Nepal Health Sector Support Programme III

(NHSSP – III)

NHSSP Quarterly Report
January 2019 to March 2019

Disclaimer

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

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

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

CONTENTS

Precis.

This report is the seventh Quarterly update of the Nepal Health Sector Support Programme 3 covering the period from January 1st to March 31st, 2019. The health sector environment is rapidly changing due to implementation of human resource reallocations, which are proving controversial, and problems with coordination and clarity of roles within and between spheres of government. Lack of clarity and delays over budgets are also occurring. The result is that impacts are starting to be seen on service delivery.

Despite these challenges, the results of technical assistance (TA) are visible at federal and sub-national levels, including improved outcomes in service provider knowledge and decision making as a result of clinical mentoring and HQIP programmes which have shown improvements in the assessment results, as compared to the previous year, as evidenced by the higher green and yellow and lower red scores in the quality domain and signal functions readiness of CEONC services in HQIP (i3.4.1) and overall higher percentage achieved by service providers on knowledge, decision making skills and practical skills as assessment done during clinical mentoring (i3.4.2).

The NHSSP team has engaged actively with other service providers, particularly MEOR, in relation to the proposed re-shape and extension. Engagement with EDPs and other stakeholders is on-going both through membership of technical working groups (TWG), for example for developing regulations for the Public Health Service Act (PHSA) 2018 and development of standard treatment protocols. The next quarter will see an increase in activity at learning lab sites as these are now staffed. This reflects the programme's move to greater engagement at sub-national level.

The development context

The implementation of federalism in the health sector has become more visible this quarter. The federal Ministry of Health and Population (FMoHP) now has two health secretaries but at present their individual responsibilities are unclear which is delaying decision-making and having a negative impact on coordination within the MoHP and between federal and sub-national governments.

The House of Parliament endorsed the Civil Servants' Adjustment Bill (2075) in February, enabling federal government to appoint provincial chief secretaries, secretaries of provincial ministries and chief administrative officers of local governments. The published lists of civil service cadres have been highly debated and challenged by health workers' associations.

Important health sector institutions at provincial level including 35 provincial health offices have been established and started functioning. However, their operationalisation is being affected by lack of clarity of roles, staff shortages, unclear budget provision and sub-optimal communication between the federal ministry and local government and within provincial authorities. A similar lack of clarity is accompanying the annual planning and budgeting process which is currently underway.

Technical assistance

Within DFID-NHSSP, a new Team Leader has been appointed and will join in May, taking over from the current interim Team Leader who will hand-over in-country and lead the induction process. The Learning Labs (LL) are now fully staffed, with six System Strengthening Officers and a LL Coordinator now in place.

Externally, the team's support to government has led to significant progress in moving forward key policies and acts, for example through development of a consolidated draft five-year development plan for the health and population sector; and approval of guidelines for gender responsive budgeting and disability inclusive health service guidelines.

Evidence is showing the positive impact of DFID-NHSSP TA on improving service delivery, for example through the skilled birth attendance clinical mentors programme through which

880 maternal and newborn health services providers have received clinical coaching. Follow-up assessment scores show that knowledge levels, decision-making and practical skills have increased significantly.

Conclusions and strategic implications

The implementation of federalism in the health sector is starting to challenge service delivery. Practical challenges and political positioning are creating staff shortages and budget delays. This, combined with lack of institutional readiness, coordination and communication, are impacting on health system functioning. This is a critical time, which offers significant opportunities for NHSSP to provide essential support and skills strengthening. A strong basis for this assistance has been established and demonstrated through the previous years' assistance at federal level and is now in place at sub-national level particularly through the LLs. System challenges beyond the control of the programme are a concern in terms of optimising the impact of TA, but the possible extension provides a timely opportunity to re-shape support, particularly at sub-national level where the challenges but also opportunities are becoming increasingly clear.

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 **1st January to 31st March 2019.**

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. A consortium led by Options Consultancy Services Ltd with HERD, Oxford Policy Management, and Miyamoto implements the Programme. Three other DFID suppliers are actively engaged in support of the Nepal Health Sector Programme (NHSP).

Long-term technical assistance (TA) personnel are deployed either by being (a) embedded within key departments of the FMoHP, (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 Quarter.

1.2 THE DEVELOPMENT CONTEXT

As Nepal progresses with implementation of federalism, managing transition is a continued focus and priority of the government. Understanding defined roles and responsibilities and duty bearers' ability to execute functions towards state building across the three spheres of government has been a debate that stayed in the foreground in this reporting period. In support of the federalisation process, the government has developed and endorsed several policies and acts including the National Medical Education Bill, which was under significant controversy due to differing political interests for a considerable time. Human resource adjustment in the federal context is considered one of the stepping-stones towards managing federal transition and has also remained a key topic during this quarter. The House of Parliament endorsed the Civil Servants Adjustment Bill (2075) on February 2019. The bill paved the way for the federal government to appoint provincial chief secretaries, secretaries of provincial ministries and chief administrative officers of local governments. A criticism made of the bill is that federal government is trying to re-centralise power instead of giving authority and autonomy to sub-national governments to hire employees. Based on the approved act, the federal government issued the civil service adjustment process with publication of lists of civil service cadres including human resources in health. This has become a highly-debated issue, with the human resource adjustment process and the adjustment list in the health sector being challenged by several health workers' associations including medical doctors working for the government. This has led to protests by these associations, demanding readjustment of both the adjustment process and the published lists. While the FMoHP has formed a committee to address the adjustment process, continued and growing frustration among health care providers especially those working in service delivery hubs, and lack of effective coordination and communication have impacted on health system functions including service delivery. With the implementation of the existing adjustment list, few key people in the Ministry will move to their adjusted location. This will reduce institutional readiness and memory which are important for coordination and smooth management of the transition process.

This reporting period also witnessed changes in high-level leadership of the FMoHP, including the health secretary. The Ministry is now led by two secretaries which is adding to the complexity of managing health sector transition in the federal context. For example, unclear

division of responsibilities between the secretaries resulted in delays in decision making process which challenged timely coordination and communication within the federal ministry and between the federal and sub-national governments. As reported in the last quarter, the provincial health structure was revised and a number of institutions/authorities established at the provincial level (Provincial Health Directorate, Provincial Health Training Centre, Provincial Logistic Centre, Provincial Public Health Reference Lab and 35 provincial health offices). The revised structure at provincial level has started functioning but effective operationalisation of these offices is challenged due to a unclear terms of reference (ToR) and overlapping roles, limited numbers of staff, competing priorities, lack of a coordination and communication mechanism between the federal ministry, local government and within provincial authorities, and unclear budget provision, among others.

The annual planning and budgeting process began in this reporting period. The FMoHP was provided NPR 34.48 billion budget ceiling for the financial year (FY) 2019/20 to develop the annual workplan and budget for the federal functions. However, this comes with sub-optimal clarity on what basis the budget ceiling was provided to the FMoHP, and the types of interventions/activities that can be planned by the FMoHP, but which require implementing at provincial and local level.

1.3   SECTOR RESPONSE AND ANALYSIS

While the FMoHP has a number of sub-sector policies and plans that are linked to and support the ongoing federalisation process, and which are being implemented at varying degrees, the sector does lack a consolidated transition management strategic plan that takes the evolving context into account and facilitates decision making processes across the government. Despite this, several decisions are being made at each sphere of government to respond to the changing context which have implications for health governance and service delivery. The Ministry has responded to lessons learnt from the previous year's annual planning and budgeting process, for example this year the Ministry has initiated the planning process earlier, going through several consultations at sub-national level and across the divisions and centres at federal level. With successful implementation of the National Annual Review, where several authorities from federal and sub-national governments along with external development partners (EDP) and other key stakeholders reviewed the context, progress and challenges in the sector, the federal ministry has stepped up its stewardship role in strengthening transition management. Signing of an Aide Memoire with EDPs, proactive engagement in the annual planning and budgeting process, endorsement of policies and guidelines including gender-based budgeting, minimum service standards (MSS) for hospitals, support to sub-national governments in resolving a budget mismatch (i.e. staff salary), and addressing the public health emergency in Terai districts were some of the initiatives towards improved sector leadership and governance. The Ministry also started drafting acts and guidelines as per the public health act, with a number of TWGs formed by the Ministry to lead this process.

Despite these actions, given the current context the FMoHP is making slow progress in managing federal transition in the health sector. Initiatives have been put in place in the Ministry towards strengthening coordination mechanisms among the three spheres of government and within the Ministry, but these are yet to be fully realised. For effective management of transition in the health sector, there is a need to strengthen decision making processes at each level and for these to be more participatory and evidence informed. This requires a renewed focus on strengthening generation of quality data that is tailored to the context and is used within mechanisms that can be implemented across the governments. The recently developed health sector monitoring and evaluation strategy should steer the process forward in this direction. Human resource adjustment is a key issue for the sector which will require considerable attention in days to come and which calls for strong leadership and management of the sector.

1.4 Changes to the Technical Assistance Team

Following the resignation of the Team Leader at the end of the previous quarter, the Senior Management Team (SMT) continued to provide strategic support to the programme. Tony Bondurant joined as interim Team Leader from the middle of February and is continuing until the new Team Leader is in place. The recruitment process for the new Team Leader has been successfully completed and Lorraine Porteous will join from the last week of May 2019. There will be an overlap between the Interim & new Team Leader for intensive induction and smooth handover.

There were a few changes in the structure and personnel of the technical assistance team during the reporting period. Six learning lab (LL) System Strengthening Officers were recruited and will be based in the respective palikas. A Learning Lab Coordinator was also appointed, to be based in Kathmandu.

1.5 Risk Management

The team has taken a rigorous approach to the identification and management of risk. Risks were identified, evaluated, and discussed in the SMT meetings and shared with DFID in monthly meetings. Two additional risks under GHTA and one under the RHITA risk matrix have been identified and are shown below.

GHTA Matrix:
- R2: Change in Team Leader may affect the stewardship of the team.
- R14: Reshaping NHSSP could lead to uncertainty among key stakeholders about how smoothly changes in TA will occur.
- R15. HR adjustment may have implications on service delivery and in annual workplan and budget (AWPB) development processes.

RHITA Matrix
- R15: Non-inclusion of retrofitting budget line in current AWPB caused delay in the budget release & bidding processes.

Based on the analysis of risk matrix against given criteria, the overall risk rating is medium. Refer to Annex 3 for updated risk matrix.

1.6 Logical framework

The HMIS data have now been finalised for the last fiscal year 17/18, and the programme indicators related to HMIS have now been updated (Annex 1).

1.7 Technical Assistance Response Fund:

The TARF application from Nepal Health Research Council (NHRC) regarding "Promoting use of evidences in health systems strengthening through National Summit of Health and Population Scientist in Nepal" was reviewed by the TARF committee and approved. The total amount of this application is £24,728.00. The amount will be release as per TARF guidelines and as stated in the contract between NHSSP and NHRC. No other applications were received from FMoHP. NHSSP continued educating Senior MOHP officials and encouraging applications for the use of TARF funds.

Progress in the Quarter

1.8 HEALTH POLICY AND PLANNING

RESULT AREA: 12.1 THE MoHP HAS A PLAN FOR STRUCTURAL REFORM UNDER FEDERALISM

Good progress has been made in this results area. TA was engaged in developing the health and population chapter of the 15th Five Year Development Plan which is led by the National Planning Commission (NPC). In relation to the health sector, this development plan envisions to realise the fundamental right as enshrined in the Constitution. FMoHP received the budgetary ceiling for the next FY only for the federal level which is different from last FY in which the ceiling was provided for all three levels of governance at the same time. The FMoHP is in consultation with the National Natural Resources and Fiscal Commission (NNRFC) in relation to the budget allocations for the Province and Local Level. Further, TA has supported FMoHP in developing the regulation for the Public Health Service Act (PHSA) which will facilitate the reform process across three levels of government. As per the newly defined organisational structure, staff have been posted across three levels of government and deployment has also started.

ACTIVITY I2.1.1 PROVIDE STRATEGIC SUPPORT ON STRUCTURES AND ROLES FOR CENTRAL AND DEVOLVED FUNCTION

On-going: The Ministry of Federal Affairs and General Administration (MoFAGA) has published the adjustment of non-health cadres (e.g. administration, finance, statistics and information technology) and some of these staff have started to shift to their respective work stations as per the adjustment.   No specific TA inputs were requested in this quarter.

Next quarter: Support will be provided if there are appropriate requests for TA from the FMoHP.

Challenge: The process of adjustment (transferring staff to new duty stations) of human resources for health (HRH) has the potential to negatively affect the quality and timeliness of critical functions of the FMoHP, for example development of the AWPB for the financial year (FY) 2019/20. To help prevent/minimise this impact, DFID-NHSSP is supporting senior officials in planning and prioritization during this process.

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

On-time: NHSSP has started dialogue with PPMD on planning next year's AWPB in line with the ceiling and framework provided by the NPC. The budget ceiling provided to the FMoHP for FY 2019/20 is NPR 34.48 billion which is only 40 crore higher than the budget of current FY 2018/19.

Support was provided to PPMD to prepare a draft of the "Policy and Program" from the next FY in line with the NHSS, draft National Health Policy and 15th five-year periodic plan. Review meetings with central hospitals, academia and councils have been conducted to discuss the AWPB implementation status for FY 2018/19 and preparation of the AWPB for FY 2019/20 in line with the framework provided by NPC. Technical support was provided to revisit the health and population sector's approach for the five-year development plan. This feedback has resulted in the NPC producing a consolidated preliminary draft of the five-year development plan (attached separately).

Inputs are scheduled for the next Quarter: Support to finalise the "Policy and Program" of FMoHP and preparation of the AWPB for FY 2019/20.

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

On-time: TA supported FMoHP to develop the regulations for the PHSA 2018. The Curative Service Division (CSD) has formed a TWG to lead and coordinate development of the regulations. The TWG comprises key officials from FMoHP, DoHS, GIZ, WHO, UNICEF and NHSSP. The regulations were drafted based on a framework structured around the key provisions of the PHSA. Five themes[1] were identified each of which was led by FMoHP officials. The thematic groups prepared a preliminary draft for their respective themes through a series of consultative meetings. The group of technical experts reviewed inputs from the thematic groups and provided feedback for refinement. The consistency and alignment of the draft regulations were reviewed and refined in a consultative workshop. The latest draft of the regulations on PHSA is attached.

Inputs are scheduled for the next Quarter. Support finalisation of the regulations.

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

Good progress was made towards achieving this result. In line with the Federal budget ceiling, the FMoHP is in the process of developing the AWPB for next FY. In the Learning Lab sites, TA has supported OCAT implementation at Palika level, and MSS and RDQA at health facility level. The findings of these assessments will be shared with DFID and also with the EDPs in consultation with DFID. The gaps identified by these tools will inform the AWPB process and the Health System Strengthening Officers at LL sites will play crucial role taking forward capacity enhancement based on these results.

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

Completed: The Gender Responsive Budgeting (GRB) Guideline was completed this quarter. The guideline provides tools and processes for integrating gender at each stage of the budget cycle. The guideline includes a phased approach to implementation, tailored to the capacity and institutional context in the sector. The guideline maintains consistency with the overarching national classification of budgets for gender responsiveness as set out by the Ministry of Finance but has adjusted the indicators to better fit with the health sector.

Development of the guideline was led by a Technical Committee with members from across the federal Ministry and Department of Health Services. The NHSSP GESI team, national consultants, international GRB specialist and international GESI specialist supported the Technical Committee to meet international standards as well as Government of Nepal's (GoN) own specific requirements in the development of the guideline.

The guideline has been finalised and validated by the Technical Committee, and shared with the FMoHP for approval. The guideline was translated into English to reach wider audiences.

Inputs scheduled for the next quarter: Follow up on approval process; print approved guideline; engage and support Policy, Planning and Monitoring Division to operationalise the guideline.

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[1] Theme 1: Basic, emergency and specialized health services, referral and QoC; Theme 2: Health systems and service management; Theme 3: Health promotion and social determinants of health; Theme 4: Blood management and human organ transplant; Theme 5: Health financing, drug management and health research.

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

On-time: Based on the budget ceiling provided by the NPC, FMoHP has provided budget ceilings to the respective departments, divisions, centres and hospitals. NHSSP has been part of the strategic dialogues with divisions and centres to review the implementation status of FY 2018/19 and discuss critical areas of budgetary gaps for the AWPB for FY 2019/20.

Inputs are scheduled for the next Quarter: Continue support for preparation of the AWPB for FY 2019/20.

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

Ongoing: NHSSP has contracted six health system strengthening officers and one coordinator. Selection of the staff was based on screening of the CV, written test (applying the blind coding system), PowerPoint presentation and interaction with the panel members[2]. These new staff members joined the programme on 18th February 2019. A week-long orientation was provided to ensure their understanding of areas of TA support including their scope of work and working modality. The orientation was led by advisors from each of the DFID-NHSSP work streams. All post holders have started working in their respective duty station (six in the respective learning lab sites[3] and the coordinator at the FMoHP).

NHSSP continued to support the implementation of the OCAT at learning lab sites. This was undertaken using an adapted approach based on lessons learnt from the initial implementation of the OCA tool in Dhangadhimai municipality. During this quarter, OCA has been completed in three additional sites and has started in a fourth (table 1).

Table 1: OCA roll-out during January – March 2019

Site	Province	District	Date
Completed			
Ithari sub-metropolitan city	1	Sunsari	January 6 – 11
Yashodhara rural municipality	5	Kapilvastu	January 28 – February 01

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[2] Panel members included Programme Manager, Strategic Advisor, HPP lead advisor and Planning Advisor.
[3] Table below consists of official details of the staff.

#	Staff Name	Designation	Duty station	Contact no.	Email
1	Randeep Kumar	HSS Officer	Yeshodhara, Kapilvastu	9851138558	randeep@nhssp.org.np
2	Dr. Rabin Gautam	HSS Officer	Pokhara-Kaski	9841828177	rabin@nhssp.org.np
3	Biswonath Khatri	HSS Officer	Kharpunath-Humla	9845042043	biswonath@nhssp.org.np
4	Bandana Neupane	HSS Officer	Itahari-Sunsari	9841824965	bandana@nhssp.org.np
5	Jitendra Nayak	HSS Officer	Dhangadhimai-Siraha	9851171116	jeetendra@nhssp.org.np
6	Prakash Deuba	HSS Officer	Ajayameru-Dadeldhura	9851197224	prakash@nhssp.org.np
7	Lal Mani Adhikari	HSS Coordinator	MoHP-Kathmandu	9851144528	lalmani@nhssp.org.np

Pokhara metropolitan city	Gandaki	Kaski	March 11 – 15
On-going			
Ajaymeru rural municipality	Sudur Pashchim	Dadeldhura	March 31– 4 April

The implementation of OCA has been led by the National Health Training Centre (NHTC), supported by NHSSP advisors. Potential EDP members from GIZ, MEOR and Strengthening Systems for Better Health - SSBH participated in the workshops which were attended by elected representatives including the Mayor/Chair, municipal team and in-charges of the health facilities within the municipality. Further, representatives from Ministry of Social Development/Provincial Health Directorate/Provincial Health Office also participated in most workshops. During the workshop, participants jointly adapted the OCAT to the local context, assessed the organisational capacity of the health sector in the municipality, and prepared a Capacity Development Plan to address the identified gaps.

