		**Baseline Value (Mid July 2016-Mid July 2017)**	**Milestone Y1 (Mid July 2016-Mid July 2017)**	**Milestone Y2 (Mid July 2017-Mid July 2018)**	**Milestone Y3 (Mid July 2018-Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	Nutrition component of SBA training manual will be revised by year 2
Number of SBA trained using revised SBA training manual on nutrition	**Planned**	Not applicable	No milestone planned	No milestone planned	400	600	300	
	Achieved		SBA training manual, including the nutrition, is in process of revision					
Source								
Revised SBA training manual, training completion report, FHD and NHTC record								

IMPACT WEIGHTING (%)	**Output Indicator 4.6**		**Baseline (Mid July 2015-Mid July 2016)**	**Milestone 1 (1 July 2016- 30 June 2017)**	**Milestone 2 (1 July 2017-30 June 2018)**	**Milestone 3 (1 July 2018-Mid July 2019)**	**Milestone 4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	Two innovative interventions will be developed and implemented in year 1 and 2

			Baseline Value	Milestone Y1	Milestone Y2	Milestone Y3	Milestone Y4	Target		
	Number of innovative interventions evaluated and disseminated	**Planned**	NA	No milestone planned	No milestone planned	No milestone planned	2	No milestone planned		
		Achieved		Not applicable	Innovative interventions are in the process of development					
	Source								**RISK RATING**	
	Evaluation report									

INPUTS (£)	**DFID (£)**			**Govt (£)**		**Other (£)**		**Total (£)**	**DFID SHARE (%)**	

INPUTS (HR)	**DFID (FTEs)**									

OUTPUT 5	**Output Indicator 5.1**		**Baseline Value (July 2015 - July 2016)**	**Milestone Y1 (1 July 2016- 30 June 2017)**	**Milestone Y2 (1 July 2017-30 June 2018)**	**Milestone Y3 (1 July 2018- Mid July 2019)**	**Milestone Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	**Assumptions**	
Availability and use of evidence is improved at all levels	% of local governments in the learning lab sites using equity monitoring dashboards based on HMIS data	**Planned**	Not applicable	No milestone planned	No milestone planned	50	80	100	Dashboard will be developed in year 1 HMIS is estimating the target population for 753 local governments. Equity dashboard will be generated based on the estimated target population by June 2018.	
		Achieved			Equity monitoring dashboard based on HMIS data has been developed and published in FMOHP website. The number of local governments using the dashboard will be monitored from August 2018					
	Source									
	HMIS									

Output Indicator 5.2

% of government health facilities achieving benchmark on RDQA in LL sites		Baseline Value (July 2015 - July 2016)	Milestone Y1 (1 July 2016- 30 June 2017)	Milestone Y2 (1 July 2017-30 June 2018)	Milestone Y3 (1 July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	RDQA benchmark will be set in Year 1.
	Planned	RDQA benchmark not set	No milestone planned	No milestone planned	20	50	80	
	Achieved		Not applicable	Web-based RDQA developed. This will set a benchmark and will be used from July 2018.				
	Source							
	NHSSP periodic progress report, review report of LL sites							

Output Indicator 5.3

Number of assessments conducted on priority programme areas and results shared with stakeholders		Baseline (Mid July 2015-Mid July 2016)	Milestone 1 (1 July 2016- 30 June 2017)	Milestone 2 (1 July 2017-30 June 2018)	Milestone 3 (1 July 2018-Mid July 2019)	Milestone 4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)		In agreement with DFID, the assessment of inter-facility free referral support is postponed for 2018/19
	Planned	Not applicable	No milestone planned	No milestone planned	3 (Free referral system, OCMC and Social Audit)	No milestone planned	No milestone planned		
	Achieved								
	Source								
	Assessment reports								

Output Indicator 5.4

Number of policy briefs		Baseline (Mid July 2015-Mid July 2016)	Milestone 1 (1 July 2016- 30 June 2017)	Milestone 2 (1 July 2017-30 June 2018)	Milestone 3 (1 July 2018-Mid July 2019)	Milestone 4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	Themes will be determined based on FMoHP priorities
	Planned	na	1	3	4	5	2	

	produced based on FMoHP priorities and shared to inform policy	**Achieved**		1 Policy brief on service utilization by caste/ethnic groups	4 Policy briefs on: 1. ANC service satisfaction 2. Inequalities in use of CS service 3. MPDSR strengthening in federal context 4. Policy gaps and recommendations							
IMPACT WEIGHTING (%)		**Source**										
		Policy briefs produced annually									**RISK RATING**	
INPUTS (£)	**DFID (£)**		**Govt (£)**		**Other (£)**			**Total (£)**	**DFID SHARE (%)**			
INPUTS (HR)	**DFID (FTEs)**											
OUTPUT 6	**Output Indicator 6.1**		**Baseline (Mid July 2015-Mid July 2016)**	**Milestone 1 (Mid July 2016-Mid July 2017)**	**Milestone 2 (Mid July 2017-Mid July 2018)**	**Milestone 3 (Mid July 2018-Mid July 2019)**	**Milestone 4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	**Assumptions**			
FMoHP has the capacity to ensure health infrastructure is resilient to environmental shocks	Number of health infrastructure related policies endorsed by FMoHP											
	6.1a) Policies	**Planned**	Health infrastructure specific policy does not exist	No milestone planned	1 (Facility prioritization and selection)	1 (Health sector infrastructure development, upgrade and maintenance)	No milestone planned	No milestone planned	FMoHP priorities for retrofitting and rehabilitation continue, and are not diverted by the move towards federalism			

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	Achieved		Not applicable	1. Policy on 'Nepal Health Infrastructure Development Standards 2017. 2. Policy on 'Health facility prioritization and categorization' (Vol. 1 of NHIDS 2017) 3. Policy on ' Health facility construction and upgrading' (Section 6 of Health Facility Design and Construction Guidelines; Vol 2 of NHIDS 2017) 4. Policy on 'Land Selection Criteria' (Section 5 of Health Facility Design and Construction Guidelines; Vol 2 of NHIDS 2017)			
	Source						
	Health infrastructure related policies and standards endorsed by FMoHP						
6.1b) Standards	**Planned**	NA	1 (Retrofitting and Rehabilitation)	No milestone planned	No milestone planned	No milestone planned	No milestone planned
	Achieved		1 Nepal health infrastructure earthquake retrofitting, and rehabilitation standards submitted to DUDBC	Process defined, and necessary steps identified to get legal status of the Nepal health infrastructure earthquake retrofitting and rehabilitation standards from concerned authorities			
	Source						
	Health infrastructure related policies and standards endorsed by FMoHP						

Output Indicator 6.2		Baseline Value	Milestone 1 (Mid July 2016-Mid July 2017)	Milestone 2 (Mid July 2017-Mid July 2018)	Milestone 3 (Mid July 2018-Mid July 2019)	Milestone 4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	Move to Federalism does not result in major staff redeployment	
Number of people trained in policy development and technical skills related to resilient design, construction and maintenance (disaggregated by government staff and construction workers)									
6.2a) Government staff	Planned	Not applicable	No milestone planned	80	90	90	No milestone planned		
	Achieved		12	140					
	Source								
	Training completion reports; Annual Impact Evaluation Reports								
6.2b) Construction sector staff	Planned	Not applicable	No milestone planned	No milestone planned	50	100	No milestone planned		
	Achieved								
	Source								
	Training completion reports; Annual Impact Evaluation Reports, Participant's list of FMOHP, DUBDC								
Output Indicator 6.3		Baseline Value (Mid July 2016-Mid July 2017)	Milestone Y1 (Mid July 2016-Mid July 2017)	Milestone Y2 (Mid July 2017-Mid July 2018)	Milestone Y3 (Mid July 2018-Mid July 2019)	Milestone Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	Government continues to prioritize roll-out of resilient health facilities with funds allocated and effective programme management.	Hazard resilience criteria need to be updated in line with the Integrated Infrastructure Development Plan 2017
% of new government health facilities designed adhering to hazard resilience criteria (structural and functional)	Planned	Not applicable	No milestone planned	100	100	100	100		
	Achieved			Annual data will be available by end of July 2018					
	Source								
	Completion report from NHSSP /consultant. Handover and completion certificate will be in 4th years. Signed contracts, payment reports and completion certificates								