Following the implementation of the OCA, assessment, one round of MSS and RDQA implementation has also been completed in all health facilities at three Learning Lab (LL) sites (Dhangadhimai, Itahari, Yashodhara) and assessment is in progress in Pokhara metropolitan city. At each LL site the Health System Strengthening Officer is supporting the development of facility-level action plans to address MSS and RDQA gaps. Two learning briefs on MSS implementation and LL approach have been produced (attached) and are uploaded on the NHSSP website.

Based on discussions with the SSBH team, OCAT will not be implemented in Kharpunath rural municipality as SSBH has already conduced a capacity assessment in Humla. However, it has been agreed that NHSSP will lead the implementation of MSS and RDQA in Kharpunath (notes of the meeting with SSBH attached separately).

Inputs are scheduled for the next Quarter: Implementation of OCAT in Madhyapur Thimi municipality in collaboration with GIZ. Implementation of MSS and RDQA in remaining LL sites. Development of factsheets for each of the Learning Lab sites to visualise the health status of the local level to inform the AWPB planning process. Support to develop AWPB for FY 2019/20 also to address the gaps identified through OCAT, MSS and RDQA implementation. Support to implement the action plan of OCA and MSS.

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

On-time: TA supported development of guidelines on LNOB budget markers. These have been submitted to FMoHP for their inputs/comments, which are still awaited.

Inputs scheduled for the next quarter: Incorporate inputs/comments received from FMoHP; revised guidelines to FMoHP for approval; translate into English.

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

Completed: The mapping of the partnerships in the health sector was completed and findings shared with the TWG led by PPMD/FMoHP. The focus of the discussions was that various types of partnership modalities exist in the heath sector and a guideline is needed to harmonise and effectively manage partnerships in health. Following this, an ISTTA was hired to undertake a political economy analysis (PEA) of private sector engagement in health. The PEA report was based on a review of literature and consultations with key informants from the public and private health sector at federal, province and local levels. The report largely

focussed on the incentives, beliefs and priorities of different people and organisations involved in public-private partnerships for healthcare. The report was finalised based on feedback, including from the DFID-NHSSP SMT, submitted to DFID on 28 February 2019 and approved.

The recommendations from the PEA informed the development of the guideline for partnerships in the health sector (Activity 2.3.5).

No Inputs are scheduled for the next Quarter.

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

Completed: The *Partnership Policy* for the health sector was developed and submitted to the PPICD in 2017. Due to changes in the government, it has not been endorsed. Key contents of the draft partnership policy were incorporated while drafting the national health policy.

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

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

On-time: The MSS for Hospitals has been approved by the FMoHP. The final copy is being printed and will also be uploaded onto the FMoHP and NHSSP websites. The MSS for health posts was also finalised by the Curative Service Division (CSD) of the Department of Health Services. During the implementation of MSS for health posts in selected LL sites, it was suggested that these should be translated into Nepali. This would enhance understanding of the document by both the local government and the health post staff. This has been done and the MSS for health posts in Nepali has been submitted to CSD for approval. The implementation guideline for MSS was also finalised and presented to the Senior Management Meeting in FMoHP. The feedback has been incorporated and the final document has been submitted for FMoHP approval.

A TWG has been formed by CSD to develop regulations for the Public Health Service Act (PHSA) 2018. The TWG comprises of key officials from FMoHP, DoHS, GIZ, WHO, UNICEF and NHSSP. Several consultative meetings have been conducted to develop the draft regulations on PHSA which is attached.

As a member of the TWG, DFID-NHSSP TA supported development of the operational guideline for the implementation of Basic Health Care Service (BHCS) package and its referral guideline. A preliminary draft of the BHCS package operational guideline and referral guideline have been developed, however, their finalisation will depend on the approval of both the BHCS package and its standard treatment protocols (STP). WHO, GIZ and NHSSP are the EDP members of the TWG and involved in developing these documents. The CSD plans to share the updated version of the guideline to wider EDPs once an updated version is available.

Inputs will be continued in the next Quarter: Continue supporting CSD to finalise the BHCS operational guideline and referral guidelines. Support printing the MSS for Health Post and the MSS implementation guideline. Prepare the final draft of the regulation of the PHS Act.

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

Completed: A TWG led by the Policy, Planning and Monitoring Division (PPMD) comprising of the key officials from the FMoHP and DoHS provided overall guidance in the development of the "Guidelines for Partnerships in the Health Sector'. The relevant findings of the activity i2.3.1 on mapping the partnerships in the health sector and the PEA on private sector engagement in the health sector was shared with the TWG to better inform the development of this guideline. Relevant findings of the PEA were also shared in the TWG meeting to inform the development of the partnership guideline. Several meetings and workshops were convened and feedback from FMoHP, DoHS, EDPs, Association of INGOs and Association of Private Health Institutions were incorporated in finalising the guideline. As suggested by DFID, an independent review of the guideline was also undertaken by a legal expert to harmonise it with other legal provisions including the procurement act and guidelines. The guideline was completed in March 2019. The English and Nepali version of the guideline along with the detailed guideline development process were submitted to DFID for approval. Feedback was received from DFID on the PD.

Inputs are scheduled for the next Quarter: Support will be provided to PPMD to address the feedback from DFID and EDPs to further refine the "Guidelines for the partnership in the health sector". The updated guideline will be submitted to DFID by 15 May 2019.

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

Completed: The final report of this completed payment deliverable was submitted and approved by DFID, and uploaded onto the Programme's website (http://www.nhssp.org.np/Resources/HPP/Stocktaking_the_Health_Policies_of_Nepal_April2018.pdf),

No inputs are scheduled for the next Quarter.

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

Completed: TA was provided to the FMoHP in the development of the National Health Policy (NHP) 2019. Along with the recommendations from Activity 2.3.6, the TA drew on the draft National Health Policy 2017, draft Partnership Policy 2017 and other key Policies and Acts to ensure their main messages are incorporated into the NHP 2019. The TA also supported finalisation of the NHP 2019 (attached) following its review. It is currently with the Cabinet for approval.

No Inputs scheduled.

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 Equality and Social Inclusion Strategy (PD 18)

Completed: Following FMoHP's endorsement of the revised Health Sector Gender Equality and Social Inclusion Strategy, this has been sent to Cabinet for approval. According to the Secretary FMoHP, the strategy has been sent to the Cabinet's Social Committee for review and feedback. Once this has been completed and any requested inputs have been completed, the Social Committee will endorse the strategy and Cabinet approve it.

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

On-time: The GESI institutional mechanism has been integrated into the revised GESI strategy avoiding the need for a separate guideline. Establishment of the mechanism will be initiated after approval of the strategy by Cabinet.

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

Not scheduled: No inputs were provided in this quarter. FMoHP has instructed the Epidemiology and Disease Control Division (EDCD) not to develop a Mental Health Policy as the revised National Health Policy will cover key concerns and areas of mental health. Preliminary discussions with EDCD indicate the division will shift its focus to developing a mental health strategy and action plan next fiscal year; this will include the roles and responsibilities of federal and sub-national levels.

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

Completed: Disability inclusive health service guidelines were developed following on from the FMoHP's Disability Management (Prevention, Treatment and Rehabilitation) Policy, Strategy and Ten-Year Plan (2017-2026). The guidelines aim to create coherent health sector understanding of disability inclusion principles and health practices. It provides guidance on how to mainstream disability inclusion in health service delivery, and how health providers can operationalise their responsibilities under disability related laws and policies. Overall, the guidelines respond to the increasing political commitment to address the vulnerability of persons with disabilities and the weaknesses of the health system to meet the health needs and rights of persons with disabilities.

The Leprosy Control and Disability Management Section of EDCD led the guideline development process through their leadership of a TWG. Consultations were held with a wide range of stakeholders including Ministry of Women, Children and Senior Citizens; National Federation of Disability Nepal, which is an organization with over 100 chapters in the country, NGOs (working on ten types of disabilities); and persons with disabilities. Consultations collected experiences and reflections on the status of health service delivery for persons with disabilities and barriers to their access to care. At provincial and local government levels, consultations with the Ministry of Social Development, Health Directorate officials, provincial hospitals and health facility staff explored the appropriateness of the draft guidelines. An international disability and development specialist and an international GESI specialist provided advice during the development of the guidelines and worked closely with the NHSSP GESI team. The TWG reviewed and finalised the guidelines at a national workshop. Translation of the guidelines into Nepali is currently under process.

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

On-time: Technical assistance was provided to revise the OCMC operational guidelines. All sectoral ministries participated including Ministry of Women, Children and Senior Citizen (MoWCSC), Office of the Prime Minister, Police Head Quarters, Ministry of Federal Affairs and General Administration, central hospitals, FMoHP, DoHS and EDPs. The revised guidelines incorporate changes to align it with the Constitution, federal restructuring and the revised GESI Strategy. It has been submitted to FMoHP for approval. Similarly, revision of the SSU operational guideline has been initiated with NHSSP's support.

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

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

Not scheduled: This activity was postponed by the MoWCSC in consultation with FMoHP. Progress depends on MoWCSC taking the National Integrated Guidelines for Services to GBV Survivors to Cabinet for approval. It is assumed that Cabinet approval will be received during 2019 and thereafter the Standard Operating Procedures will be developed. NHSSP is following-up with the MoWCSW on a regular basis, for further actions and any support required. NHSSP has also aligned with EDPs, especially UNFPA to move this forward.

No inputs are scheduled for the next quarter.

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

Not scheduled: No inputs were provided in this Quarter. Regular review of seven OCMCs and six SSUs functionality has been taking place at hospital level as planned in this quarter. Annual reviews are due to be conducted next quarter.

Functionality has been a problem of some OCMCs (especially the newly established ones) but the majority are working well. Transfer of OCMC focal persons, inadequate capacity to handle GBV cases, lack of trained counsellors, lack of consistent and coordinated monitoring from ministries and inadequate coordination are some of the factors that hinder complete functionality. NHSSP will discuss with ministry its further capacity building needs for OCMC based hospitals related to GBV and human resources and plan on how this can be facilitated.

Inputs scheduled for next quarter: Annual reviews of OCMCs, SSUs and geriatric wards.

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

Not scheduled: FMoHP's Secretary and Chief Specialist were orientated about GESI and LNOB and updated on revised policies and strategies related to GESI including the Medico-Legal Service Guidelines recently approved by Cabinet. A brief note describing each policy (GESI strategy, GRB guidelines, disability inclusive health service guideline, medico-legal guidelines) was shared on 29th March and 7th April, 2019 as requested by them.

Others:

Detailed inputs/comments were provided on the National Social Inclusion Policy drafted by MoFAGA to harmonize with the health sector GESI strategy on behalf of FMoHP. Technical support for social audit orientations was given to Provincial Health Directorates of provinces 1 and 2, in the month of May.

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

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

Delayed: The FMoHP will identify new date for the Partnership Forum in consultation with EDPs.

Inputs are scheduled for the next Quarter. It is expected that the Partnership Forum will now be held in 2019. However, a specific date will be agreed upon in consultation with EDPs.

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

On-time: The Mid-year review and Joint Consultative Meeting is scheduled for 15th May 2019.

Inputs are scheduled for the next Quarter: Support will be provided to conduct the JCM on the agreed date.

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

Not scheduled: There was an agreement with USAID to map the TA and use that.

Follow up will be done with USAID on this in the EDPs meeting.

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

On-time: The draft report of MTR was shared with the TWG, who provided feedback that the final report of the MTR should be shared at the JCM.

1.9 HEALTH SERVICE DELIVERY

HEALTH SERVICE DELIVERY

I3.1 THE DoHS INCREASES COVERAGE OF UNDER-SERVED POPULATIONS

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

Ongoing: TA supported the capacity enhancement of the Family Welfare Division (FWD) and service sites in order to ensure functionality of CEONC services (see below for more detail).

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

Cancelled: Establishment of CEONC services at Sotang PHCC has been cancelled due to a very low catchment population.

Inputs are scheduled for the next Quarter. Visit to Rukum (East) for the feasibility assessment at Rukumkot PHCC. Continue technical support and facilitation for HR transfer to ensure functionality of CEONC sites, especially to problematic and newly established sites.

Improving reporting, monitoring, and response mechanisms

Ongoing: Functionality of CEONC sites improved in this quarter.

TA monitored and reported to the FWD's Safe Motherhood Section Chief and Director on the functionality status of all CEONC sites. Of the 84 CEONC sites[4] (in 77 districts) monitored, functionality status improved from last reporting. A total of 73-76 sites were fully functional over the quarter (table 2) and C-section services provided. Between 8-11 CEONC sites, services were not able to provide C-section. Deployment of recently graduated scholarship holders of MDGP and MD/OBGYN at non-functioning sites has improved the functionality, however, six graduates were deployed to upgraded hospitals which are mostly within 30 minutes of a major referral hospital. Concerted efforts to advocate to all levels of governments not to expand surgical (CEONC) services should become a major concern of all stakeholders (federal government and partners) concerned.

Among 72 districts with established CEONC services in the district, 62 districts had a functioning CEONC site for the entire three months of the report quarter, three more districts had a functioning CEONC service site for two months and one district had one month. Six out of 72 districts did not have functioning CEONC services for the whole three months (excluding five districts where CEONC services is not yet established). TA is consistently supporting FWD to monitor and respond based on the human resources gaps.

Table 2 Status of CEONC functionality over the Quarter Jan-Mar 2019[5]

	Provinces							Total	Last Quarter
	P1	P2	P3	P4	P5	P6	P7		
Existing sites	16	8	14	10	13	11	12	**84**	83
Functioning									
Poush	14	7	11	8	13	8	12	**73**	69 (Ashwin)
Magh	14	7	12	8	13	8	12	**74**	71 (Kartik)
Falgun	14	7	13	8	13	10	11	**76**	69 (Mangsir)

TA continues to support the monitoring through a combination of off-site follow-up as well as joint visits with FWD to the CEONC sites, to improve reporting and response mechanisms. TA provided on-site technical and management support to two newly established CEONC sites, to start providing C-section services, and supported seven non-functioning and problematic CEONC sites to address bottle necks. Approaches and solutions identified included working with the management committee, providing guidance to local palikas on recruitment of human resources (HR) and selection of candidates for advanced skilled birth attendant (ASBA) and Operation Theatre management trainings. TA also provided HR situation analysis to

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[4] Ampipal hospital added in the list (existing site, but was not monitored in the past)

[5] Non-functioning CEONC sites during last quarter: non-functioning new sites (Inaruwa, Kolti); non-functioning for three months (Sarlahi, Manthali, Dhading, Sindhupalchowk, Tanahu, Parbat, Burtibang, Jajarkot, Humla, Dolpa, Gokuleswor); non-functioning for two months (Trishuli); non-functioning for one month (Salyan, Upayapur).

FWD/DoHS/FMoHP to support appropriate transfer of C-section service providers including doctors, anaesthetists and nurses.

Inputs are scheduled for the next Quarter. These will include continued monitoring, and exploration for developing a sustainable monitoring system linking with the existing MIS.

Potential challenge: Expansion of primary hospitals with surgical facilities including CEONC services. These may negatively affect the availability of service providers in more remote sites. DFID-NHSSP TA is working to avoid this potential challenge through engaging with government (as described above) to ensure appropriate, needs-based planning and HR management.

Continuation of the caesarean section study and implementation of recommendations

On-time: Introduction of the Robson criteria, has been included as a part of the Safe Motherhood and Newborn Health (SMNH) Roadmap recommendation. FWD have also included a budget allocation in the 2019/20 AWPB for introduction of the Robson classification and monitoring institutional C-section at selected hospitals with high C-section rates in both public and private hospitals.

Inputs are scheduled for the next Quarter through discussion with the Nepal Society of Obstetricians and Gynaecologists (NESOG) for introduction of the Robson classification. The Aama programme guideline finalisation has been shifted to next fiscal year.

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

Changed: As reported in previous quarters, the selection and upgrading by DHO for the strategically located sites to deliver Basic Emergency Obstetric and Neonatal Care (BEONC) has been discontinued. However, as part of the SMNH roadmap planning, recommendations for criteria to select service sites (for CEONC, BEONC and strategic BC) by palikas have been discussed and are included in the roadmap. The draft SMNH roadmap 2030 recommends not to expand/establish CEONC/BEONC/BC within 2 hours' distance of these service sites, but to expand at strategic locations in hill and mountain areas.

Inputs are scheduled for next Quarter: Finalisation of SMNH roadmap after feedback from FWD and submit for endorsement; and dissemination of the roadmap once endorsed.

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

Completed: Attended meeting organised by NSSD for revision of the Female Community Health Volunteers (FCHV) strategy. A TWG was formed for revision of the strategy.

Inputs are scheduled for the next Quarter, inputs to the FCHV strategy.

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

Ongoing: the following activities were completed during this reporting period for the piloting mHealth for FCHV:

- Completed formative research in the three pilot districts during January and February (Tehrathum, Rautahat and Darchula districts).

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- Completed theory of change workshop with stakeholders on 17-19 March 2019 (==output attached==)
- Agreed on the two pilot concepts from the theory of change workshop (Pilot 1 akin to Mobile Academy and Pilot 2 akin to Mobile Kunji)
- Formative research report ready for presentation to DFID in early May

Inputs are scheduled for the next Quarter. Sharing of formative research findings with NSSD/NHSSP and then with DFID; finalising the research report; finalisation of two prototypes and selection of messages for human centred users testing; sharing with "TAG" after the first round of user testing for choice of prototype to be presented by NSSD and IT section of FMoHP.

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

On time: FWD provided funds to implement postnatal care (PNC) home visits by existing health facility staff in 51 Palikas in FT 2018/19. Three Palikas made a similar commitment. Out of the 51 Palikas who received funds from FWD, 33 Palikas received funds directly from FWD and another 18 Palikas received funds via Provinces. NHSSP TA supported FWD to review the PNC home visit programme and to plan workshops in three provinces this quarter. A total of 163 participants attended. These were: managers from 7 provinces, health coordinators and service providers from 54 Palikas (30 old +24 new). The main aim of these workshops was to enable Palika coordinators and service providers to review programme processes and to plan PNC home visits for their Palikas using the 2018/19 budget. The second objective was to raise awareness of the importance of the PNC home visit programme and budgeting through Province AWPB for the next FY. Thirty old Palikas are continuing postnatal care (PNC) home visits while 3 new Palikas[6] have completed their Palika planning process and started PNC home visits. The effect of this PNC home visit programme on PNC coverage is monitored using HMIS data. The result will be presented on a yearly basis. HMIS reporting shows increased post-partum home visits among women who had institutional delivery, from 38.5% in 2016/17 to 50% in 2017/18 fiscal year in 30 Palikas where they have started PNC home visits in second quarters of 2017/18. Institutional delivery rate in these 30 Palikas was 30% in 2017/18.

Delayed: Delay in implementation in 18 Palikas is mainly due to delayed budget release from Provinces.

Inputs are scheduled for the next Quarter. This will focus on off-site monitoring of implementation status and advocacy on the importance of PNC home visits, and budgeting through Provinces' AWPB for FY 2019/20.