	Output Indicator 6.4		Baseline (Mid July 2015- Mid July 2016)	Milestone 1 (1 July 2016- 30 June 2017)	Milestone 2 (1 July 2017-30 June 2018)	Milestone 3 (1 July 2018- Mid July 2019)	Milestone 4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	Timely agreement between FMoHP and DFID on hospitals to be retrofitted, timely release of fund and procurement of contractor. Design and preparation of tender documents will be completed in year 1; and contract awarded and mobilized in year 2.
	Number of health facilities/hospitals retrofitted or rehabilitated with support from DFID's earmarked Financial Aid	Planned	Retrofitting of two priority hospitals proposed using DFID FA	No milestone planned	No milestone planned	No milestone planned	2	No milestone planned	
		Achieved			Design for retrofitting of two priority hospital and preparation of procurement document has been completed and submitted to DUDBC and DFID on Feb 2018.				
IMPACT WEIGHTING (%)		Source							
		Standards and retrofitting completion certificate from FMoHP							**RISK RATING**
INPUTS (£)	DFID (£)		Govt (£)		Other (£)		Total (£)	DFID SHARE (%)	

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Appendix 2 Payment Deliverables

PD number	PD descriptions	PD submission date	Invoice date	Status
18	Gender and equity strategy updated by FMoHP	June-18	July-18	PD submitted
30	Exit and sustainability plan	May-18	June-18	Approved
31	Report on policy stocktake for the health sector which identifies policy gaps with recommendations	April-18	May-18	Approved
33	RQDA tools for different levels developed and rolled out by FMoHP	April-18	May-18	Approved
34	DUDBC Technical Skills Development Training Design and Implementation	April-18	May-18	Approved
35	FMOHP and DUDBC design and tender training complete	April-18	May-18	Approved
36	Quarterly reports 3 Jan - March	April-18	May-18	Approved
37	Consolidated Annual Procurement Plan (CAPP) produced within agreed timeframe, incorporating relevant information from all DOHS divisions each year	June-18	July-18	PD submitted
38	Policy Development Training Impact Evaluations implemented	May-18	June-18	Approved
39	Technical Skills Training Impact Evaluation	May-18	June-18	Approved

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APPENDIX 3 RISK MATRIX ASSESSMENT

NHSSP Risk Matrix Assessment (Updated on 20 July 2018)

General Health TA 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
		Likely-hood	Impac t			Likely-hood	Impact						
	Contextual												
R1	Weak coordination between development partners and FMOHP.	Medium	Medium	🟨	NHSSP Team support FMOHP to work with development partners; Team Leader supports the DFID in coordination	Low	Medium	🟩	Yes	Yes	Continue to Facilitate FMOHP and development partners for the implementation and monitoring of transition plan and agreed action points	Team Leader/Strategic adviser	Treat
	Political												
R2	Inadequate political will to drive key reform processes for example procurement reform	Medium	High	🟥	NHSSP advisors work closely with senior staff in FMOHP to advocate, build understanding and buy in to planned reform processes.	Medium	Medium	🟨	Yes	Yes	Pace of changes will be carefully planned. Regular meeting of CAPP monitoring committee.	Team Leader /Public Finance Management Lead Adviser/Strategic Advisor	Treat

R3	Uncertainty over the sub National structure; may affect programme implementation	High	High		NHSSP Advisors are supporting the FMOHP to develop a health sector transition plan, informed by best available evidence. The Strategic Adviser is working closely with FMOHP and providing regular updates and advice to NHSSP adviser for on-going work.	High	High		Yes	Yes	NHSSP team will work closely with FMOHP and take flexible and adaptive approaches	Strategic Adviser and HPP Team Lead	Treat
R4	Insufficient capacity of local government in Health sector management may affect timely delivery of quality health service	High	High		Capacity building of local government including orientation on programme implementation guides and planning support in coordination with all supporting partners development partners	High	Medium	Y	Yes	Yes	Regular engagement with the FMOHP in planning processes to recognise if changes need to be made	Concerned Advisers	Treat
R5	Competing priorities at the local level may result less attention to public health interventions	High	High		Support FMOHP in advocating for health and Capacity building of local & provincial government including orientation on programme implementation guides and planning support in coordination with all supporting partners development partners	High	Medium	Y	yes	Yes	NHSSP will support FMOHP in developing minimum service standard and implement HQIP at different level health facilities.	Service Delivery Adviser	Treat

R6	Change in FMOHP structure may affect the relationship management with the counterpart	Medium	Medium		NHSSP advisers will engage with relevant department/units in strategic issues in terms of planning and implementation.	Low	Low				NHSSP will participate in induction processes in the relevant department.	All advisers	Treat
	Programmatic												
R7	*Routine reporting system may be affected due to structural change at local level*	Medium	High		*Engage with FMOHP to provide onsite coaching to Local Government for electronic reporting of HMIS in DHIS2 platform*	Medium	Low		Yes	Yes	*NHSSP IS engage with FMOHP to develop, AND MONITOR implementation plan*	*EA adviser*	Treat
R8	*MOHP priorities/demands are changeable due to external and internal pressures which deflects TA from sector targets*	High	Low		*NHSSP team is and will continue to closely collaborate with key counterparts to ensure a shared understanding of work plans. NHSSP is being flexible and responsive to make certain that adapting plans will have limited impact on overall quality of delivery of the TA.*	Low	Low		Yes	Yes	*NHSSP team will work closely with FMOHP colleagues and remain flexible and strategic*	*Concerned Advisers*	Treat

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R9	Evolving priorities of FMOHP means that less attention is paid to NHSSP supported activities.	Medium	Medium		NHSSP will engagement with FMOHP and provide flexible and responsive support within the scope of NHSSP	Low	Low		Yes	Yes	NHSSP team will work with other partners for resource leveraging	Concerned NHSSP Advisers	Treat
R10	High staff turnover in key government positions limits the effectiveness of capacity enhancement activities with FMOHP and DOHS.	Medium	Medium		NHSSP adopts capacity enhancement at institutional and system level besides individual capacity enhancement so that institutional memory remains in place	Medium	Low		Yes	Yes	NHSSP works with different cadre of Health Staff.	Concerned NHSSP Advisers	Tolerate
R11	Health workers are not able to complete training/engage in programme activities due to workload, and/or frequent staff turnover, limiting effectiveness of activities to improve QoC.	Low	Low		Capacity enhancement to improve quality of care will be planned with District Health Offices and facility managers; refresher trainings will be offered on a regular basis; focus is on building capacity and the functionality of the facility, not just training.	Low	Low		Yes	Yes	NHSSP will actively encourage on site coaching / training and support training needs identification	Concerned NHSSP Advisers	Tolerate
	Climate & environmental												
R12	Further earthquakes, aftershocks, landslides or flooding reverse progress made in meeting needs of population through disrupting delivery of healthcare services	Medium	High		Continue to monitor situation reports/GoN data; ensure programme plans are flexible, and re-plan rapidly following any further events. Comprehensive	Medium	Medium		Yes	Yes	NHSSP will support FMOHP to update disaster preparedness plan	Concerned NHSSP Advisors	Tolerate

					security guidelines will be put in place for all staff.								
	Financial												
R13	The TA programme has limited funds to support the strengthening of major systems components such as HR systems.	Medium	Low		Support policy and planning in the FMOHP. Engage with other development partners who are supporting related areas.	Low	Low		Yes	Yes	Continue to work with FMOHP and WHO and other partners who may have financial resources to support these	Advisers	Treat
R14	Financial Aid is not released for expected purposes.	Medium	High		Planning and discussions with FMOHP and Ministry of Finance. Health Financing TA will support the government in managing release of Financial Aid.	Low	Medium		Yes	Yes	Continue with regular and quality monitoring of FMR and regular meeting of Public Finance Management committee	Lead Public Finance Management Adviser and Public Finance Management adviser	Treat
R15	Financial management capacity of subcontracted local partners is low.	Low	Medium		Carry out a due diligence assessment of major partners at the beginning of the contract.	Low	Low		Yes	Yes	Carry out regular reviews of progress against agreed work plans and budgets.	Deputy Team Leader	Treat
R16	Weak Public Finance Management system leads to fiduciary risk	High	High		To work actively to support the FMOHP in strengthening various aspects of Public Finance Management via an updated FMIP, regular meeting of Public Finance Management committee, update the	Medium	medium		Yes	Yes	Continue to monitor risks and mitigate through periodic update of FMIP, CAPP, and PIP, through the Public Finance Management and CAPP monitoring committee. Engaging FMOHP Secretary, FCGO and	Lead public Finance Management Adviser and Sr Procurement Adviser	Treat