Challenge: Delays in the process of Provinces releasing budgets through to Palikas has delayed or prevented implementation in the 18 new Palikas.

i3.1.5 Support the FHD/Child Health Division (CHD)/PHCRD and DHO 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: NHSSP TA had provided planning support in three remote Palikas (Bigu and Gaurishankar Gaunpalika in Dolakha and Umakunda Gaunpalika in Ramechhap) and off-site monitoring of palikas' implementation of activities. Monitoring is an ongoing process, but at present each Palika has been implementing activities as per their approved budget. The

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[6] Sunabarsi Morang, Umakunda Ramechhap, Ganyapdhura Dadeldhura

complete picture of their implementing status will be updated at the end of this FY 2018/2019. The case study report will be ready by August 2019.

Inputs are scheduled for the next Quarter: Follow up to the three Palikas on implementation of their budget.

Implement social mobilisation and behaviour change approaches ~~with local non-government organisations (NGOs)~~

Ongoing: NHSSP TA has provided the training needs assessment format and FCHV basic and refresher training (as needed) to all 7 LL Palikas. These Palikas are now assessing the number of FCHVs who need basic and refresher training. The aim of this assessment is to plan enhancing capacity of FCHVs.

Inputs will be provided in the next Quarter. TA to complete FCHVs' training needs assessment report and ensuring budget planning for FCHVs' capacity enhancement through Palika AWPB in 7 LL sites for next FY (2019/2020).

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

Ongoing: Visiting Providers (VP) programme activity is planned in 7 Provinces with a budget allocation of NRs 4 lakhs per Province. This programme is to be implemented by Provinces. Roving Auxiliary Nurse Midwives (RANM) programme activity is planned in 46 municipalities of 23 districts in 2075/76 (2018/19) with a budget allocation of NRs 3 lakhs per municipalities. This RANM activity is to be implemented by municipalities. FWD has planned orientation on Family Planning/Expanded Programme of Immunisation (EPI) integration activity in two districts (Parbat and Bajhang) in the 2nd four months.

In preparation for this, NHSSP TA had on-going communication through phone calls, during field visits (during the United Nations Family Planning Programme (UNFPP) annual review meeting and planning and PNC microplanning workshops in Feb/March 2019) and taking stock of the status of VP implementation in Provinces. During interactions with Provincial Health Directors and other staff, NHSSP TA reinforced the importance of VSP implementation and shared VSP and RANM implementation guidelines with Directors and focal persons of Provincial Health Directorate and Health Sections, and the Ministry of Social Development in all Provinces. NHSSP TA made presentations and facilitated discussions on the Government of Nepal (GoN)-led VSP approach during the NFPP Annual Review Meeting Planning workshops at Janakpur, Biratnagar, Butwal and Dhangadhi. Suggestions for improved VSP implementation guidelines and monitoring format appropriate for a GoN-led approach were discussed.

The discussions resulted in a resubmitted Technical Note "Visiting Service Providers: Expanding access to Long Acting Reversible Contraception in Nepal" (part of PD 52) both in English and Nepali version. This was approved in February 2019. Copies of the Technical Note were distributed during (1) UNFPP Annual Review Meeting Planning at Dhangadhi, 3rd March 2019 (40 copies each of English and Nepali) and (2) National Conference of Family Planning (NCFP), 18-19 March 2019, Hotel Yak and Yeti, Kathmandu (200 copies each English and Nepali). The Technical Note has been uploaded onto the Programme's website:

https://nhssp.org.np/Resources/SD/Technical_Note_Expanding_Access_to_LARC_in_Nepal_English_Feb2019.pdf;
https://nhssp.org.np/Resources/SD/Technical_Note_Expanding_Access_to_LARC_in_Nepal_Nepali_Feb2019.pdf),

Currently the VP programme is implemented only by Province 6. The Provincial Health Directorate in this province published a vacancy announcement for VSPs but it was informed that no applications were received. As per the AWPB programme implementation guideline,

Province 6 chose an alternative approach and mobilized already working and trained nurses as VSPs. The province has now identified 4 districts for VSP mobilization namely Jumla, Kalikot, Salyan and Jajarkot. Two existing ANMs in both Jumla and Kalikot were mobilized as VSP for a one-day VSP event and provided a total of 40 implant insertions (Jumla-19, Kalikot 21). Apart from Province 6 no other provinces had been able to implement VP activity by end of March 2019 despite repeated communication and reminders.

Delayed: VP activity implementation is delayed in all provinces except Province 6. Some of the reasons that have delayed VP activity implementation are: (1) delay in receiving budget from the Ministry of Finance (MoF), (2) delay in receiving the provincial programme implementation guideline, (3) delay in budget transfer from Provincial MoSD to Provincial Health Directorate, (4) confusion and difficulty in breaking down the budget for VP as this activity is clumped together with MPDSR, (5) budget ceiling allocated for VP (NRs 4 lakh per province) is not adequate (6) programme focal persons have little awareness and lack of understanding of the VP programme concept and implementation approach, and (7) time taken for human resource deployment at PHD and MoSD in most provinces, and significant time taken for civil service staff adjustment.

Roving Auxiliary Nurse Midwives (RANM): 4 additional municipalities have implemented R-ANM programme in this quarter through FWD, making a total of 44 municipalities (out of 46 municipalities) implementing this programme.

NHSSP TA is supporting this initiative, largely through off-site management support to health coordinators of municipalities with RANM programme activity; and updating the status of programme implementation. Provincial health directorate staff including Directors are also kept informed of the RANM programme activity in municipalities under their provinces.

Orientation on the Family Planning/Expanded Programme on Immunisation (FP/EPI) integration by FWD has been postponed to the third or the last quarter of this fiscal year. District orientation on the programme was conducted in 2 districts (Baitadi and Udayapur) by the Adventist Development and Relief Agency (ADRA Nepal (under UNFPP/UNFPA/DFID support). ADRA Nepal will conduct health facility level orientation and community level orientation on the FP/EPI programme in the second quarter of this year. NHSSP TA is supporting the FWD focal person responsible for FP/EPI orientation to prepare for this in Parbat and Bajhang.

Challenges: VP activity implementation: as there is hardly 3 months left for programme implementation in this fiscal year it is unlikely that the provincial health directorates will be keen to initiate VP hiring or VP mobilization of existing staff. In addition, as the civil service staff adjustment has completed, it will take time to settle the relocated HR situation at provinces and this will further delay the chances of VP programme implementation.

Inputs are scheduled for the next Quarter. NHSSP TA will continue to monitor Visiting Provider and RANM implementation status by provincial health directorates (PHDs). NHSSP TA will support FWD/DoHS to scale up the GoN-led VSP approach and RANM during the 2019/20 AWPB preparation (March/April 2019).

Except for simple programme orientation during VP and RANM hiring or mobilization (included in AWPB programme implementation guideline) no formal capacity/skill enhancement activity and budget has been planned/allocated for VP and RANM activities in AWPB. However, NHSSP TA planned to support capacity enhancement of VPs and RANMs.

NHSSP TA is in communication with the Provincial Health Directorate and Health Section of provincial MoSD on the possibility of holding RANM programme review and capacity enhancement meetings (attended by health coordinators, district focal persons and provincial health staff) at selected sites. Most Provincial Health Directors have verbally agreed to this concept. Save the Children, after discussion, is also willing to participate and co-facilitate the RANM review meeting in selected sites. NHSSP TA met one RANM and Health Coordinator (HC), during the UNFPPA Annual Review Meeting at Butwal Rupendehi, of Maharajgunj urban

municipality Kapilvastu. NHSSP TA gained information on programme activity progress from these service providers and handed over 2 copies each of WHO MEC wheel and pregnancy rule out job aid chart and taught how to use them effectively. Although this interaction was only with two service providers it reflects the way in which DFID-NHSSP TA can take advantage of unforeseen contact opportunities to provide important technical support and enhanced understanding of the situation on the ground from those who directly implementing services.

NHSSP TA also provided one copy of WHO Family Planning - A global handbook for providers, 2018 edition and Wall Chart ("Do you know your family planning choices?") to all Provincial Health Directorates.

Delayed: No inputs due to delay in recruitment of VSPs. Review of the RANM activity and capacity enhancement of R-ANM and HCs through group meetings or workshops at selected venues was delayed because of requests from most GoN health workers and authorities including Provincial Health Directorates to wait until the civil service staff adjustment situation is finalized/completed.

Challenges: Opportunities to enhance the capacity of VPs is becoming slim as VPs activity is yet to be implemented by most provinces. Holding review meetings and capacity enhancement relating to the RANM programme at selected provincial sites is also challenging as current HCs are expected to be relocated.

Inputs are scheduled for the next Quarter (in the new financial year) for capacity building of VP and RANM recruited by provincial and selected local government.

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

Ongoing: FWD in this fiscal year took responsibility for implementing voluntary surgical contraception (VSC) camps and almost NRs 8 crore budget was allocated for this in the AWPB. Much time was taken to overcome the procedural hurdles of this new implementation approach, however, FWD for the first time, outsourced the implementation of VSC camps to five suppliers/implementing agencies (Sumaulo Pariwar Nepal/MSI, Family Planning Association of Nepal-FPAN, Environment Awareness Group/EAG-Arghakhanchi, Lumbini Medical College and Teaching Hospital Ltd-Palpa, and Human Right and Community Development Centre-Saptari).

The five supplier/agencies started provision of VSC services in their assigned districts. As per programme update reports (end of March 2019) made available by 3 suppliers (FPAN, MSI and EAG) a total of 1181 female sterilization, 412 male sterilization, 43 IUCD insertions, and 413 implant insertion services were provided from 104 sites, 184 camp operational days and 22 districts (Table 3).

Table 3: Provision of VSC services

Item/Suppliers	FPAN	MSI	EAG	Lumbini Medical Collage	Human Right and Community Development Centre
NSV	239	94	79	Event not conducted until end of March – data not yet available	Event not conducted until end of March – data not yet available
ML	785	78	318		
Total VSC (NSV+ML)	1024	172	397		
IUCD	41	2	-		
Implant	386	27	-		
Total LARCs (IUCD+Implant)	427	29	-		
# VSC camp sites	68	11	25		
# of camp operational days	112	25	47		
# of districts covered	13 (of 21)	4 (of 43)	5 (of 6)		
NSV: no-scalpel vasectomy; ML: minilaparoty; LARCs: long acting reversible contraceptive					

TA supported FWD in the outsourcing process and monitoring government-funded VSC camps through telephone calls.

Challenges: Two of the 5 supplier/agencies have yet to initiate activities. The performance of the three suppliers in above table is far from satisfactory. Some of the key reasons for this appear to be: (1) delay in outsourcing, (2) unavailability (low demand) of VSC clients at this time of the year (summer started), (3) budget norm fixed by FWD for VSC case/client is not adequate for most suppliers/agencies.

Inputs are scheduled for the next Quarter. NHSSP TA will continue to support FWD monitor VSC camp activity, especially the camps implemented through contracted organisations.

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

Completed: no inputs provided during this period.

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

Delayed: The SBA strategy review process started with an initial meeting with the FWD and NHTC, but the process has been held up due to delayed approval from FWD. Both divisions have now agreed to revision of the SBA training strategy, reduced scope of training and a revised training manual. One meeting has been conducted with SBA stakeholders and SMNH sub-committees to discuss the process of revision and how SBA training and midwifery production/deployment will be aligned. The actual revision has been delayed due to poor health of the short-term consultant.

The HMIS ANC card containing ANC messages has been drafted and sent to Suahara for nutrition inputs. FWD and the HMIS section have had meetings on how the HMIS-ANC card printing can be funded using AWPB fund. Further "tipanni" process is required for approval to change the HMIS-ANC card. This will be done once the messages for the card have been finalised and the tentative cost for printing estimated.

Inputs are scheduled for the next Quarter to review and revise the SBA strategy so it is aligned with the nursing and midwifery policy and strategy. The SBA training manual will also be reviewed and revised to include nutrition.   Refresher training of SBA trainers and clinical mentors will take place. All the above will be completed by end of July 2019.

i3.1.10 Strengthening and scaling up of OCMCs

Completed: During this quarter, an OCMC was established in Narayani hospital following a half-day orientation with the hospital management committee, hospital staff and multi-sectoral stakeholders.[7] OCMC Case Management Committee (CMC)[8] meetings were held in three zonal hospitals[9]. This provided an opportunity to assess the functionality of OCMCs – the types of cases being reported, the types of services being provided, referrals and the current status of the case/survivor. This information was used to guide the CMC on how OCMCs can be strengthened to respond to the needs of survivors. As requested by CMC, TA has supported the development of an OCMC Referral Directory. The referral directory includes specific information on services available at referral facilities, how to access them (e.g. phone numbers, procedures, etc.) and a contact name. Site visits were also made to Bajhang hospital and B P Koirala Institute of Health Science (BPKHIS). In addition to routine

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7 District police, district attorney, deputy mayor, women police cell, safe home, CDO, I/NGOs and others
8 CMC plays a vital role for the effective functioning of OCMC. This committee includes 7 members – medical officer, emergency in-charge of the hospital, district police officer, officer from women police cell, district attorney, representative from safe home and OCMC focal person. The CMC members meet once a month or as required for the management of cases that are complex in nature or cases requiring advance treatment/s or referral to the higher centers.
9 Sagarmatha zonal hospital, Rajbiraj, Koshi zonal hospital and Bheri zonal hospital, Nepalgunj

quantitative data collection, important and powerful qualitative data is also being obtained on the impact of OCMCs on individual lives (see Box below).

> *A couple years back, I was labelled as an anti-social personality due to my engagement with survivors of GBV. I endured different forms of violence from my community and the local leaders/politicians for advocating the rights of survivors and supporting them. I was transferred from my work to the most remote part of the country, away from my family where I could not use the skills that I had learned at my job. However, I did not give up and fought back and reclaimed my place. I have been back to what I was doing - but with more vigour, enthusiasm and determination to support these women who have experienced so much in their lives.*
>
> Radha Poudel, OCMC Focal Person, Rapati Sub-regional Hospital, Ghorai-Dang

NHSSP supported the FMoHP/GESI Section to conduct GBV Clinical Medico-Legal Training as per the directives of the Office of Prime Minister and Office of the Attorney General to train all hospital medical officers. The training has been completed in provinces 1 and 3, for 36 Medical Officers from 24 hospitals. The training is led by Forensic Department-Institute of Medicine (IOM), Marajgunj and is 5 days long inclusive of practical exercises. The cost of the training will be covered by FMoHP through the red-book budget under the capacity development heading. This is particularly significant and timely as the Medical Superintendent from the hospitals reported that due to the lack of trained medical officers, there have been difficulties in the examination of GBV cases, especially rape cases and preparation of medico-legal reports. After the training, an estimated 135 Medical Officers will have enhanced capacity to undertake medico-legal examinations and treat GBV cases more appropriately.

Likewise, given the dearth of competent human resources to conduct GBV related clinical medico-legal examination in many hospitals throughout the country, NHSSP in partnership with the Medico-Legal Society of Nepal (MeLeSoN)[10] has planned 3 days intensive training on the same for 24 forensic specialists from 13 government and private teaching hospitals.

Inputs scheduled for next quarter: Strengthen newly established OCMCs; scope two new OCMCs[11]; finalise the OCMC Referral Directory; GBV clinical medico-legal training of medical officers from remaining provinces[12]; 3 days intensive GBV clinical medico-legal training for 24 forensic specialists.

Challenge: Delays in transferring budgets from provinces to some referral and district hospitals has created confusion and disrupted service delivery. This has also caused delays in establishing new OCMCs, affected multi-sectoral cooperation and collaboration to ensure integrated one-door services to GBV survivors, and hampered regular meetings of OCMC district coordination committees. To mitigate the challenges, NHSSP has lobbied the concerned FMoHP division and provinces to transfer the budget.

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

Ongoing: Site visits have been held for coaching/mentoring and monitoring in seven OCMCs[13] and meetings held with district-level multi-sectoral stakeholders to review progress,

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[10] Medico-Legal Society of Nepal (MeLeSoN) is the only agency in the country that conducts training on GBV clinical medico-legal aspects.

[11] Parbat and Myagdi districts.

[12] Province 2, Gandaki Province, Province 5, Karnali Province and Sudur-Paschim Province.

[13] Narayani hospital, Sarlahi hospital, Kalaiya hospital, Gaur hospital, Bharatpur hospital, Rapati hospital and Maternity hospital

challenges, and achievements in OCMC strengthening. At the Federal level, TA facilitated a quarterly meeting with multi-sectoral partners, FMoHP/GESI section and Nursing and Social Security Division/DOHS. The meeting enabled stakeholders to understand each other's scope of work, share progress with activities and identify avenues to strengthen GESI activities and integration.

A day-long workshop entitled "You are Not Alone" was held with GBV survivors in Dang district (Province 5) in coordination with OCMC Dang. The main objective of the workshop was to strengthen the survivors' network "Sachham Mahila"- to boost their self-esteem, empower them to be advocates/champions and motivators to fight GBV. Many women during the workshop shared that they have found the network very beneficial (see the Box below) - this has allowed them to see that they are not alone, built solidarity among women who confronted similar circumstances and find their voice. A similar workshop is planned at Bharatpur next quarter. Workshops like this provide opportunities to reach directly to survivors/beneficiaries – making them aware of their rights, working with them to identify ways, strengths, resources, and mechanisms to overcome violent situations as well as making the government and civil society accountable to address GBV issues.

> *The network has supported us to feel empowered (as manifested through improved self-esteem, action of personal courage, and actions for the benefit of other women), feel safer, more self-confident and less fearful, provide emotional support to other women outside the group, particularly in denying the common justifications for violence and change our attitude from negative and pessimistic to positive and optimistic.*
>
> -Survivors (members of the network - *Sachham Mahila*)

Inputs scheduled for the next quarter: Mentoring and follow-up support to select newly established OCMC hospitals especially in the *Terai*; update the status of all 44 OCMCs including reporting for the dashboard; and conduct "You are Not Alone" workshop with GBV survivors in Bharatpur.

i3.1.11 Supporting the roll-out the GBV clinical protocol

On-going: Four days' training of trainers (TOT) to medical officers and senior nursing staff on GBV clinical protocol in two hospitals (Koshi and Bharatpur). TA supported development of presentation slides and facilitation of sessions, and coordination with NHTC for trainers. Roll-out of the GBV clinical protocol is planned at Bheri zonal hospital following hospital management and department chiefs request.

Inputs scheduled for next quarter: Follow-up support and monitoring of training sites; strengthening of monthly interdepartmental GBV case conferences held with service providers; roll-out GBV clinical protocol training at Bheri zonal hospital and Sagarmatha hospital.

i3.1.12 Rolling out the GBV Standard Operating Procedures (after approval)

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

i3.1.13 Scaling up Social Service Units

Completed: Orientation has been completed for the establishment of a new Social Service Unit (SSU) at Sagarmatha zonal hospital, Rajbiraj. Hospital management report that services have been on-going since mid-January.

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

Ongoing: Progress, challenges and achievements in terms of strengthening SSUs were reviewed with NGO partners. Site visits also took place to SSUs[15] for coaching/mentoring and monitoring, with a focus on the issues highlighted during the review. The confidence and capacity of all staff has been increased at three newly established hospital-based SSUs[16]. Hospital reports show that more than 425,000 target group patients have received free and subsidized services from SSUs since their establishment. Total target group patients in 2017/2018 were 125,300 of which 51% were female. The largest group of beneficiaries were classified as poor (47.70%) and senior citizens (36.40%) with smaller numbers of people classified as persons with disabilities (4.00%), destitute (3.25%), and GBV survivors (0.7%). Three-day workshops were held after OPD hours (from 01:00 pm – 04:00pm). The main objective of the workshop was to enable service providers and facilitators at the SSUs including all staff of the hospitals to identify target group patients more appropriately, help boost the staffs' self-confidence in this area of work and further encourage them to take initiative and leadership within an environment that is supportive and inclusive. The workshop included some unique sessions such as "service with smile and heart", "self-realization", "mind-set modules" (to establish a new set of attitudes and perceptions) and other interesting sessions that included edutainment, meditation and music. The workshop received overwhelming positive responses from the hospitals and request for refreshers along these lines. Such workshops have helped to identify and increased coverage of target groups (79% in 2013 to 98% in 2018) as well as improve compliance with operational guidelines (63% in 2013 to 92% 2018) as reported by the facilitators and SSU Chiefs.

Inputs scheduled for next quarter: Mentoring and follow up support to select new SSUs; plan capacity building for another five new hospitals based SSUs by May 2019.

i3.1.14 Capacity building to put LNOB into practice

Completed: A day-long orientation was provided on GESI and LNOB to more than 60 students (Master of Nursing) at the Institute of Medicine (IOM) by NHSSP. Each presentation was followed by a question-answer session and discussion. The students showed profound interest to learn further about GESI and GBV and how to implement these at all levels. They also requested further, on-going orientation on these issues. Similarly, at the request of the Nepal CSW 63 committee, NHSSP and the GESI Section Chief/FMoHP participated and conducted a GESI-LNOB orientation during the national consultation workshop concerning the Commission on Status of Women (CSW 63). The orientation covered OCMC, SSU and other social health protection programmes in the health sector. Likewise, orientation was also provided to the staff of Narayani hospital and the staff of the National Women's Commission (NWC)GBV-Helpline project. Since there have been changes at all levels, continuous orientation on the GESI framework of the FMoHP, the revised GESI strategy, Gender Responsive Budgeting Guidelines, Disability Inclusive Health Services Guidelines and targeted interventions (OCMC, SSU, disability and mental health) are required to build capacity and to raise the awareness of stakeholders at all levels.

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[14] Dadeldhura hospital, Mental hospital, Lalitpur and Tulshipur hospital, Dang
[15] Bheri zonal hospital, Koshi zonal hospital, Bharatpur hospital, Narayani hospital and National trauma center
[16] Surkhet hospital, Bardiya hospital and Narayani hospital

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

Ongoing The TWG/NHTC agreed on the scope of the training curriculum and core skills appropriate for this HA level. The TWG included members from the National Disabled Fund (NDF), Spinal Injury and Rehabilitation Centre (SIRC), Hospital and Rehabilitation Centre for Disabled Children (HRDC), Humanity and Inclusion (HI), Nepal Physiotherapists Association (NEPTA), Nepal Academy of Medical Sciences (NAMS) and Anandaban hospital.

The group proposed the following topics to be included in the curriculum:

A) Knowledge base for early identification, assessment and referral
1. Congenital Conditions/anomalies: Cleft Lip/Palate, Congenital Talipes Equinovarus (CTEV), Congenital Limb Absence, Hydrocephalus, Spina bifida,
2. Trauma: Fractures and its complications- supracondylar fracture of humerus (child), Colle's fracture (Adult), Spinal Cord Injury, Burn, Amputation, Head Injury,
3. Neuromuscular Conditions: Muscular Dystrophy, Stroke,
4. Infection: Post-Polio Residual Paralysis (PPRP), Osteomyelitis,
5. Neuro Development Condition: Cerebral Palsy (CP), Autism, Downs Syndrome,
6. Others: chronic obstructive pulmonary disease (COPD), Gynae-obstetric (Pelvic organ prolapse: this will be included in SBA training package)

B) Competencies
1. Assessment of joint movement
2. Assessment of muscle function
3. Positioning of patients (Techniques for prevention of bedsore, deformity and tightness/contracture)
4. Transfer techniques on wheelchair, bed and mat/floor
5. Assistive devices - Orientation of walking aids, orthotics & prosthetics and wheelchair
6. Uses of walking aids, repair and maintenance
7. Upper and lower extremity functional skills
8. Deep breathing exercise and spirometry for respiratory conditions
9. Dyspnoea reliving positions,
10. Complication if tight bandage/cast
11. Do and Don'ts to Lower back pain, osteoarthritis and cervical spondylosis, pelvic organ prolapse

c) Counselling skills
1. Patients
2. Parents and/or care-takers

HI are undertaking a needs assessment in three programme intervention districts (Dhanusha, Dolakha and Dhading). The overall purpose of the needs assessment is to assess health assistants' needs, assess potential training sites' needs and to assess provision of a referral system from community to health facility and between the health facilities. The findings of the needs assessment will be included in the PD. NHSSP commissioned Partnership for Sustainable Development (PSD) for evaluating "Physio innovations".

curriculum will be updated and first batch of training will be initiated. Evaluation design will be finalized and approved by DFID.

i3.2.2 Support the institutionalisation of mental health services

Completed: Two rounds of meetings with the Epidemiology and Disease Control Division (EDCD) and partners[17] were organised for the Standardisation of Psychosocial Counselling Curricula. The key discussion revolved around the modality of the curricula – duration, issues/themes, target groups including harmonization with NHTC standards (Trainers' Manual and Participants Handbook) etc. Similarly, NHSSP contributed to the finalisation of the Operational Guidelines for Destitute, Deprived and Severe Mental-Psychosocial Patients' Treatment and Rehabilitation, as a TWG member. The FMoHP has allocated NRs 13.9 million for this purpose. Selected hospitals and rehabilitation centres will receive the funds in the form of a grant to provide free care for destitute, deprived and severe mental-psychosocial patients.

Inputs scheduled for next quarter: Initiate revising and standardising psychosocial counselling curricula under the leadership of EDCD; and development of geriatric health strategy under the leadership of Nursing and Social Security Division (NSSD) upon NSSD's request.

~~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/THE DOHS HAS EFFECTIVE STRATEGIES TO MANAGE THE HIGH DEMAND (OF MNH SERVICES) AT REFERRAL CENTRES

i3.3.1 Free emergency referral for obstetric complications

Changed: A rapid assessment was conducted with concerned health workers, Palikas and DHO on the implementation of free referral under the new federal system in Ramechhap and Dolakha district. The report is currently being completed and will be shared with DFID in May.

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

Ongoing: One provincial level consultation for Provinces 1 and 2 was conducted at Janakpur in early January. The health minister, the health secretary and Provincial minister for social and development ministry participated in the closing session. National level consultation to finalise the SMNH roadmap was also conducted in mid-February 2019. The health secretary and almost all FMOHP and DOHS directors and majority of partners' representatives participated in the meeting. A consensus on the major recommendations was made. The SMNH roadmap was revised after the meeting and submitted to FWD director. The FWD director has not yet provided his feedback till end of March. In the meantime, FWD has included some recommendations in their central level AWPB for 2019/20.

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[17] CVICT, TPO and CMC

Inputs are scheduled for next Quarter: The SMNH Roadmap finalisation after feedback from FWD director (expecting 3rd week of April) and will submit to FMoHP for endorsement. Costing of the SMNH roadmap is planned and TOR drafted for discussion, to be finalised once the roadmap is finalised.

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

Ongoing: Both the SMNH roadmap 2030 and the national nursing and midwifery policy, strategy and action plans till (2019-25) recommend establishment of a nurse/midwife led birthing unit at referral hospitals with more than 300 deliveries per month.

Inputs scheduled for next Quarter include finalisation of national nursing and midwifery policy, strategy and the SMNH roadmap. Develop advocacy materials on nurse/midwife led birthing unit to be included at infrastructure work-stream meetings and trainings. Advocacy for building birthing units at referral hospitals at FMoHP and at Provincial government health plan.

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

Ongoing: A ToR for **PD 65** Aama programme implementation status report in public facilities was shared with DFID. A series of meetings was organised to consider feedback from DFID and a new ToR is being prepared which will be shared with DFID. The proposed PD will look into the Aama programme implementation in light of federalism, BHCS and health insurance.

Inputs are scheduled for next Quarter: Upon agreement of the ToR with DFID, a detailed methodology and tools will be developed

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

Ongoing: The TA provided support in selecting the EOI for the Aama programme rapid assessment round XII. Six institutions out of fourteen have passed the initial screening criteria. Out of six institutions only five send their technical and financial proposal to FWD. On 29th March, technical proposals were formally opened in the presence of the institutions and were handed over to the technical evaluation committee. FWD officials could not provide their time for Aama monitoring in the RA districts given their engagement in planning and budgeting for the upcoming fiscal year. In early April of the new quarter, a joint field visit with chief finance controller and legal adviser DoHS was conducted in two problematic districts identified from RA round XI Surkhet and Dang. Registar, Medical Superintendent, Aama focal person and Account section from Rapti Academy of Health Sciences, Rapti Provincial hospital, Provincial hospital Surkhet and Mehellkuna hospital were also a part of the visit. A report which includes management solutions has beenshared with the DG. Data request has been made to the Management Division to share Palika wise data on delivery which will assist in proper planning of Aama budget at the Palika and province level.

Inputs are scheduled for next Quarter: A general management letter will be sent from the DoHS/FMoHP to all Aama implementing facilities managed by FMoHP. Support to evaluating the technical proposal of Aama Rapid Assessment round XII, conducting the training, and providing input to tools witll be provided.

I3.4 CONTINUOUS QUALITY IMPROVEMENT INSTITUTIONALISED

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

Completed: TA supported and facilitated training in AWPB planning for CSD at Provincial level on "MSS implementation at HP/PHCC level". The provincial trainers will provide training to local level health managers/coordinators and clinical mentors.

Inputs are scheduled for next Quarter: Inputs will be provided after MSS at HP level is endorse by the FMoHP, being led by the HPP and EA work-streams at the Ministry, for implementation guides through Palika health coordinators and clinical mentors. Continue to support CSD and provinces in annual workplan planning and budgeting for MSS implementation.

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

Ongoing: A total of 35 hospitals have implemented Hospital Quality Improvement Process (HQIP) from the beginning of the programme to the beginning of this quarterly reporting period. This includes four monthly self-assessments and action planning to improve delivery service readiness at CEONC. Twenty-six new HQIPs are planned at central level (10 sites), provincial level (10 sites through the hospital strengthening programme – 4 by Province 7, 3 by province 5, 3 by province 2), and partner support (6 sites) for FY 2018/2019. NHSSP TA supported FWD to continue monitoring the old HQIP sites and plan for capacity enhancement of staff at Province and Palika levels on the Quality Improvement process at HQIP new hospitals.

Out of the 26 sites, 9 hospitals (5 NGO partner supported and 4 FWD)[18] have implemented the QI self-assessment to date. None of the hospitals supported by Provincial budget have implemented HQIP due to problems with the budget release process.

Among the 35 old HQIP hospitals, 33 hospitals were due to conduct HQIP in this reporting quarter. Only 13 hospitals[19] (39%) completed HQIP self-assessments and undertook follow up actions (see Challenges below). The small number of hospitals completing the self-assessment is due to FWD not providing a budget in FY 2018/19 to implement HQIP, including implementation of hospital's action plans (this is due to fund flow problems from central level to hospitals). As a result, a declining number of hospitals are conducting self-assessments.

Table 4 shows scores achieved by the 13 hospitals conducting self-assessments of 8 domains of quality and signal functions in this quarter. Overall scores improved from their previous assessment.

Table 4: HQIP self-assessment scoring

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

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[18] The Partner supported 5 hospitals are; Sankhuwasabha, Khotang, Bhojpur, Sindhupalchok and Solukhumbu and FWD implemented Udayapur, Sarlahi, Jajarkot and regional hospital Surkhet. ,

[19] Terathum, Mahottari, Baitadi, Darchula, Panchthar, Ilam Rolpa, Taplejung, Gulmi, Syanja, Myagdi, Arghakhachi, Bara

	Total	50	54	48	49	6	1

		Green		Red	
9 SIGNAL FUNCTIONS		Last assessment	Current assessment	Last assessment	Current assessment
SF1	Parenteral antibiotics	11	10	2	3
SF2	Parenteral utero tonic drugs	8	8	5	5
SF3	Parenteral anti-consultants	12	13	1	0
Sf4	Manual removal of placenta (MRP)	8	10	5	3
SF5	Removal of retained products (MVA)	13	13	0	0
SF6	Assisted vaginal delivery (Vacuum)	12	13	1	0
SF7	New born resuscitation	13	13	0	0
SF8	Perform blood transfusion	10	12	3	1
SF9	Perform surgery (CS)	11	13	2	0
	Total	**98**	**105**	**19**	**12**

HQIP will be integrated into MSS through the MNH service readiness component. However, the practices component of HQIP will continue during clinical mentoring

Challenge: Previously budgets were allocated to the Provincial health offices. Currently, budget release from one district to another is not possible. This is resulting in delays in implementation. Continuing HQIP at hospitals without a budget for this is challenging for the clinical mentors who are facilitating this process. For 2019/20, HQIP self-assessment will be integrated with bi-annual clinical mentoring of SBA staff and allocated budget to CEONC sites with HQIP for follow-up in 2019/20 AWPB.

Inputs are scheduled for next Quarter: Support FWD for continue monitoring the old HQIP sites and plan for capacity enhancement of staff from new HQIP sites. Revision of HQIP tool based on MSS to avoid duplication, and HQIP process will be integrated with the SBA clinical mentoring process in both BC/BEONC and CEONC sites.

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

Ongoing: FWD scaled-up the SBA on-site clinical skills mentoring programme to 33 districts in 2017/2018, and has continued the programme through AWPB in 33 districts in FY 2018/2019. Provincial government provided budgets for 9 districts through province 7 (4 districts overlapped with FWD budget). Partner organisations (One Heart World Wide and UNICEF) have implemented the same approach in 8 districts. A total of 46 districts are currently implementing SBA clinical mentoring in 2018/19.

Out of 324 Palikas in the 33 districts that received a budget from FWD, 46 Palikas implemented an on-site clinical coaching and mentoring programme during this quarter. NHSSP also supported FWD to coordinate with Palika Health Coordinators and District mentors through phone calls to plan and implement a Palika level coaching and mentoring programme as all the Palika health coordinators do not know the SBA clinical mentors programme (this programme was implemented by DHO in 2017/18). As a result of this continued coordination, 46 Palikas have been able to implement a clinical mentoring programme. Across 46 Palikas, 23 district clinical mentors were mobilised to visit 76 health facilities and coached 189 MNH service providers. They also introduced QIP in 41 of these health facilities.

NHSSP TA supported FWD to enhance the capacity of district clinical mentors through training and onsite support at CEONC and birthing centre sites to make them competent coaches/mentors. In this quarter, NHSSP supported two SBA trainers to enhance the capacity of three clinical mentors based in Mahottari and Lamjung districts.

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To date, a total of 880 MNH service providers from 294 health facilities have received SBA clinical coaching from 91 clinical mentors. Clinical coaching was mostly undertaken at the mentees' facility a total of 195 health facilities). When this was not possible mentoring was provided at the clinical mentor's or another mentee's facility. Among these mentees were 31 providers who had received follow up coaching by the end of the 2017/18 fiscal year. Their current assessment scores on knowledge, decision making, and practical skill shows improvement from base-line year (2016/2017) to 2017/2018 in all selected areas except in referral management. Data from 2018/19 are not yet ready for analysis. Table 5 shows improved knowledge and skills except in following referral process and will be updated when data from 2018/19 are available.

Table 5: SBA clinical coaching scores

		Base-line (%) 2016/2017	(%) 2017/2018
Knowledge		79	87
Decision making skills	Management of shock due to PPH	58	71
	Plotting Partograph	50	69
	Management of Eclampsia	58	63
Practical skill	Condom Tamponade	0	69
	Normal delivery	69	84
	Assisted Delivery	59	65
	New-born resuscitation	51	73
	Kangaroo mother care	75	78
Following referral process		73	70

The clinical mentors visited 154 health facilities for clinical coaching and facilitating the QIP process in these health facilities by the end of the 2017/18 fiscal year. Clinical mentors and Palika health coordinators facilitate the QI self-assessment and action planning process during clinical coaching in these health facilities. All the health facility staff and health facility operation and management committee (HFOMC) members are involved in the assessment process. In this quarter, a total of 41 health facilities completed the MNH readiness self-assessment and action planning process for improving quality of delivery services. At HPs/PHCCs QIP was repeated only at the time of clinical mentoring i.e. at 16 health facilities in 2017/18 and 5 in 2018/19. Improvement in QIP scores was observed after the one-year follow up. It is likely that improvements are due at least in part to QIP but, methodologically, this cannot be definitively proven. QIP data from this quarter is not yet analysed.

Challenge: The government staff adjustment process and massive quantity of transfers will impact on systematic implementation of the programme and may result in the need for new mentors in existing sites. In the same way, any new Health Coordinators' capacity will need to be strengthened to enable them to implement, monitor and report after completing the adjustment process. Implementation of clinical mentoring through district clinical mentors in this federal system is also challenging as Palikas without clinical mentors (the majority of clinical mentors are based at district hospitals) need to rely on clinical mentors from other Palikas and the willingness of other Palikas to send these mentors. After staff adjustment, new mentors will be selected and trained, based on the mentors' transfer situation. Clinical mentors will also be established, drawn from well-functioning BEONC sites.

Delayed: The plan was to support FWD for two batches of mentoring training in this quarter, but it was not completed because FWD staff could not release advance budget for training.

Inputs are scheduled for next Quarter: TA will support the FWD and NHTC for three batches of SBA clinical mentors' training and onsite support to clinical mentors and Palika coordinators in at least 5 districts. An online (mobile) app for reporting by clinical mentors on mentoring and QI findings will be developed. Review, planning and refresher/update training of clinical mentors from all implementation sites will take place.

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

Ongoing: NHSSP TA has been supporting the development of operational guidelines and standard treatment protocols (STP) for Basic Health Care Services. Three short-term consultants led by a senior doctor specialising in Family Medicine and Obstetrics/Gynaecology revised the STP using available clinical protocols from Nepal and the latest WHO guidelines. The first draft was shared with FMoHP/DoHS technical specialist and section chiefs for consultation and to ensure alignment with existing national clinical protocols. A two-day consultation workshop was also held with more than 50 clinical specialists from various faculties, directors and section chiefs from DoHS. FMoHP, partners working as technical specialists, and WHO consultants to ensure the STP aligns with latest WHO clinical management protocols.

FMoHP is currently costing the BHCS package with the support of WHO.

Inputs are scheduled for next Quarter: A two-day consultative workshop with potential users from HP, PHCC and primary hospitals and managers will be conducted in April to ensure the STPs are user friendly. Once the BHCS package is endorsed the STP will be shared with FMoHP directors for finalisation.

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

Ongoing: TA attended a meeting organised by WHO to share a toolkit on "Antimicrobial Stewardship Programmes in LMIC Hospitals". Based on HQIP data, infection prevention practices have improved. Among 36 hospitals that had already completed more than one assessment, the infection prevention red score has reduced from 20 hospitals in first assessment to 3 hospitals in latest assessment.