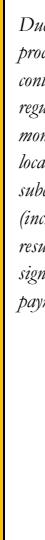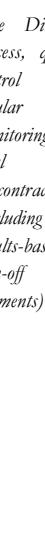| Risk No	Risk	Gross Risk		Risk Factor RAG rated	Current controls	Net Risk		Risk Factor RAG rated	Net Risk Acceptable?		Additional controls / planned actions	Assigned manager / timescale	Actions
					internal control guideline and add cash advance module in TABUCS to reduce fiduciary risk and the formulation of procurement improvement plan (PIP) and establishment of a CAPP monitoring committee						*PPMO.*		
R17	*Further devaluation of the £, reduces the value of FA and TA commitment.*	*Medium*	*Medium*		*Monitor exchange rates and planned spend against these*	*Medium*	*Low*		*Yes*	*Yes*	*Strengthen regular monitoring and verification of workplans against budgets*	*Team Leader/Deputy Team Leader*	*Tolerate*

Infrastructure 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												

	Political												
R1	*Lack of buy-in from senior government stakeholders on revising and adopting policies, codes and standards, and drive key reform processes for example procurement reform*	Medium	*Medium*		*Infrastructure Advisors work closely with senior staff in FMOHP, DUDBC and NRA to build ownership of proposed policies, codes and standards and buy in to planned reform processes. Pace of planned changes will be carefully considered.*	*Medium*	*Low*		*Yes*	*Yes*	*NHSSP will work closely with the Health Building Construction Central Coordination and Monitoring Committee*	*Lead Infrastructure Advisor*	*Treat*
R2	*The political process of federalism is complete; However, the creation of sub National structures, with allocations of powers, finance and staff is a long process. This delay will limit the rate and scale of improvements in health infrastructure.*	*High* *High*	*Medium* *Medium*		*The Team will work closely with FMOHP and DUDBC in responding to federalism, providing support in adapting health infrastructure plans and targeted capacity enhancement as the decentralisation process becomes clear.*	*High*	*medium*		*Yes*	*Yes*	*We will coordinate with other initiatives under NHSSP (such as Learning Labs) to develop improved models of service delivery under federalism*	*Team Leader*	*Tolerate*

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R3	Lack of clarity over roles and responsibilities of FMOHP, DUDBC and other related departments in health infrastructure	Medium	Medium		Team will support clarification of the roles and responsibilities of departments, and NRA / PCU.	Medium	Medium		Yes	Yes	NHSSP will build links and regular communication between FMOHP and DUDBC, and take forward recommendations of institutional review	Lead Infrastructure Advisor	Transfer
	Programmatic												
R4	MOH and DUDBC priorities and requests for non-planned TA draw advisors away from agreed workplan and exhaust available resource	High	Low		Close collaboration with key counterparts in the mobilisation phase of the TA resulting in shared understanding of work plans.	Medium	Low		Yes	Yes	We will regularly review workplans with counterparts and adapt flexible approach.	Lead Infrastructure Advisor	Treat

R5	High staff turnover in key government positions limits effectiveness of capacity enhancement activities with FMOHP and DUDBC.	Medium	Medium		NHSSP capacity enhancement approach will focus on institutionalising approaches and systems, not rely on individual capacity building to ensure sustainability				Yes	Yes	NHSSP will engage with different level staff to strengthen the institutionalisation processes.	Lead Infrastructure Advisor	Tolerate
R6	Local construction companies not responsive/engaged in capacity building activities.	Low	Medium		Our team has established working relationships with local companies, design of capacity building will respond to identified needs.	Low	Low		Yes	Yes	Capacity building will be part of the contractual arrangement.	Seismic Resilience Advisor	Treat
	Climatic and environmental												
R7	Further earthquakes, aftershocks, landslides or flooding reverse progress made in rehabilitation of existing health infrastructure.	Medium	High		Continue to monitor situation reports/GoN data; ensure programme plans are flexible, and re-plan rapidly following any further events.	Medium	Medium Medium		Yes	Yes	Health and Safety guidelines to be developed and shared with staff and to ensure all consortium staff are covered by the relevant insurance scheme.	Lead Infrastructure Adviser	Tolerate