Inputs are scheduled for next Quarter: Rational prescription and monitoring are included under STP.

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

On-time: At the request of NHTC, NHSSP supported revising/updating the National Health Training Centre's Training Management Guideline -TMG (2012). Nine hundred copies of the Nepali vision of the TMG were handed over to NHTC during previous reporting period. Four hundred copies of the English version of the revised TMG were handed to NHTC in this reporting quarter.

Inputs are scheduled for next Quarter: support NHTC in the introduction of new NHTC TMG in selected venues, (to be collectively decided by NHTC and NHSSP).

I3.5 SUPPORT FWD 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: Provided TA to NSSD to develop "national nursing and midwifery policy, strategy and action plans 2019-2022". This is now in the process of finalisation. TA is also supporting FWD, CSD, NSSD, NHTC, and NHEICC on evidence-based planning and budgeting for central level AWPB for 2019/20.

Orientation on the FWD implementation guideline was conducted during PNC home visit planning and a VP workshop. A total of 163 participants drawn from provincial and local level health managers and providers have now been oriented on the guidelines.

Inputs are scheduled for next Quarter including finalisation of the "national nursing and midwifery policy, strategy and action plans 2019-2022". Continue support to Divisions and Centres on AWPB planning for central level and for Provincial and local budget as appropriate. Support to and advocacy at 7 provinces, 7 learning Lab sites and selected Palikas such as Palikas with CEONC sites on AWPB planning.

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

Ongoing: Jointly with NHTC facilitators and HPP work streams, an additional three OCA workshops took place in three LL sites, Yasodhara rural municipality with 30 participants, Lekhnath metropolitan with more than 90 participants, and Ajayameru rural municipality with 25 participants. These workshops have been described earlier in the report under the HPP work stream.

Inputs are scheduled for next Quarter, including activities planned under Learning Lab sites Review CDP plans in five LLs, complete two OCA workshops remaining in two LLs and draft OCA User's Guide for the facilitators.

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

Not scheduled: No inputs were provided in this Quarter.

No inputs scheduled for next quarter

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

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

Discussion with the FWD director and SMNH section chief revealed that TA for monitoring of safe abortion is being provided by IPAS and free new born care is being provided by UNICEF.

Inputs are scheduled for next Quarter: continue support monitoring of Aama as reported in i3.3.3

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

1. Knowledge updated on contraceptives and FP: (1) 20+ programme managers and service providers at Bardibas; (2) 3 FP trainers (on request by mobile phone); (3) 9 ADRA VSPs and project coordinator; (4) 3 ANMs/service providers and 1 FPS/O
2. TA also responded to government requests and provided technical expert inputs on several areas of work including:
   a. Technical inputs to Decision Making Tool (DMT) and WHO medical eligibility criteria (MEC) for contraception wheel implementation guideline
   b. RH Bill regulation for the FP and SMNH group
   c. Vendor assessment tool for VSC outsourcing
   d. interaction meeting between FWD and Blind Youth Association Nepal on FP2020 Rapid Response Mechanism project initiation
   e. Post-Partum FP programme managers guide sensitization meeting at FWD
   f. National Conference on Family Planning (NCFP) as member of scientific committee and reviewed abstracts

g. NCFP 2019: made oral presentation "Can skilled service provider visit expand availability and uptake of long Acting Reversible Contraceptives (LARC) services in rural Nepal" and 2 poster presentations—"Visiting Providers (VP) in Nepal increase access to family planning services in remote areas – Experiences from a post-earthquake context" and "Is there discordance between Nepal family planning practitioner's knowledge and views of eligibility for contraception and criteria set out in the WHO Medical Eligibility Criteria (WHO MEC) guidelines?"

h. FP microplanning TOT at Dhulikhel

i. led Implant, DMPA and male condom bidders' specification verification meeting at Logistic Section/MD

j. NHEICC--BCC Technical Committee for Nari Paila mobile apps finalization meeting

k. reviewed, as member of technical working group, on CREHPA led "Greater investment in modern contraception and maternal and new-born care in Nepal would reduce unintended pregnancies, abortions and maternal deaths" press release document (English and Nepali)

3. Participated, made PPT presentations and facilitated UNFPP Annual Review Meeting Planning sessions in Butwal and Dhangadhi

4. Participated and facilitated NFPP Joint Field Visit (DFID, USAID, UNFPA, MSI, ADRA, NHSSP) to Dhangadhi, Kailali, Arghakhanchi, Kapilvastu, Rupandehi districts

5. Participated and made programme update PPT presentation during UNFPP Annual Review suppliers meeting at UNFPA

1.10 PROCUREMENT AND PUBLIC FINANCE MANAGEMENT

RESULT AREA: I4.1 EAWPB SYSTEM BEING USED BY THE FMOHP 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: In FY 2019/20 a total of 56.82 billion has been allocated in health sector which is 1.2% increase in compare to last fiscal year. FMoHP received a budget celling of NPR 34.48 billion (60.6%) for 2019/20 from the MoF. Similarly, provincial and local governments received NPR 4.18 billion (7.4%) and NPR. 18.15 billion (32%) respectively . There is no significant increase in the total health budget. The PPFM team along with the planning adviser of NHSSP is supporting the FMoHP to draft AWPB preparation guidelines for FY 2019/20. The Head of PPMD, Dr. Bikash Devkota, has been taking the lead role in updating the guidelines. The findings of FMoHP budget analysis FY 2017/18 are included in the guidelines. The guidelines have clearly instructed budget offices to review the Office of the Auditor General's (OAG) audit queries of FY 2017/18 and make sure the required suggestions are included in the programme and budget. NHSSP has supported FMoHP in acquiring the programme expenditure information using TABUCS.

The Political Economic Analysis (PEA) of Local level has been completed and Province level is underway, carried out by PPFM (the oversight agency) team. We expect that the report will be available by PPFM in the next quarter. The recently formed National Natural Resource and Fiscal Commission (NNRFC) has requested FMoHP to explore the best ways of allocating conditional grants to provincial and local governments.

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

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On time: Completed

http://www.nhssp.org.np/Resources/PPFM/Budget_Analysis_of_Nepal_Federal_MoHP_FY2 018_19_Sep2018.pdf.

The budget analysis for FY 2019/20 is planned for next quarter.

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

On time: TABUCS has been updated and the changes presented in the meeting of the TABUCS implementation unit. The new update has upgraded the existing eAWPB which allows FMoHP to interface with SUTRA and other financial systems. The concept of 'chart of activities' is included in the eAWPB, which allows all level of governments to capture the budget expenditure on activities of all sources (conditional, equalisation and local etc.).

In next quarter, the suggestions from the independent review of TABUCS will be included in the TABUCS update.

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

On time: The draft guideline of the business plan was prepared in consultation with FMoHP's planning and finance section. The draft has been presented in the TABUCS Implementation Unit (TIU) meeting held on 18th March 2019. The draft was also shared with EDPs. The Business Plan guideline is in the process of being endorsed by the FMoHP.

Inputs are scheduled for the next Quarter. The business plan guidelines will be endorsed by FMoHP and a sample business plan for hospital will be prepared.

Activity i4.1.5 Requirement analysis of Aama programme in eAWPB

On-time: Completed. The decision was made to maintain the original activities of the Aama guidelines in the revised eAWPB (i.e. transport incentive, ANC incentive and reimbursement cost).

Inputs are scheduled for the next Quarter. When the new chart of activities in eAWPB and TABUCS have been finalised, the requirements will be provided to the system designer. A draft concept has been built into the draft eAWPB which will be endorsed by next quarter.

Activity i4.1.6 Package evidence into advocacy materials

On time:

This activity has now been taken up under the overall NHSSP communication activities.

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

Inputs are scheduled for the next Quarter. A new chart of activity will be presented in the meeting of the PFM committee planned for the end of April 2019. The overall system, manuals,

instructions, materials will be updated and handed over to FMoHP. The suggestions made in the spot check analysis have been incorporated in the updated TABUCS.

Challenge: The frequent transfer of trained staff may jeopardise the effective implementation of TABUCS by spending units functioning under the FMoHP. The new chart of activities allows FMoHP to capture health-related expenditures from other ministries, provincial and local government. A training package will be required to develop a pool of TABUCS trainers at provincial level.

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

On time: Ongoing support was provided to the finance and planning section. The updates on the audit queries are on-going and the entry of almost NPR 1.97 billion has been completed in TABUCS . This informationwas presented in the meeting of the public financial management (PFM) committee. NHSSP has supported the finance section to prepare the instruction letters for compliance and these have been sent to all hospitals, almost all of which have responded positively (%)(60%).(%) The updated figures will be presented in the next PFM committee meeting in May 2019.

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

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: There were no specific activities in this quarter

Inputs are scheduled for the next Quarter. All systems manuals, a training manual and user handbook of TABUCS and maintenance of the system will be completed in next quarter and the system will formally be handed over to FMoHP.

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

On time: Ongoing support was provided, for example addressing the IT related issues from 102 spending units. This included maintenance of server.

Inputs are scheduled for the next Quarter. Ongoing support will be provided. NHSSP will discuss with MoHP to provide orientation to potential software providers and support in designing the orientation package.

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

On-time: Ongoing support was provided.

Inputs are scheduled for the next Quarter. Ongoing support will be provided

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

On time: This is an on-going process.

Inputs are scheduled for the next Quarter. During on-going TABUCS training, we will support FMoHP to provide specific planning, budgeting and expenditure capturing skills to the finance officers from DUDBC.

> **Challenge:** Staff transfer is an issue in terms of institutional knowledge. This is beyond the direct scope of NHSSP to prevent, but efforts are being made to compensate for this by rolling out additional training and uploading the electronic manuals in the FMoH's website.

Activity i4.2.7 TABUCS monitoring and monthly expenditure reporting

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

Inputs are scheduled for the next Quarter. We are planning to provide a 2-hour follow-up training to high-level officials with the aim of consolidating their knowledge.

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 next Quarter. An independent review of TABUCS will be carried out. An international consultant has been identified to carry out the review and the report will be received by the first week of June 2019.

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

On time: This is an on-going process.

The first draft financial monitoring report (FMR) for FY 2018/19 was sent to DFID on 19th December 2018 to review. Following feedback from DFID a final first FMR (FY 2018/19) was submitted on 1st March 2019.

Inputs are scheduled for the next Quarter. FMR-2 of FY 2018/19 will be finalised.

Activity i4.2.10 Support FMoHP with the further development of TABUCS to capture the Nepal Public Sector Accounting Standards (NPSAS) report

Not scheduled: No inputs were provided in this Quarter

Inputs are scheduled for the next Quarter. A new chart of activity will support FMoHP in preparing the NPSAS report.

> **Challenge:** How to fully capture the NPSAS report in TABUCS is being discussed. At present, it appears that the expenditures can be captured from all spending units functioning under FMoHP. The current design of SUTRA focuses on capturing the expenditure of budget provided through the federal Red Book and local revenue. Improvements are needed to capture all the requirements of NPSAS and activities from health conditional grants.

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

Completed: The requirements in terms of capturing the budget and expenditure are now included in TABUCS.

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

Completed: FMoHP has provided the source code to FCGO on 15th January 2019. There has been no progress from FCGO to roll out TABCUS across other ministries.

Inputs are scheduled for the next Quarter. Support FMoHP in finalising the software, guidelines, training manuals and user handbooks. NHSSP will handover TABUCS to FMoHP.

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

Activity i4.3.1 Update internal control guidelines

Completed: No activities have taken place in this quarter.

Inputs are scheduled for the next Quarter: NHSSP will organise consultative meetings to initiate discussions on updating the internal control guidelines in federal context.

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

Deleted: DFID has advised that the PETS will be carried out by the World Bank at some point in the future.

No inputs are scheduled for the next Quarter.

Activity i4.3.3 Conduct PER

Deleted: DFID has advised that the PER will be carried out by the World Bank at some point in the future.

No inputs are scheduled for the next Quarter.

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

The PFM Committee meeting decided to revise the existing FMIP and a team of national and international consultants are supporting this. A draft revision has been prepared and shared with the national and international consultants for comment and review. FMoHP is planning to send a draft FMIP to EDPs by the end of April 2019.

Inputs are scheduled for the next Quarter. With the inputs from PPFM team, we will support FMoHP to finalise the new FMIP.

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

On time: The minutes of the PFM and Audit Committee are regularly shared with the concerned development partners. Some of the agreed actions from audit committee meeting held on 21st February 2019 includes:

- Prepare a work plan to clear the audit queries by 50% at the end of FY2019/20
- Organise a one day orientation session for financial managers and officers working at the federal GoN entities and hospitals for audit clearance.

The first agreed action is on-going and the orientation programme which was completed on 17th &18th March 2019. There was no PFM meeting held in this quarter. A PFM team led by the Finance chief of FMoHP and the NHSSP team visited Okhaldhunga, Solukhumbu, Khotang, Bhojpur districts in Province 1 from 21-24 March 2019, and monitored PFM functions. It was found that most of the hospitals' budget release process was disrupted due to hospitals being handed over from Palikas to Province. This has caused confusion in authority, flow of funds and the role of the District Treasury Comptroller Office (DTCO). FMoHP is aiming to resolve these issues through consultative meetings with fiscal commission and MoF.

Inputs are scheduled for the next Quarter. The findings from the field visit will be presented in the meeting of the PFM committee. A joint team of FMoHP, EDPs and NHSSP is planning a

forthcoming r field visit to monitor FMIP. Next PFM committee meeting will be help on third week of May 2019.

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

On time: A new Financial Procedural and Accountability Bill has been presented to Parliament. After this is approved, the GoN will make regulations which will, in turn enable the training manual to be updated.

This will be completed in the next Quarter**.** Once the new Act and regulations have been passed the manual will be completed, and a workshop held. At present, it is not clear when this will be.

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

On time: Provided technical support to conduct one-one day orientation workshop on audit clearance for finance mangers and officers from federal GoN entities and hospitals on 17th and 18th March respectively organised by FMoHP. NHSSP has transferred the necessary skills to the finance managers and officer from FMoHP to be able to run the orientation workshop on audit clearance using TABUCS The discussions were organised to analyse the key components of the DRAFT Bill that needs to be included in the new manual.

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

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

On-going: An international consultant has been recruited to review the internal control and audit process and the report will be shared with DFID and FMoHP. Once it is approved by FMoHP the draft version will be shared with relevant EDPs. The internal audit data have been collected in this quarter and an Internal audit status report (payment deliverable) is scheduled for May 2019.

Inputs are scheduled for the next Quarter. We will organise a workshop to finalise the draft internal audit improvement plan (IAIP). Before that, we will organise a one-day meeting with PPFM team to prepare a final draft.

Challenge: The FMoHP needs to ensure all spending units have entered data into TABUCS. In the present federal context, the federal, province and local financial procedural Act and Regulation may affect the FMoHP's IAIP. We will raise this issue in the workshop as this is felt to be the most effective environment in which to discuss this challenge and collaboratively agree an approach to try to resolve it.

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

On time: The TA team provided a series of updates on PFM and procurement in development partners' meetings. PIP, IAIP, FMIP, TABUCS are key strategic documents and systems and need to be revised and updated in the context of Federalism. NHSSP is supporting, and will continue to support, FMoHP to have wider level discussions to ensure the current guidelines, systems address changing needs, and that these talk to each other.

Inputs are scheduled for the next Quarter. We will organise consultative meetings in provincial level (Karnali Province, and Provinces 2 and 5).

Activity i4.3.10 Support to the PFM & Audit committee

The last formal meeting of the PFM technical committee, chaired by the Chief of Finance Section, was held on 8th March. The meeting discussed progress made in TABUCS' update, business plan guidelines and PBGA and agreed a set of actions including….. The last meeting of the Audit Committee, chaired by the Secretary, was held on 21st January 2019. The committee discussed the progress of audit clearance, and the annual audit clearance plan, responding to OAG's primary audit report within 35 days, and instructed to its subordinate entities to follow the meeting minutes.

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

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

On time: In the last PFM committee meeting DFID has suggested organising a meeting on PBGA. In order to get the further information, a joint team including the members of FMoHP and NHSSP officials visited the Mission Hospital Okhaldhunga on third week of March 2019. The committee made a strong recommendations to the hospital that they need to regularly submit their reports against the grant received from FMoHP. During the visit the hospital expressed willingness to implement the performance-based grant agreement framework. They have raised the issues including insufficient funds, delayed funds flow, insufficient monitoring and weak reporting system. They are willing to implement TABUCS in the hospital.

Inputs are scheduled for the next Quarter. MoHP will present the update in PBGA in next PFM committee meeting to be organised on third week of May 2019. Okhaldhunga hospital to present its concept note to implement PBGA at the PBGA learning café and Bayalpata are to share their experience in implementing PBGA in the meeting of PFM committee.

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

Completed: The issues from the field were presented in the meeting of the TIU held on 8th March 2019. These issues included weak reporting practices, lack of focal person to manage the PBGA, irregular monitoring from FMoHP and weak institutional home at FMoHP. As a result, it was agreed to make an agenda for the meeting of the PFM committee and to explore the solutions. A well-functioning section at FMoHP would help in addressing these issues.

In next quarter, FMoHP will present the update on the a performance-based grant agreement (PBGA) guideline will be developed and presented in the ongoing PBGA learning café and the meeting of PFM committee

Challenge: A lack of an institutional home for the PBGA might undermine its implementation. After the upcoming structural changes, TA may need to provide additional support to identified focal person in FMoHP. A discussion is required in the meeting of PFM committee, which will help in outlining the key recommendations. The next PFM committee meeting is due in February 2019, and we will request this is put on the agenda.

Activity i4.3.13 Redesign PBGA for hospitals

On time: This is an ongoing process. A series of discussions were held to explore the scope of PBGA in public hospitals. In last PFM committee meeting the implementation of TABUCS and audit modules in hospitals was discussed. Okhaldhunga hospital has agreed to implement the FMoHP requirements. This requires further discussions and approval from FMoHP. We will ensure there is an agenda item related to PBGA in public hospital in the next meeting of PFM committee.

Inputs are scheduled for the next Quarter. TA will test the willingness of hospitals in PBGA and draft initial modality. The new modality will be prepared after having the discussion at PFM committee.The new modality can be tested in FY 2019/20.

Activity i4.3.14 Policy discussion on PBGA for Hospitals in the federal structure

Ongoing: Several rounds of discussions were conducted with the FMoHP/PPMD to Surkhet provincial hospital and Okhaldhunga mission hospital on the scope of PBGA implementation in the federal context. PFM committee need to discuss on having focal entity, focal person and recommend a scope of PBGA implementation in federal context. DFID may need to raise the importance of dedicated discussion on BPGA with PPMD.   .

Inputs are scheduled for the next Quarter. A 3-hour meeting with FMoHP/PPMD will be organised to discuss the PBGA and business planning process of the central level hospitals.

Activity i4.3.15 Expansion of PBGA in selected hospitals

Not scheduled:

Inputs are scheduled for the next Quarter, particularly initiating a dialogue with national heart hospital.

Activity i4.3.16 Contribution to the learning laboratories

Not scheduled:

No inputs are scheduled for the next Quarter. The PPFM team has assigned one adviser to provide ongoing/required inputs to the Learning Labs. The adviser is coordinating PPFM issues with the LL focal person. This is not considered as an independent activity.