ID	Risk												
R8	Retrofitting and completed in advance major seismic event; retrofitting does not prevent significant damage if there is another earthquake	Medium	High	🟥	Insurance will be in place for construction and retrofitting work to cover damage during such events. There will be 1-year defect liability period for the contractor for any defects against the specification to make it correct.	Medium	Medium	🟧	Yes	Yes Yes	NHSSP will ensure that retrofitting work will comply with building codes and work is completed as early possible	Lead Infrastructure Advisor	Tolerate
	Financial												
R9	Financial Aid is not released for expected purposes.	Medium	High	🟥	Joint planning and early discussions with FMOHP and Ministry of Finance.	Low	Medium	🟨	Yes	Yes	public Finance Management and Health Infrastructure teams will continue to support the government in managing release of Financial Aid.	public Finance Management Adviser	Treat
R10	Financial management capacity of subcontracted local partners is low.	Medium	Low	🟨	We will carry out a due diligence assessment of major partners at the beginning of the contract.	Low	Low	🟧	Yes	Yes	We will carry out regular reviews of progress against agreed work plans and budgets.	Deputy Team Leader	Treat

R11	*Risk of fraud with locally contracted construction companies.*	*Medium*	*Medium*		*Due Diligence process, quality control and regular monitoring of local subcontracts (including results-based sign-off and payments)*	*Low*	*Low*		*Yes*	*Yes*	*Procurement processes, construction risk management and monitoring will be strengthened*	*Lead Infrastructure Adviser*	*Treat*
R12	*Further devaluation of the £ reduces the value of FA and TA commitment.*	*Medium*	*Low*		*Monitor exchange rates and planned spend against these*	*Low*	*Low*		*Yes*	*Yes*	*Strengthen regular monitoring and verification of work plans against budgets*	*Team Leader/Deputy Team Leader*	*Tolerate*
R13	*Disagreements over land allocations at Bhaktapur Hospital may cause delay in retrofitting work*	Medium	*High*		*NHSSP team will seek to promote resolution between the principal parties*	*Medium*	*Medium*		*Yes*	*Yes*	*NHSSP will work with Bhaktapur municipality to settle disputes between parties.*	*Lead Infrastructure Adviser*	*Treat*

R14	*Delay in institutional decision-making delays the tendering processes.*	High	*High*		*Strategic dialogue facilitates the decision making.*	*Medium*	*Medium*		*Yes*	*Yes*	*NHSSP will prepare all required document in advance and facilitate the early tendering processes*	*Team Leader & Lead Infrastructure Adviser*	*Treat*
	Overall risk rating	*Medium*											

Risk definitions:	
Severe	This is an issue / risk that could severely affect the achievement of one or many of the Department's strategic objectives or could severely affect the effectiveness or efficiency of the Department's activities or processes.
Major	This is an issue / risk that could have a major effect on the achievement of one or many of the Department's strategic objectives or could have a major effect on the effectiveness or efficiency of the Department's activities or processes.
Moderate	This is an issue / risk that could have a moderate effect on the achievement of one or many of the Department's strategic objectives or could have a moderate effect on the effectiveness or efficiency of the Department's activities or processes.
Minor	This is an issue / risk that could have a minor effect on the achievement of one or many of the Department's strategic objectives or could have a minor effect on the effectiveness or efficiency of the Department's activities or processes.

Risk Categories:

Risk category	NHSSP interpretation
Tolerate	Risk beyond programme control, even with mitigation strategy in place, but not significant enough to disable the planned work in its status, even if it can affect overall end results
Treat	Risk NHSSP has means and plans to further minimise / mitigate as part of programme's key objectives
Transfer	Risk NHSSP identifies other stakeholders are better placed to minimise / mitigate further
Terminate	Risk beyond NHSSP control that would render some / all of the work impossible

APPENDIX 4: VALUE FOR MONEY

Value for Money (VfM) for the DFID programs is about maximising the impact of each pound spent to improve poor people's lives. DFID's VfM framework is guided by four principles 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.

The VfM framework has been updated in June 2018 to align with the changing context of the country, and to reflect the inputs of each of NHSSP units. NHSSP has formed a VfM committee that meets every Quarter to monitor the progress against the indicators. Detailed below are the indicators that 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 £573 for international TA and £147 for national TA. The average unit cost of both international and national STTA is below the benchmark of £611 and £224, respectively. Furthermore, the average cost of this Quarter is also in line with the last year's average and compares well to the benchmark which was calculated based on Options' programmes globally and agreed by the DFID under NHSSP2.

Inter National STTA	Total (March 2017- March 2018) Year 1	Average Unit Cost (GBP) (March 2017 – March 2018) Year 1	Total (April – June 2018) Q1, Y2	Average Unit Cost (GBP) (April – June 2018)
Days	233	548	56	573
Income	127, 631		32,113	
National STTA	Total (March 2017 – March 2018) Year 1	Average Unit Cost (GBP) (March 2017– March 2018) Year 1	Total (April – June 2018) Q1 Y2	Average Unit Cost (GBP) (April – June 2018)
Days	315		418	147

Income	52,195	166	61,282	

Indicator 2: % of total STTA days that are National (versus inter National)

The majority (88%) of STTA used in this Quarter are Nationals which is well above the benchmark. This Quarter witnessed substantial inputs from the National STTAs mostly for health infrastructure and GESI related works. Likewise, the international STTA days were used to provide strategic inputs to the Programme's exit and sustainability plan and exploring opportunities in innovations. The table shows that the percentage of inputs from National STTAs in this Quarter increased significantly than that of last year which fares well for this indicator.

Short Term Technical Assistance Type	In client contract budget*		Actuals Y 1 (March 2017 – March 2018)		Actuals Q1 Y2 (April – June 2018)	
	Days	%	Days	%	Days	%
Inter National TA	2291	44%	233	43%	56	12%
National TA	2942	56%	315	57%	418	88 %
TOTAL	**5233**	**100%**	**548**	**100%**	**474**	**100%**

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

Nearly one third (30%) of the budget was spent on administration and management in this Quarter. This is less than the percentage that was spent last year (34%). Likewise, there is an increase in the percentage of NHSSP expenditure in this Quarter when compared to last year. Office running and set up costs have slightly increased in this Quarter as NHSSP relocated its office to new premises to accommodate its management and infrastructure staff. Following these one-off relocation costs, the administration and management cost is expected to decrease notably in succeeding Quarters.

Category of admin / mgmt. expense:	Client budget		Actuals Y1 (March 2017 – March 2018)		Actuals Q1 Y2 April - June 2018	
	GBP	%		%	GBP	%
Office running costs (rent, suppliers, media, etc.)	88,550	2%	34,535	5%	12,003	9%

Equipment	26,063	1%	25,873	4%	1,748	1%
Vehicle purchase	120,000	3%	52,875	8%		0%
Bank and legal charges	13,110	0%	1,789	0%	249	0%
Office Set up and maintenance	29,090	1%	24,162	3%	4,489	3%
Office Support Staff	383,318	9%	75,772	11%	16,869	13%
Vehicle Running cost and Insurance	73,998	2%	10,936	2%	3,085	2%
Audit and other Professional Charges	16,000	0%	11,986	2%	5	0%
Sub-total admin / management	750,129	18%	237,928	34%	38,448	30%
Sub-total programme expenses (see below)	3,385,899	82%	455,888	66%	90,670	70%
Total	**4,136,028**	**100%**	**693,816**	**100%**	129,118	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, eight sessions of capacity enhancement trainings were conducted to 349 participants. At the National level, five training sessions were conducted to reach 209 participants. Likewise, at the local level, three training sessions were conducted to 140 participants. The unit cost per participant, per day incurred for both National and local level training is below the benchmark cost which was set during NHSSP inception.

Level of Training*	Cost per participant/day Benchmark** GBP	No. of capacity enhancement training conducted	No. of Participants Q1, Y 2 (April – June 2018)	Average Cost Per Participant/Day (GBP) Q1, Y2 (April – June 2018)
National	62	5	209	35

Local	39	3	140	15

 * 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)

VfM results: Effectiveness

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

So far, the Programme has submitted 34 payment deliverables; 32 PDs have been approved by the Government of Nepal and signed off by DFID. Two PDs: Gender and equity strategy updated by FMOHP and Consolidated Annual Procurement Plan (CAPP) are under review by DFID.

	Payment Deliverables (March 2017 – June 2018)
Total technical deliverables throughout NHSSP3	105
PDs submitted to date	34
PDs approved to date	32
Ratio %	**94%**

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APPENDIX 5: SUCCESS STORY

Impact Evaluations: NHSSP training makes an impact in Nepal

"*Your training programmes are having a real impact*"

That was the message to Ganesh Ram Nhamafuki, the Capacity Enhancement Advisor for the Nepal Health Sector Support Programme (NHSSP) when he received feedback on workshops held in Kathmandu for government staff.