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

Achieved

No inputs are not scheduled for the next Quarter.

Activity i4.3.18 PBGA training (preparation of manual)

 Achieved

No inputs are not scheduled for the next Quarter.

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

The TA team has discussed this with Naya Health and Okhaldhunga mission hospital. The field visit team has recommended Naya Health and Okhaldhunga mission hospital to present its modality at the next PFM committee meeting to be held on the third week of May 2019.

Inputs are scheduled for the next Quarter. TA will follow up our request to PPMD to have a presentation from Naya health and Okhaldhunga at the meeting.

Activity i4.3.20 Initiate PBGA learning group

Not scheduled: No learning group meeting was organised in this Quarter. This is a loose forum which has issue-based discussions as and when they are needed. Three meetings were held in the previous quarters.

Inputs are scheduled for the next Quarter. A meeting will be organised at an appropriate time during the forthcoming quarter in which the PBGA receiving agencies, the FMoHP, and TA will participate. The agenda will address the evolving grant management issues.

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

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

The plan to conduct an organisation and management survey has now ended and has been dropped in the new plan. The new FMoHP structure includes a Logistic Management Section under the Management Division of DoHS, which is responsible for delivering the procurement functions of DoHS Divisions.

Activity i4.4.2 Revise Standard Operating Procedures and obtain endorsement by the DoHS

Completed.

No inputs are scheduled for the next Quarter.

Activity i4.4.3 Workshop, Approval of Standard Operating Procedures (SOP) by the DoHS

Completed (See 4.4.2)

No inputs are scheduled for the next Quarter.

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

Delayed: Hiring of Senior Pharmacist process has been completed.

Inputs are scheduled for the next Quarter. The process of preparing SOP for PDI and QA will be started. A draft will be shared among the EDP's PSM group.

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

This activity is merged in i4.4.7 in new plan

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

Ongoing: Capacity building including support to the procurement clinics and systematic support on procurement functions is ongoing. In this quarter 12 clinics were supported.

Inputs are scheduled for the next Quarter. These will be on-going embedded support.

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

Ongoing: NHSSP TA, at the request of the public procurement monitoring office (PPMO), is reviewing the draft document prepared by the PPMO Consultant and will provide comments/suggestion on behalf of DoHS-MD.

Inputs are scheduled for the next Quarter. If feedback on the draft SBD of FA has not been obtained from PPMO, we will request FMoHP to follow up and try to speed up the process. We will also continue to request PPMO to provide feedback.

Activity i4.4.8 Preparation and endorsement of SOP of FA

Delayed: (See 4.4.7 above) As the SBD is not endorsed and announced by PPMO, the preparation of its SOP has not been not initiated. In the meantime, the PPMO is also preparing a Procurement Guideline for Framework Contracts. NHSSP TA is also reviewing this document.

Inputs are scheduled for the next Quarter.

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

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

Inputs are scheduled for the next Quarter.

Activity i4.4.10 Train the DoHS staff on FA

No inputs are scheduled for the next Quarter until the SBDs have been issued by the PPMO and are ready to use (see 4.4.7 above).

Activity i4.4.11 Orient suppliers on FA

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

Inputs are scheduled for the next Quarter (See 4.4.7 above)

Activity i4.4.12 Revise and update the Procurement Improvement Plan

Ongoing: A new updated procurement implementation plan (PIP) was prepared in 2017. However, within the new planning this activity has changed to *"Revise Federal PIP and continuous monitoring and support to develop Provincial PIP"*. As a result, the PIP needed to be further revised and it was also necessary to prepare a framework for guiding provinces, in preparation for their provincial PIP. The Nepal Health Sector Public Procurement Strategy Framework (NHSPPSF) has been drafted and shared with EDPs. NHSSP intends to finalise the document through a workshop in next quarter. In the meantime, PFM-SP is also going to support provinces to prepare Provincial PIP.

Inputs are scheduled for the next Quarter. The consultative meetings and workshops will be organised to prepare the comprehensive PIP.

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

Ongoing: It is now time for preparation of the AWPB. Continuous support is being providing to prepare the CAPP and its execution.

Inputs are scheduled for the next Quarter.

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

On time: The sixth CAPP Monitoring Committee meeting was organised in February at the DoHS. Progress of procurements against the CAPP were discussed and instructions were given to expedite the remaining procurements needed during this fiscal year. Data show that 65 procurement items out of 114 items of CAPP 2017/18 (57%) were initiated till February 2018. Whereas 48 procurements out of 65 procurements in CAPP 2018/19 (74%) had been initiated by February 2019, reflecting progress. Similarly, the use of online e-GP in February 2018 was only 14%, whereas it is 83% in February 2019.

Additionally, there was a small presentation of the Grievance Handling and Redressal Mechanism system in use by the Management Division. This is a web-based system launched by MD this year.

Inputs are scheduled for the next Quarter. The seventh CAPP Monitoring Committee meeting will be organised and held in April 2019.

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

On time: The e-CAPP designing, development and testing along with preparation of a training manual and a system manual had already been completed in previous quarter. In this quarter training was organised to all the federal level health institutions. Thirty-two working staffs from 28 organisations participated in the training.

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

Activity i4.4.16 CAPP produced within the agreed period

On time: Execution of the present Fiscal Year CAPP is being monitored by CAPP Monitoring Committee. The new CAPP for the F/Y 2076-77 (2019-20) will be prepared in time, with support of NHSSP TA

Inputs are scheduled for the next Quarter.

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

Ongoing: Meetings with PPMO are in progress, to make the PPA and PPR health sector friendly. The amendment bill is waiting for review by the cabinet.

Inputs are scheduled for the next Quarter.

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

Delayed: The SBD for the procurement of Health Sector Goods had already been prepared and submitted to the PPMO. Continuous discussion and presentations are now on-going at the PPMO. In an effort to move things forward, the TA team have engaged the FMoHP's Secretary with the PPMO to get the endorsement.

The World Bank is reviewing the above document as well as the Bidding Document from which the DoHS is procuring the medicines now and will endorse it for the purpose of the DLI assessment. The bidding documents presently used by the DoHS for procurement of medicines are customised SBDs of PPMO for procurement of goods with allowed changes in

the necessary sections. NHSSP TA was involved in preparing the customised bidding document for procurement of medicines by the DoHS.

Inputs are scheduled for the next Quarter. Continuing efforts will be made to obtain endorsement of new document from PPMO. This will be done directly by NHSSP but also by working with others such as the FMoHP who may be able to exert more pressure.

Challenge: The challenge is that there is lack of capacity within PPMO to understand the need and use of special conditions for procurement of health sector goods, which are to be included in the SBD. Requirement of separate SBD for health sector goods is realised by PPMO. However, they have not prioritised this task along with the SBDs of Framework, Design and Build, and Turnkey Supply.

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

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

No inputs are scheduled for the next Quarter.

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

Ongoing: Capacity building of provincial and local government is continuing. Standard operating procedures (SOPs) for the standardisation of the procurement of drugs and eGP have been prepared with the involvement of the DoHS staff and distributed to all provincial and local governments including health institutions since April 2018. In this quarter, NHSSP TA facilitated provincial government in procurement functions by visiting Provincial Health Directorates, Health Offices, and Provincial Ministries of Social Development, and by providing distance support through telephone as and when necessary. Provinces 1, 2 and Gandaki Province offices received on-site coaching and other provinces got distance support in the procurement of medicines and equipment.

Inputs are scheduled for the next Quarter. We plan support provincial Procurement trainings. In addition, NHSSP TA will take some sessions for any capacity building training/workshops organised by any level of Government or partners.

Challenge: As there are a huge number of procurement units, if local governments are included, the capacity of NHSSP to effectively facilitate implementation and monitoring at all of these remains a challenge.

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: The list of "Free Essential Drugs" has been completed. This is different to the far greater number of drugs in the essential drug list. For 'essential equipment', an expert group needs to work on this under DoHS, FMoHP to define the term "essential equipment" and a workshop should be organised to achieve this.   Currently, there are more than 600

users registered in e-TSB and more than 10,000 downloads have been registered for different specifications.

Activity i4.5.2 Prepare and endorse Grievance Handling Mechanism

Already Completed

Inputs are scheduled for the next Quarter. A study will look at its use in the Management Division, with a report will be prepared during the next quarter.

Activity i4.5.3 Specification bank updated by LMD in consultation with development partners

Ongoing: Updating of the TSB is in progress. Ten additional approved specifications of medical equipment have been uploaded on the TSB in this quarter. These approvals are by DG following the agreed process, as MoHP has provided the authority to approve TS to DG, which is also mandated by the PPA.

Inputs are scheduled for the next Quarter. These include updating the TSB, formation of technical committees, and hiring a pharmacist.

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/LMS 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

Already Completed: The e-GP guidelines for the health sector and the facilitation booklet were prepared, printed and distributed to all the health facilities including provincial and local level governments in August 2018.

Inputs are scheduled for the next Quarter. The development of the e-GP guideline has been completed but there is concern about its use and the overall capacity of LLGs. It is clear that e-GP is being started by the Provincial Health Directorates and that NHSSP TA needs to facilitate this, but it is difficult to do this for all LLGs given their numbers.

Challenge: Developing the capacity of the local institutions to use e-GP has been challenging. As a result, NHSSP will involve its TA to facilitate capacity enhancement of provincial and local procurement entities by providing appropriate trainings.

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

Not scheduled: A separate web-based grievance handling mechanism was adapted in LMD/LMS for the health sector.

No inputs are scheduled for the next Quarter.

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

Not scheduled: FCGO will be taking over this activity.

No inputs are scheduled for the next Quarter.

1.11 EVIDENCE AND ACCOUNTABILITY

RESULT AREA: *I5*.1 QUALITY OF DATA GENERATED AND USED BY DISTRICTS AND FACILITIES IS IMPROVED THROUGH THE IMPLEMENTATION OF THE ROUTINE DATA QUALITY ASSESSMENT SYSTEM

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

Completed: Web-based RDQA tools and the related e-learning materials aimed at facility based staff and health governance units, have been developed in collaboration with GIZ, USAID and WHO and published on the FMoHP website (www.rdqa.mohp.gov.np).

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

Ongoing: NHSSP is engaged with the local governments in the LL sites to facilitate the roll out of the RDQA. Till date, RDQA has been completed in Itahari sub-metropolitan City (Province 1), Dhangadhimai Rural Municipality (Province 2) and Yasodhara Rural Municipality (Province 5). It is ongoing in Pokhara Metropolitan City (Gandaki Province). The remaining LL sites will be covered in the next quarter (Ajayameru Rural municipality in Sudur Paschim). SSBH/USAID will support the provincial and local governments in roll out of the RDQA in its programme areas (including Kharpunath Rural Municipality, Karnali Province).

This year FMoHP (FWD, DoHS) has provided a conditional grant to the provinces for roll out of RDQA. This quarter PPMD, FMoHP also supported the Provincial Health Directorate Province 1 to roll out RDQA at health facilities and is planning to cover other provinces in next quarter. NHSSP is engaged with M&E Section, PPMD, FMoHP and IHIMS, MD, DoHS to include implementation of the RDQA as one of the key activities related to information management for the next AWPB.

Continuous follow up of the progress on action plan developed as a part of the RDQA implementation will be the key inputs in the Learning Lab sites in the next Quarter.

RESULT AREA: *ACTIVITY I5.2* FMoHP HAS AN INTEGRATED AND EFFICIENT HEALTH INFORMATION SYSTEMS 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: Under FMoHP's overall leadership, NHSSP coordinated the development of 'Health Sector M&E in Federal Context'. This is a guideline for the three levels of government. DFID/NHSP3, NHSSP and MEOR jointly collaborated with GIZ, WHO, USAID and other EDPs in the development process. The document defines the health sector M&E functions of the three levels of government, identifies the data needs at each level and includes a survey plan to meet the data needs with specific response to the NHSS RF and the health-related Sustainable Development Goals. Support to implementation at different levels is explained in section i5.2.2 below.

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

Ongoing: TA was engaged with the local governments at the learning lab sites to support them in planning their health sector M&E activities in line with the 'Health Sector M&E in Federal Context'. They were also supported to develop a work plan based on the organizational capacity assessment. This will be continued in the next quarter.

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

Ongoing: A series of focussed consultations were held within FMoHP and with development partners on harnessing digital technologies to strengthen health systems including expansion of the electronic health record (EHR) system at different levels of health facilities. NHSSP is supporting the FMoHP in introducing EHR in at least one facility in each province (Activity 2.2 of Aid Memoire). NHSSP will support implementation of EHR in one facility in one of the seven learning lab sites. FMoHP is planning to assess digital readiness of tertiary level of hospitals managed by the federal government to initiate the EHR.

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

On-going: FMoHP is practicing the electronic attendance system but TA's support to maximize the utilization of the data/information for human resource management has been delayed due to changes in the FMoHP leadership. However, TA is now engaged with the newly formed IT section at the FMoHP to make best use of the data through use of dashboard at the FMoHP. At the subnational level, NHSSP TA will support the LL site(s) that chose to use electronic attendance system. Support will be for the development, institutionalization and maximization of its use to better manage human resources as needed. TA support on this initiative will not include the hardware support in procurement and installation of the device.

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

Ongoing: TA is engaged at the strategic level in supporting the IHIMS to plan and implement the training package aimed at building the capacity of local governments on e-reporting of HMIS in the DHIS2 platform. In the LL sites, the TA is coordinating with the IHIMS/DoHS to support them in ensuring e-reporting from facilities.

In the next quarter the TA will prioritize follow up and onsite coaching to ensure e-reporting occurs at the less capacitated LL sites.

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

The TA is working with the IHIMS at the DoHS and FMoHP to digitize the OCMC and SSU recording and reporting tools in DHIS2 platform for better integration with the HMIS. The recording and reporting forms are being reviewed internally and the technical details for customization in the DHIS2 platform are being discussed with the technical persons.

Digitization of the recording and reporting tools of SSU and OCMC in DHIS2 platform will begin from the next quarter

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

On-going: Under the FMoHP leadership, NHSSP has been coordinating the development of national e-health guideline in collaboration with other partners particularly GIZ, WHO, Medic Mobile. This quarter a concept note and terms of reference (ToR) for development of the National eHealth Guideline have been finalized and the ToR got approved from DFID. This guideline will help standardize, integrate and better harmonize the e-health initiatives. As stated in the ToR, the TA has been seeing input from an international expert in developing the outline of contents and other technical areas of the guideline. The TA is also carrying out wider discussion with relevant stakeholders to develop the guideline further. The development of guidelines is due for submission to DFID as a PD for May 2019.

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 Maternal and Perinatal Death Surveillance and Response (MPDSR) in hospitals and communities

On-going: The TA is continuously engaged with the FWD, WHO and USAID for better implementation of MPDSR in the federal context. There have been focussed discussions around finalization of the MPDSR implementation guideline in the federal context; collaboration with provincial academies of health sciences for strengthening and expansion; development of e-learning packages; improving digitization of the recording and reporting tools; and analysis of the data collected so far to better inform the decision-making process in general and the 'response' component of the system in particular.

Inputs are scheduled for the next Quarter. Also, refer to Sections i5.3.2, i5.3.3 and i5.3.4 below.

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

On-going: This quarter the TA continued the focussed technical consultations with the government and partners supporting the FMoHP on mHealth (like Medic Mobile, Nyaya Health, BBC Media Action, Aamakomaya) to harness the mHealth initiatives to strengthen the community health in general and addressing the issue of strengthening MPDSR with focus on effectiveness, scalability and sustainability in particular. The consultations have revealed that rapidly spreading coverage and ever reducing cost of mHealth technology have created a number of opportunities in community health like delivery of health messages directly to households; empowering health workers for more effective health care coordination between health workers and clients as well as among health workers of different levels; and delivering latest clinical and public health information to community health practitioners. However, these consultations have also identified the need of working towards developing platforms for sharing of good practices in digital health technology at all spheres of government; developing a mechanism for mentoring and supervision of community health workers using digital health technology; adequate legal instruments to govern data confidentiality and data sharing; and building interoperability among different digital health systems. The proposed National eHealth Guideline is expected to address these and other issues (see activity I5.2.7 above).

The technical discussions and initiatives to address the gaps identified will be continued in 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-going: The TA is continuously engaged with the FMoHP counterparts and partners including WHO and USAID/SSBH to advocate for collaboration with the provincial Academy of Health Sciences for institutionalization and expansion of MPDSR at the provincial level. Despite the growing acceptance of this approach among the FMoHP counterparts and other stakeholders there has not been good progress on this due to the FMoHP's competing priorities related to the staff adjustment in federal context. The TA will continuously engage with the government counterparts, development partners and academic institutions to take this initiative forward.

Detailed activities will be planned and implemented in the next Quarter.

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

On-going: This quarter TA held consultations with M&E Section, PPMD, FMoHP; IHIMS, MD, DoHS; and WHO to develop e-learning packages on MPDSR. There has been common understanding among the stakeholders to first revise the MPDSR implementation guideline in the federal context and then develop e-learning package adhering to the guidelines. TA is working with the government counterparts and WHO on revision of the guideline.

TA will work towards revision of the guideline and development of the e-learning packages in the next Quarter.

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

On-time: The TA along with WHO and GIZ continued to support the process of integrating the routine MISs and the surveillance systems including EWARS in line with the spirit of forming the IHIMS in the federal context. With regards to EWARS, work is in progress towards updating the web-based information system in the DHIS2 platform. This will enable automatic reporting of selected indicators to HMIS.

Inputs are scheduled for the next Quarter - updating the EWARS reporting in DHIS2 platform

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-going: In this quarter TA continuously engaged with FMoHP and USAID to plan a health facility survey in 2019/20, in line with the Aide Memoire 2019. The discussions focussed on having a census among all health facilities to develop a baseline for all the 753 local governments and 7 provinces; identifying country specific modules, if any; consultation with provincial and local governments regarding the survey; costing; and timeline of the survey.

As agreed with the FMoHP and World Bank, TA is also preparing for a comprehensive health infrastructure assessment at the seven LL districts. (For details see Section i5.6).

Detail planning for the NHFS 2019/20 and implementation of the infrastructure assessment is planned for the next Quarter.

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

Analysis of the equity gaps in health service utilisation

On-going: Supported FMoHP to complete the compendium of indicators for the NHSS results framework and M&E guideline in the federal context.

Supported IHIMS in different activities. First, to select the key indicators and generate local level data for these key indicators for FY 2074/75. This data will be made public through the DoHS website for use in local level planning. Second, to prepare data and write this up for DoHS Annual Report FY 2074/75. Third, to improve the quality of HMIS data. This included standardizing the measurement of selected indicators and removing duplicate indicators.

The TA also supported the FWD in analysis of HMIS data related to family planning and safe motherhood programme. The LL sites were supported to prepare their profile using the HMIS data.

Inputs are scheduled for the next Quarter. Based on the updated compendium of indicators, the NHSS RF dashboard will be updated. The plan is also to prepare evidence briefs using HMIS data.

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 i5.2.1.

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

On-going: Following the National Annual Review 2018, TA was continuously engaged with the FMoHP and partners to finalize the Aide Memoire which was jointly signed by the Secretary and the EDP chair on 26 March 2019.