Ganesh leads the Capacity Enhancement Programme, part of the NHSSP's Health Infrastructure work, which is helping to strengthen institutional capacity and skills of staff in the Ministry of Health and Population (FMOHP) and Department of Urban Development & Building Construction (DUDBC). It also focuses on sharing information
and knowledge with private sector construction contractors and professionals.

Improve delivery and design

Ganesh has designed and implemented workshops, training sessions and other activities, helping nearly 400 people to develop their skills. But without knowing the impact of these sessions, Ganesh doesn't know if it's making any difference; *"Impact evaluation exercises will become increasingly important from now on"* he said. *"I need to measure how effective these events are and look for ways to improve NHSSP delivery and design."*

To do this he commissioned Kathmandu-based companies HURDEC and Scott Wilson Nepal to carry out independent assessments of three training exercises held in November 2017 and April 2018 on 'Policy Skills Development', 'Orientation on Retrofitting and Government Procurement', and 'Planning, Design and Implementation of Multi-hazard Resistant Health Infrastructure'.

Policy skills for decision-makers

The 'Policy Skills Development' was led by NHSSP specialists in health infrastructure and experts in Nepal governance issues; Mr Balananda Poudel, a former senior civil servant and widely rated as the architect of the new Nepal federal structure, and Mr Sudip Pokheral, an adviser to the former Minister of Health and Population.

Following this training, HURDEC interviewed senior staff from FMOHP and DUDBC to find out how they found it. Everyone said they now had a better understanding of federal and sub-National government structures and roles and responsibilities that meant they were more confident in designing activities, programmes and services to cater for their operational objectives and work plan.

Technical skills for technical staff

"The skills modules are a key part of our commitment to enhance the technical expertise of government engineering and design professionals", said Ganesh. *"We need to ensure that our counterparts are familiar with new techniques of retrofitting and health facility standards, particularly those workers located in district offices."*

The NHSSP's Health Infrastructure team and Nepal government partners ran two training events covering approaches to seismic retrofitting, standards and guidelines for the construction of health infrastructure, and the Nepal government's online procurement system.

The evaluation showed government staff were very engaged – 70 per cent of the workshop participants rated the NHSSP team's approach to facility decanting as a key area of learning. The training on different forms of retrofitting was also ranked as a key area of learning by almost 50 per cent of all trainees.

Making sure that training is applied in the workplace is the main objective for any capacity enhancement exercise. Ganesh was pleased to find that more than half of the evaluation respondents said they had sought further information on retrofitting after they took part in the training. Even more exciting is that 30 per cent of participants reported that they had been assigned tasks or projects related to retrofitting after the training. They all said that the learning event helped them to overcome challenges and be more efficient in their work.

Lessons learned, moving forward

Participants were keen that these trainings should continue and be rolled-out to more technical staff in DUDBC. They felt retrofitting and procurement were key learning areas, and there was a call for more practical exercises to be introduced as part of the in-depth training. *"This kind of feedback is essential,"* said Ganesh, *"and I'll be developing ideas for hands-on training at the next round of workshops."*

Moving forward, the NHSSP Health Infrastructure team will roll out more training events to government staff, as well as briefings to private sector contractors and construction professionals. Spreading the skills of retrofitting is an essential part of NHSSP's objective to show how to make Nepal's hospitals seismically secure.

BACKGROUND

Retrofitting: Seismic retrofitting strengthens the structural integrity of the hospital buildings against earthquakes. This means reinforcing walls, floors and framework to survive in a disaster. It also includes protecting non-structural building components – such as partitions, ceilings, shelving, and utility supplies. Together, these aspects seek to ensure that service delivery will continue immediately after an earthquake.

Decanting: The Programme's retrofitting works will take place at two priority hospitals. These will remain operational throughout the construction period. 'Decanting' refers to the temporary transfer of medical services, units, wards and patients to a purpose-built facility on site, allowing work to take place in those areas. On completion, the areas are re-occupied. Decanting is a critical component of the Programme's approach to patient-centred construction and will be essential to the smooth implementation of these projects.

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