TA has prepared a list of quality related indicators from routine MISs and surveys; and their compendium to feed into the development of a Quality Improvement Management Information System (QIMIS). This will be finalized in consultation with the FMoHP counterparts and other stakeholders next Quarter. Finally, it will be added as a separate section to the existing dashboard in FMoHP's website. TA has supported the FMoHP to develop a web portal to showcase narratives of good practice within the health sector at different levels (goodpractices.mohp.gov.np). This includes different types of interface for recording and approval of submitted information along with an interactive dashboard for public access. The purpose is to compile these innovative practices in the health sector which have been initiated at the local level and disseminate them to wider stakeholders. This is expected to create a positive synergy and also provide a common platform for shared learning.

TA continued its engagement in supporting the FMoHP in preparation of 15th periodic plan, revision of the National Health Policy and long-term vision paper.

As a TWG member, TA was continuously engaged with the NHSS MTR team and supported them by providing them the necessary information and reference documents.

Inputs are scheduled for the next Quarter. The quality-related indicators and Quality Improvement Management Information System will be completed in coordination with stakeholders.

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

Ongoing: The TA is working together with MEOR to develop policy briefs based on equity analysis of DLI 12 indicators and burden of disease. The team also drafted a policy brief to reflect inequality in utilisation of maternal health services.

The TA developed technical notes on the family planning and safe motherhood programme based on further analysis of HMIS and NDHS data. These were used to inform the AWPB process. This included current status of key indicators and recommendations.

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

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

On-going: This quarter the TA was engaged with the FMoHP to form a new M&E TWG with an updated ToR and structure aligned with functions in the federal context. The structure and scope of work of the new TWG has been aligned with the new structures and responsibilities of the FMoHP, DoHS, DDA and DoA; it also includes representation from EDPs. The new M&E TWG was formed by the FMoHP on 01 February 2019 (18 Magh 2075); and its first meeting was held on 12 February 2019. During this first meeting the concerned officials provided an update on the Tuberculosis Prevalence Survey, Health Infrastructure Information System (HIIS), TABUCS and the Nepal report on Burden of Disease.

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

On-going: The TA together with IHIMS, DoHS is coordinating with the National Health Training Centre (NHTC) to develop a M&E training package for the health workforce at different levels as a part of induction training being conducted by the NHTC. This package will also be applicable for the provincial health training centres. The package will be based on the e-learning leveraging the digital technologies.

 Inputs are scheduled for the next Quarter. This includes development of the M&E training package as part of induction training.

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.

The strategic review of social auditing will be completed by November 2019. The social audit guidelines revision will take place after the strategic review of social audit. The review will inform for the changes to be fed in the guidelines. The task of development of reporting mechanism and enhancing the capacity of partner NGOs will be done after revision of the guideline. ***Activity i5.5.2 Support the development and operationalisation of smart health initiatives, including grievance management system for transparency and accountability***

On-going: NHSSP together with WHO, GIZ and other EDPs have been providing technical assistance to the FMoHP in the development of national e-health guideline and finalizing the e-health road map in line with the national e-health strategy. FMoHP is updating the health facility registry in coordination with the provincial health directorates. TA is also engaged with the IT Section in the FMoHP for operationalization of the e-health initiatives like updating the dashboards, grievance management system, file tracking system and knowledge management portal.

In the next quarter the TA will support the local governments in learning lab sites in updating and use of the health facility registry and the dashboards for evidence-based monitoring and decision making.

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

Delayed: TA in coordination with partners like WHO, GIZ, Medic Mobile and others supported the FMoHP to conduct policy dialogue on harnessing digital technologies to strengthen health systems, but it could not take place due to the storm in Bara and Parsa districts. The Deputy Prime Minister and Minister to FMoHP has shown interest and commitment on digital health so FMoHP is planning to have this and other similar series of events on digital health.

Inputs are scheduled for the next Quarter. This will be support to facilitation of the postponed policy dialogue and its follow up activities.

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. The TA will coordinate and collaborate with SAHS for the activities related to citizen engagement forums**.**

No inputs are scheduled for the next Quarter

Other activities

1. Supported MEOR in knowledge management for DFID's NHSP3 suppliers. In collaboration with MEOR, a website was developed for NHSP 3 which includes separate domains for NHSP 3 suppliers. These domains will be owned and operated by individual suppliers in the future.
2. Continued regular monthly meetings between NHSSP's EA team and MEOR. The monthly meeting minutes have been shared with DFID.
3. Supported the PPMD, FMoHP in collecting the policies, strategies, guidelines, protocols and survey reports produced by different entities within the FMoHP to facilitate the development of Knowledge Management Portal. This portal is now published in the FMoHP's website (km.mohp.gov.np).

4. An EA member participated in the "Training Workshop on Country Led Implementation Research on Universal Health Coverage (CIRU) in Nepal" from 27-28 February 2019.
5. Published a blog 'Accessible evidence leads to better decisions for health in Nepal' to reflect the work done by the TA to develop online interactive data dashboards that have made evidence accessible to health managers, policy makers and other stakeholders (https://options.co.uk/news/accessible-evidence-leads-to-better-decisions-for-health-in-nepal).
6. Working with MEOR to produce evidence briefs
7. Supported development of a protocol for a study to evaluate task shifting of physiotherapy services. Participated in several meetings and workshops to refine the protocol further.

1.12 HEALTH INFRASTRUCTURE

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 (DRR) activities and policies in the Federal Ministry of Health and Population (FMoHP) and aims to improve and enhance the coordination mechanism for DRR governance in the changed context of federalism.

Results in this area are improving, with the Health Infrastructure team (HI team) actively supporting the work of the FMoHP Health Emergency and Disaster Management Unit (HEDMU). The HI team provided inputs to orientation and planning sessions led by the HEDMU, including hospital safety planning and the Health Sector Emergency Preparedness and Disaster Response Plan workshop in January 2019.

The HI team is working with other NHSSP work streams to develop an assessment tool to support disaster preparedness and response planning for health facilities within the Learning Lab districts (see HIIS section below).

Inputs are scheduled for the next Quarter: The HI team will use this tool to identify Disaster Risk Reduction (DRR) actions at health facility level linked to each local municipality's DRR plan. The HI team will continue its support to HEDMU in developing materials to support health emergency and disaster preparedness and response.

Challenge: The changes in functions and relationships under the new federal dispensation may impact on the approach to mainstreaming DRR across the different spheres. This situation will be monitored continuously, and if necessary, adjustments made to the implementation modality.

i7.1.2 Upgrade HIIS to integrate functionality recommendations

On time: The Health Infrastructure Information System (HIIS) continues to provide valuable support for evidence-based decision-making, and to make the case for efficient, rational and cost-effective planning of health facilities.

The Federal government has decided that there should be a health facility in each local ward. The HIIS supported the FMoHP in identifying 2 472 wards that were without any type of health facility. The HIIS was used to measure ward population, distance and type of nearest health facilities located in adjacent wards (within two km in hills/mountains and three km in the Terai). Key findings were:

- 1 766 wards had another health facility in an adjacent ward

- 508 health facilities served a population of less than 2 000
- 1 466 wards have populations below 2 000 and proximity to other health facilities
- There were no plans to equip or staff the proposed facilities
- The proposed approach would be costly and difficult to implement

Despite NHHSP technical advisers making the case that a blanket approach should not be applied, the federal government decided to abide with its decision. Consequently, the HI team proposed two new types of facilities, reduced in size and designed to serve smaller populations.

The HI team has also used HIIS analysis to support the federal government's decision to develop a 15-bed hospital in each local authority. This enabled the FMoHP to identify 192 PHCCs which could be easily converted to meet this requirement in their areas. HIIS data was also used to show that given small catchment populations, not all local authorities would require 15-bed hospitals. As a result, the FMoHP has decided to conduct a needs assessment for these facilities through the DUDBC.

The HIIS is also being used to support facilities planning for the provincial sphere. In Province Three, the HI team workshop on NHIDS was also used to make the case for identifying appropriately located facilities to serve multiple municipalities.

This approach has been adopted in Karnali province, which will prioritise and develop only eight existing facilities only as primary level hospitals. The HI team also successfully advocated for completing the development of Surkhet Hospital to a maximum of 300 beds, instead of the 500 beds previously demanded. This now provides an opportunity for rational integrated development of this hospital, with money saved on capital works being used to procure equipment, add support services and initiate effective human resource planning.

In the local sphere, the plans for the HIIS survey of health facilities in the Learning Lab municipalities and associated districts are now complete. Survey logistics and route planning have been finalised, and the survey tool has been completed in consultation with other NHSSP workstreams and digitised in a in a web-based android application. Data collection in the field will begin in April 2019.

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

- Continuing and regular update of HIIS drawing on primary and secondary source information
- Support to the Learning Lab data assessment team in fieldwork and analysis from April 2019
- Support federal, provincial and local spheres of government in the use of HIIS for HI analysis and information dissemination
- Continued advocacy for rational HI planning using HIIS evidence and information

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

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

On-time: The HI team is building the capacity of FMoHP, DOHS and DUDBC officials to use the HIIS for HI planning and development of health infrastructure.

The FMoHP has used the HIIS as a starting point in a partnership with the World Bank for health infrastructure data collection, incorporating a vulnerability assessment of facilities. The HI team has supplied the data framework, questionnaire and current HI information to the World Bank, and will receive access to the strengthened datasets.

In this quarter, the online web-based HIIS portal was configured to enable each local authority to access the information on health facilities under their jurisdiction. HIIS user account credentials for each local authority and province along with GIS-based data packages have been planned for dissemination to the officials and representatives from local and provincial government.

Instructions on how to use the HIIS will be transferred to provinces and local governments so that they can update the HI information themselves. A user manual and data description will be developed and disseminated as part this process

Inputs are scheduled for the next Quarter.

- Preparation of user authentication system and credentials for dissemination in Karnali, Province 5, Province 3 and selected local authorities
- Preparation of data subsets for dissemination in provincial and local levels
- Situation analysis of data centre infrastructure status and requirement analysis
- Onsite participation of government counterparts in HIIS operations, work sessions, workshops and interaction programmes.
- The HI team will initiate a gap and readiness analysis of FMoHP's capacity to take the full ownership of HIIS, and develop a timeline and implementation plan

i7.1.4 Revision of the Nepal National Building Code (NNBC) in relation to retrofitting, electrical standards, Heating, Ventilation and Air Conditioning (HVAC), and sanitary design.

Progress is being made towards achieving this result through support to DUDBC to improve the codes to institutionalise better standards. The development of new training modules and handbooks for electrical services, water supply and sanitary services, HVAC and waste management were initiated this quarter. As well as supporting the implementation of health facility construction projects, these resources and training activities will be used by the HI team and DUDBC to initiate discussion on appropriate design and quality standards.

Inputs are scheduled for the next Quarter.

The HI team brought FMoHP, DUDBC and outside experts together in March 2019 to discuss scope and content of the modules and handbooks. These will be finalised and submitted for endorsement by DUDBC in June 2019. Once endorsement is complete, the HI team will support DUDBC in the process of updating the existing codes.

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

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

Completed: The PD was achieved during Quarter Four, Year One.

There is continuing progress towards this result, with agreement between NHSSP and DUBC on a road map for concluding and adopting these standards. The process will comprise overview of latest standards, contents finalisation, official review process, and legal review procedures with a target date of December 2019.

The review of existing documents on retrofitting in Nepal was completed in February 2019 and submitted to DUDBC. Discussions on implications and progress will continue.

The review and development process has been strengthened with the participation of the Retrofitting Alliance Nepal (RAN). RAN includes DUDBC, Institute of Engineering (IOE), Nepal Society for Earthquake Technology (NSET), Centre of Resilient Development (CORD), Build Change and other similar organisations involved in retrofitting of infrastructures in Nepal. DUDBC has established the alliance to support the development of new retrofitting standards and updated codes.

Inputs are scheduled for the next Quarter: The HI team aim to conclude the draft code contents in May 2019, after which this will be submitted for discussion with DUDBC.

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

Completed: Achieved in Quarter Four, Year One.

The HI team is applying the Climate Change and Health Infrastructure framework in planning upgrades for provincial health facilities. The team was asked by the Karnali Province Ministry of Social Development (MSD) and the Director General DOHS to support DUDBC in developing the Jajarkot Hospital masterplan based on passive solar energy design and low environmental impact. The request to NHSSP was made by the government after the designers contracted by KFW failed to come up with a suitable design after two years and had not met the standards developed by FMoHP.

The masterplan maximises the use of sunlight for heating and illumination. More openings, terraces and verandas have been placed facing south and east, and the sloping site has been terraced to reduce major excavation. Courtyards have been developed to create sun-basking and meeting spaces for patients, visitors and staff.

The plan showcases energy efficiency design and an approach to construction that is effective, cost-saving and reduces environmental impact. The plan has been approved by DUDBC, and endorsed by the Karnali MSD, hospital management and the Federal Minister for Forest and Environment Shakti Bahadur Basnet.

The design includes an insulated decanting space, which later will be re-purposed as an in-patient block for the hospital.

The structural design, sanitary design, electrical design and cost estimates for the project are underway, along with development of detailed architectural drawings in close coordination with DUDBC. A skills transfer programme will be put in place with DUDBC counterparts to build expertise on this form of design. The tendering process for the construction works is expected to take place by the end of May 2019. The funding for the project comes from the pool fund (planned in the AWPB).

The HI team will develop a case study on this project, and an implementation guide which will disseminated to DUDBC and other government agencies

The Climate Change and Health Infrastructure framework forms a key component in the application of multi-hazard resilience and has been used by the HI team as part of the detailed conditions assessment of existing health facilities in seven Learning Lab Districts (see i7.1.1).

i7.1.7 Support the development of implementation plan for Infrastructure Capital Investment Policy (PD 89), and Preparation of framework for the development of supporting tools for effective implementation of the categorisation of health facilities (PD 46)

On-time: The Infrastructure Capital Investment Policy and its provisions were developed previously in NHSSP Year One, with the subsequent development of an action plan for

dissemination and updating of NHIDS. The objective is to build capacity of provincial and local government to adopt the NHIDS, and design and implement integrated health infrastructure development plans.

In line with this objective, the HI team conducted the following orientation events:

- Manthali Municipality, Ramechhap, January 2019. The orientation programme was demanded by the Municipality and included discussions on making the Manthali Hospital site safer and develop it as a primary hospital in line with NHIDS categorisation and standards.
- Province Three MSD, Hetauda, March 2019. The orientation was focussed on applying NHIDS standards. against the budget allocated by the MSD for construction of 18 primary level hospitals and other health infrastructure. Technical oversight support is being provided to the MSD for implementing the designs (architectural, electrical, sanitary, structural and waste management) and multi-year planning and budgeting. It is anticipated that the tenders for these hospital projects will be issued in the current fiscal year.

Inputs are scheduled for the next Quarter. A similar event has been planned at the request of Province Five, with the date to be confirmed.

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

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

On-time: Requirements for Gender Equity and Social Inclusion (GESI) / LNOB compliance in health infrastructure development were incorporated in the orientation programmes held in Manthali and Hetauda. The health facility designs for Jajarkot Hospital, Kalikot decanting space and Humla Hospital Masterplan also incorporate these elements.

Inputs are scheduled for the next Quarter. The HI team will carry out orientations on GESI/LNOB issues in the tender process for retrofitting the two Priority Hospitals. This will involve DUDBC officials, construction professionals and contractors at separate events before the contracts for the retrofitting projects are awarded. This activity was originally supposed to happen in the second year of the programme and has been postponed due to delays in the tender process.

i7.1.9 Implementation Plan for Health Infrastructure Development, upgrading, repair and maintenance (PD 68)

Completed: The Implementation Plan for Health Infrastructure Development, Upgrading, Repair and Maintenance (PD 68) was approved by DFID in March 2019. The comprehensive document is being prepared in Nepali that can be presented for adoption by the Federal Government in the coming quarter. On adoption, this will become the official guiding document for sub-national governments. A version will be translated into English for further distribution.

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

Inputs are scheduled for the next quarter. The final draft document will be produced by end of April 2019 and submitted to FMoHP and DUDBC for review and feedback. A workshop will

HEALTH INFRASTRUCTURE KPA 2: CAPACITY ENHANCEMENT

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

Capacity development support to FMoHP / DUDBC including identifying new capacity building needs is a regular process and carried out in consultation with the members of the committee formed in August 2017 for the purpose. The HI team is continuing to shift resources for capacity enhancement from federal level to meet demand from provincial and local governments.

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

Support in technical Monitoring of Reconstruction Project to FMoHP

At the request of FMoHP the HI team provided technical monitoring support with counterparts for health posts (prefab type-II) funded by KOICA and implemented through UNDP at different locations of Nuwakot. The sites visited were Suryamati health post, Samudayik Swasthya Kendra Panchakanya, Ghyangphedi health post, Thaprek health post, Panchakanya health post, and Sallemaidan health post.

Similarly, the team supported the technical monitoring visit at three health posts (Bhumlutar health post, Salle Bhumlu health post and Phalate health post) on the request of FMoHP constructed by Terre De Hommes (TDH) at Kavrepalanchowk.

Support at Province and Municipal Level

The HI team supported the Karnali MSD in the design of a model CSSD unit, concept for entrance gate reflecting the culture of Karnali Pradesh, landscaping design and design overhead water tank for Mid-Western Regional Hospital. The support for the designs was requested by the Karnali provincial government. The cost estimates, designs and tender documents for all these works have been completed and presented to the Provincial Minister and officials from MSD, hospital management and DUDBC Project Implementation Unit (PIU) in Surkhet. The DUDBC PIU in Surkhet will implement the project. All these projects will be financed by the Provincial government.

Support was provided in developing design, cost estimates and the bidding document for new oxygen plants for the Surkhet hospital. Support was also provided to prepare the specifications and cost estimates of the equipment in line with the integrated approach to infrastructure development.

The large-scale Surkhet hospital upgrade project was initiated in 2006, but not completed within 10 years. It was formally identified by FMoHP and DUDBC as a 'sick project'. A technical team formed under NHSSP as recommended by the 2014 Joint Annual Review during NHSP 2 under TARF funding from DFID had completed the project redesign in December 2015. All the designs and cost estimates were handed over to DUDBC that month. DUDBC successfully appointed the contractor in June 2017. With HI team technical backstopping and monitoring support, DUDBC has been able to complete the project (worth more than NPR 600 million) ahead of time, with the handover process scheduled for the next quarter - six months prior to the actual agreed handover date. Some parts of the building are already in use.

The HI team also supported the Karnali MSD in preparing a master plan for Humla district hospital. The design proposes upgrading existing buildings and adding services to meet Primary Hospital Type A3 requirements. This approach reduces the amount and cost of new construction and decanting services.

Support has been given to Karnali Province MSD to develop a decanting solution to facilitate imminent construction works at Kalikot Hospital. The design of the decanting space for accommodating critical services at the hospital has been developed and submitted in this quarter and is currently under discussion.

Road accident fatalities in Nepal have increased to over 2 500 per annum over the last four years. The planning of Roadside Trauma Centres has been led by FMoHP, with one centre envisaged for each province. In response to a request from Province Five, the HI Team has produced a preliminary Trauma Centre concept, equipment list, land requirement and cost estimate. The funding of this project will come from the provincial level authority. The proposed design is planned later to be refined and adopted as a standard model, supporting FMoHP for development of similar centres if required.

The HI team is providing technical support at the request of Province Three MSD to assist technical staff in implementing standard designs for Primary Hospital type B1, B2 and B3. The structural, electrical, and sanitary services designs for these hospital types are underway. The support process will help build technical capacity at municipal level in the design and implementation of future health facilities. In addition, and in response to a further request from MSD Province Three, the HI team distributed standard designs for Community Health Unit / Urban Health Centre to 36 municipalities.

The HI team has continued to build capacity in procurement procedures and systems. The Bhaktapur Hospital was supported for the e-GP registration in PPMO, the verification of specifications and cost estimates of equipment, and adoption of the standard e-Procurement bidding documents.

Support at the Federal Level

The HI team supported FMoHP in the evaluation of bid documents of four different hospitals funded by KFW for reconstruction.

The HI team has two structural engineers designated to support counterparts at DUDBC in the production of retrofitting designs at the two Priority Hospitals. While the tender process for these projects has been delayed, these engineers have provided support to DUDBC structural engineers in structural analysis and design of two blocks at Bheri Zonal Hospital, four blocks at Myagdi Hospital and nurse quarters at Lumbini Zonal Hospital in Butwal. Support was also provided in the analysis and design review of Baguwa health post in Gorkha, and the retrofitting design of Jingawada health post, Rautahat.

The HI team supported the development and signature of the Memorandum of Understanding (MOU) setting out the roles and responsibilities between the different stakeholders for reconstruction and retrofitting of Western Regional Hospital and Bhaktapur Hospital. The MOU has been signed by DUDBC, FMoHP, the respective health management committees and NHSSP. This practice is very important for improved relations and support between the stakeholders and will serve as a model for DUDBC and implementing agencies in other projects.

The Bhaktapur Hospital retrofitting programme launch event took place this quarter with support from the HI team. The event aimed to disseminate information about the proposed development plans to senior representatives from DFID, FMoHP, the Province Three MSD, DUDBC, local government representatives and the media. Attendance included Dr Surendra Kumar Yadav, Social Development Minister of Province Three, Mr Yubraj Dulal, and the DFID Director General for Policy, Research and Humanitarian Mr Richard Clarke.

i7.2.2 Training Needs Analysis (TNA) for FMoHP and Staff (PD 14)

Completed: The PD was achieved in Quarter Three of Year One.

The establishment of DUDBC Provincial Project Implementation Units (PIUs) and Infrastructure Development Offices (IDOs) under the provincial Ministries of Physical Infrastructure has generated increased demand for technical skills and programme management training for DUDBC mid-level managers and deployed staff in these units.

The HI team has begun the development of an in-service training course to support and strengthen the technical skills and competencies of these managers to develop, plan and implement health infrastructure. The initial concept design and training methodology for this course has been tested with subject experts, the Nepal Administrative Staff College (NASC) and DUDBC. Focus areas include transitional arrangements and priorities, finance arrangements, policies, standards, and guidelines related to health infrastructure development, as well as organisation management and health programme leadership. It is envisaged that the proposed training will be initiated in August 2019.

Inputs are scheduled for the next Quarter. The in-service training course design will be finalised by May 2019, covering course contents, training methodology materials, proposed participants, logistics requirement, subject experts for developing contents and resource persons

Challenges: This is a complex and high-profile initiative that is designed to meet urgent needs. It must be developed in close consultation with DUDBC and relevant counterparts. The HI team must also ensure that the services of key experts are secured for the course design and implementation.

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

On time: The Health Infrastructure Policy Development Training Programme Implementation (PD 67) was conducted in third quarter of 2018. The PD was approved by DFID.

Inputs are not scheduled for the next Quarter.

i7.2.5 Health Infrastructure Policy Development Training Programme Implementation Y3

On time: The Health Infrastructure Policy Development Training Programme Implementation (PD 88) is scheduled for May 2019.

Inputs are scheduled for the next quarter.

The Health Infrastructure Policy Development Training will be conducted in partnership with Nepal Administrative Staff College (NASC)

i7.2.6 Policy Development Training Impact Evaluation (PD 38)

Completed: This activity was achieved during the last year.

No inputs are scheduled for the next Quarter.

i7.2.7 Policy Development Training Impact Evaluation (PD 61)

On time: Independent service provider Scott Wilson Nepal Pvt Ltd. has been chosen after a competitive selection process to carry out this impact evaluation and is due to report by the end of April 2019.

Inputs are scheduled for the next quarter. The recommendations from the impact evaluation will be considered in the design of the next Policy Development Training event scheduled for May 2019.

i7.2.8 DUDBC technical skill training design and conducted Y1 (PD 34)

Completed: This activity was achieved during last quarter Year One.

No inputs are scheduled for the next Quarter.

i7.2.8 DUDBC technical skill training design and conducted Y2

On-time: This activity was achieved during last quarter Year two

No inputs are scheduled for the next Quarter.

i7.2.9 DUDBC technical skill training design and conducted Y3

Completed:

The skills training event on retrofitting design of masonry buildings was successfully completed in March 2019. The training content was developed in close consultation with DUDBC, and included design of new masonry building construction, seismic vulnerability analysis, retrofitting of masonry buildings, non-destructive testing, experience sharing and case studies A further event on reinforced cement concrete (RCC) building retrofitting design training for DUDBC engineers has been planned to take place by the end of the next quarter.

Inputs are scheduled for the next quarter. It is anticipated the module design and handbooks for health facility electrical, water supply and sanitary, heating, ventilation and air conditioning (HVAC) services and waste management design will be completed by the end of this quarter and submitted to DUDBC for endorsement.

i7.2.10 Technical Skills Training Impact Evaluation (PD 39)

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

No inputs are scheduled for the next Quarter.

i7.2.11 Technical Skills Training Impact Evaluation (PD 69)

On time: The impact evaluation has been scheduled for May 2019.

Inputs are scheduled for the next quarter: An independent service provider will be appointed via competitive selection to carry out the next impact evaluation.

i7.2.12 Feasibility Study and Recommendations for Establishment of Mentoring Support (PD 54)

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

No inputs are scheduled for the next Quarter.

i7.2.13 Skills Development Training for contractors and professionals designed and implemented Y1 and Y2

Completed: On time in Year One.

i7.2.14 Skills Development Training for contractors and professionals designed and implemented Y3

Inputs are scheduled for the next Quarter. This is kept under review, given the timing of the tender process for works at the two Priority Hospitals.

Challenges: The HI team will need to ensure that training arrangements are in hand and can be quickly implemented when the tender process starts.

i7.2.15 Design & Roll-out of Roadshows & Information Sessions in Priority Districts (PD 47)

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

No Inputs are scheduled for the next Quarter.

i7.2.12 Design & Roll-out of Roadshows & Information Sessions in Priority Districts (PD 73)

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

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 Year One Quarter 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: Achieved in Year Two Quarter Second.

No inputs are scheduled for the next Quarter.

i7.3.4 On-site training to FMoHP and DUDBC technical staff on seismic assessment of hospital buildings

Completed: On-site training to FMoHP and DUDBC technical staff on seismic assessment of the priority hospitals was completed last Quarter Year One.

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 DUDBC and DFID in Year One.

The retrofitting designs were reviewed in the last quarter by the International Monitoring and Verification team contracted by DFID (M&V team). The design calculations, drawings and design report were modified based on the M&V team's comments. The modified designs and drawings of both hospitals have been re-submitted to FMoHP and DUDBC for their approval and tender process preparation. The first DLI payment has been released as per the retrofitting design approval from FMoHP/ GoN.

The Bhaktapur Hospital decanting block design has been revised to save a tree at the construction site, as well accommodate new public toilet construction by Bhaktapur municipality.

The Western Regional Hospital decanting block has been revised to provide space for the pharmacy on the request of hospital management. The hospital management insisted that the pharmacy service should not be disturbed during the retrofitting works and that the service should operate from the decanting block during the entire period of retrofitting works.

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

Inputs are scheduled for the next Quarter. In the next Quarter, capacity enhancement of DUDBC staffs will continue through working together on drawings and design modifications if required after test results during the construction period.

Prior to tendering, DUDBC has scheduled a design sharing event supported by the HI team to disseminate the retrofitting design, tendering and construction process as well as monitoring and supervision plan to all relevant stakeholders.

In addition, the field assessment and design of a Decentralised Waste Treatment System (DEWATS) in both Hospitals has been scheduled in the next Quarter.

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

Completed: Achieved in Quarter one 2018.

In line with the TNA report, a further event on retrofitting design training has been provided as *explained in i7.2.9 above.*

Inputs are scheduled for the next Quarter as explained in *i7.2.9 above*.

i7.3.7 Preparation of final drawings

Completed: In this Quarter, the architectural, structural, sanitary, and electrical drawings (with cost estimates modified and updated based on the M&V team's comments) have been completed and submitted to the DUDBC for inclusion in the tender package. The final verification of the drawings and cost estimations are ongoing with DUDBC engineers.

Inputs are scheduled for the next Quarter but these depend on the budget release process.

Challenges: The NHSSP team is in close engagement with FMoHP and DUDBC to expedite` the budget release process.

i7.3.8 Production of Bills of Quantities

Completed: The Bills of Quantities has been revised several times due to changes in designs and changes in rates. The final Bills of Quantities have been submitted to DUDBC and joint review is in progress and near completion.

Inputs are scheduled for the next Quarter. The Bills of Quantities will be updated as required for the tender packages.

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

Delayed: Due to the budget allocation issue. It is hoped that this will be resolved in the next Quarter and all the tendering process underway by May 2019

Inputs are scheduled for the next Quarter. This will depend on the tender process.

Challenge: It is necessary that the FMoHP send programme budget approval and release to DUDBC as soon as possible. The HI team is continuously following up to solve the issue and avoid any unnecessary delays.

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: In Year One.

No inputs are scheduled for the next Quarter.

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

The HI team and DUDBC health building unit engineers and architects (including sanitary and electrical engineers) are involved in jointly reviewing all the designs, drawings and estimates for the retrofit of the two priority hospitals as required

Inputs are scheduled for the next Quarter. It is anticipated that all designs and tender documents will be completed, approved and issued as part of the tender process.

2 CONCLUSIONS

This reporting quarter included a mix of achievements and continued challenges. The team's efforts have facilitated notable successes, particularly the finalisation of the safe motherhood road map and the approval of the MSS for Hospitals, the GRB guidelines, and the disability inclusive health service guidelines. These provide opportunities for the health system to move forward significantly in improving maternal health for disadvantaged and vulnerable women, and making broader health services more accessible and of better quality for persons living with disabilities. Similarly, progress is being made in setting the scene for implementation of LNOB, including setting LNOB budget markers and providing training and orientations on GESI and LNOB (as noted above). During this quarter the AWPB process began and the team was engaged closely with the FMoHP and DoHS, as well as some provinces, in preparation and meetings. The baseline Learning Lab assessments were being completed, and the initial assessment will be ready next quarter.

The transition to federalism is starting to negatively impact on health system in terms of human resources and budget allocations and/or utilisation. In addition to the chronic frequent transferring of staff, the move to "adjust" some Federal staff to sub-national levels has been met by strong resistance. NHSSP does not focus explicitly on HRH, but we will monitor closely and NHSSP TA will need to be prepared to adapt our support to meet new challenges but also new opportunities to provide timely and appropriate assistance. In addition, we are thinking through ways to mitigate these transfers, such as getting manuals and other key documents available online. Finally, although the HI portfolio is making generally good progress, the continued delays to the tendering process for the Bhaktapur and Pokhara Hospitals retrofitting are creating concern for the HI team. We are working to resolve this in the next quarter.

Internally, there are two further areas of progress. Firstly, the successful introduction of an interim team leader, and the appointment of a new Team Leader, is exciting. We feel that the quality of outputs has improved, and we are confident that this will continue over the life of the programme under the new Team Leader who will bring fresh eyes to the programme and a further sharpening of strategic focus. Secondly, on top of the normal workload much work was done to produce a concept note for the proposed programme extension. Progress towards achieving an extension to the programme will be reported in the next quarterly report.

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME (March 2016- December 2020)									
OUTCOME 1	**Outcome Indicator 1.1**			**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)**	**Assumptions**	**Remarks**
Health system is more resilient to environmental shocks and natural disasters	% of newly constructed health facility buildings adhered 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.
		Achieved			Revised standards are endorsed by FMoHP.					
			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	For Year 1, milestones for NHSSP was not established because the programme started from March 2016 only, which accounts 4 months of inception phase.
Equitable utilization of quality health services	% point reduction in gap between the average SBA delivery (disaggregated by Province) 2.1.a) % point reduction in gap	**Planned**	Not applicable	No milestone planned	5.0	No milestone planned	No milestone planned	No milestone planned		Y1 - Y2:
		Achieved			2.0					

between the average SBA delivery of the bottom 10 and top 10 districts (for MY1, MY2)		**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	5	5	No milestone planned
	Achieved						
		Source					
		HMIS					

HMIS does not report data by local government so districts are monitored. Y2: Annual data is updated on the basis of HMIS data downloaded in 19 November 2018. Average % of the top 10 districts was 86.8 in 2016/17 and 86.4 in 2017/18 and average % of the bottom 10 districts was 17.0 in 2016/17 and 18.6 in 2017/18. From Y3 HMIS will generate data by local governments so from Y3 onwards local governments

			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)		
										will be monitored. Y3 milestone has been updated based on the HMIS data of the Fy 2017/18.
OUTCOME 3	**Outcome Indicator 3.1**		**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)**	**Mileston e Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	For Province and Local Government , baseline and targets will be established by December 2018.	Baseline data for Central level accessed from TABUCS on 10 Aug 2017.
Improved governance and accountabilit y 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		
		Achieve d			82					
			Source							
			AWPB, TABUCS, FMR							
	3.1b) Provincial government	**Planned**	Not applicable	No milestone planned	No milestone planned	NA* (Pls see the notes below)	NA* (Pls see the notes below)	No milestone planned		
		Achieve d		Not applicable	Not applicable					
			Source							
			AWPB, TABUCS, FMR							

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			Planned/Achieved							
	3.1c) Local government	**Planned**	Not applicable	No milestone planned	No milestone planned	TBC* (Pls see the notes)	TBC* (Pls see the notes below)	No milestone planned		
		Achieved		Not applicable	Not applicable					
			Source							
			AWPB, TABUCS, FMR *Note: Y3 update: Not applicable: Tracking of the % of allocated health budget expended at provincial and local levels is not possible as they do not use TABUCS and there is no such mechanism in the FMoHP to track this through the systems in practice.*							
INPUTS (£)	**DFID (£)**		**Govt (£)**		**Other (£)**		**Total (£)**	**DFID SHARE (%)**		
INPUTS (HR)	**DFID (FTEs)**									
OUTPUT 1	**Output Indicator 1.1**		**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)**	**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 (defined in terms of the sanctioned posts of health staff at local government/Palika)	**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 finalized by July 2018.				
	Source							
	FMoHP report on organization restructuring in federal context							
Output Indicator 1.2		**Baseline Value (Mid July 2015 - Mid 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)**	**Mileston e 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 (Partnershi p in Health)	1 (AMR)	1 (National Health Policy)	To be determin ed based on FMoHP priority	To be determine d based on FMoHP priority	
	Achieve d		1 (Policy on Partnership in Health drafted. The partnership issues are included in the revised National	1 AMR is included in the revised National Health Policy (draft) developed with NHSSP support.				

e

					Health Policy)				
	Source								
	FMoHP endorsed policies, strategies and guidelines								
1.2b) Strategies					1 (GESI)	1 (Health strategy - a section in the national '15th Periodic Plan 2076/77-2080/81) - NPC)	To be determined based on FMoHP priority	To be determined based on FMoHP priority	
	Planned	FMoHP priorities set for Year 2	No milestone planned						
	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					1 (National Standard Treatment Guideline)	2 1. National eHealth Guideline 2. Public Private Partnership Guideline	To be determined based on FMoHP priority	To be determined based on FMoHP priority	
	Planned	FMoHP priorities set for Year 2	No milestone planned						

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Achieved		Not applicable	5 Development of NSTG is awaiting finalization 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 Value (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 1.	Year 2: The new structure of facilities is not implemented yet .
% of public hospitals implementing the minimum service standards bi-annually (in learning labs sites)	Planned	Not applicable	No milestone planned	No milestone planned	50	70	100		
	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					
	Source								
	Updated Minimum Standards for primary hospitals, NHSSP periodic progress reports								
Output Indicator 1.4		Baseline Value (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					

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					with the FMoHP once the health structures are finalized in the federal context.						

Source
OCAT progress report, NHSSP periodic progress reports

Output Indicator 1.5			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)	
% 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)	

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OUTPUT 2	Output 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)	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 finalized and implemented in year 1.	
		Achieved			FMoHP has finalized IAIP and sent to FCGO. Implementation monitored by PFM committee					
		Source								
		OAG Annual Report								
	Output Indicator 2.2		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)	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	
	2.2a) Revised eAWPB	Planned	Not applicable	No milestone planned	100	150	200	No milestone planned		Y2: Align the milestone of 2.2a (training on e-AWPB) and 2.2b
		Achieved		Not applicable	109				The figures in milestones	
		Source								
		Health sector eAWPB, Training completion report								
		Planned	Not applicable	No milestone planned	100	150	200	No milestone planned		

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2.2b) Updated TABUCS	Achieved		156	126				and targets are cumulative.	(training on TABUCS) from Nepali fiscal year 2018/19. Since FMoHP has developed eAWPB as an integral part of TABUCS, it will provide 'one training' which is included in 2.2b (updated TABUCS). This shows that systems are now integrated and integrated training to the accountants and planners are planned.
	Source								
	Health sector eAWPB, Training completion report								
Output Indicator 2.3		**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)**		Of the total 312 FMoHP spending units, 81 units reported to have no recorded audit
% of FMoHP spending units having no	**Planned**	30	No milestone planned	32	34	37	No milestone planned		

	Recorded Audit Observations	Achieved			26.0						observations.

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 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)	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)	Planned	48	No milestone planned	50	60	70	No milestone planned		Y2: 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
		Achieved		60 (Out of 176 procurement contracts in CAPP, a total of 106 contracts were signed as of mid-July 2017)	56.8					
		Source								
		LMD Record on CAPP (Baseline taken from NHSS 2015-20, RF)								

									(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).
Output Indicator 3.2		**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)**	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		

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	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	
	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 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)**	**Mileston e Y4 (Mid July 2019-Mid July 2020)**	**Target (Mid July 2020-Dec 2020)**	Procuremen t clinic will be established in Year 1.

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	% 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 4	**Output Indicator 4.1**		**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)**	**Assumptions**	
MoHP 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. Note: 86 hospitals were monitored; 5 facilities-non-functional.	On the basis of internal monitoring system, total 68 CEONC sites provided service in the month of Poush (December 2018/
		Achieved			81					
		Source								
		HMIS, and NHSSP update								

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				Among 81 public/district level facilities functional based on NHSSP monitoring.	January 2019) 2075.

Output Indicator 4.2		**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)**
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			443,531			
	Source						
	HMIS						
4.2b) IUCD	**Planned**	169,299	No milestone planned	183,533	197,055	209,901	No milestone planned
	Achieved			143,282			
	Source						
	HMIS						
4.2c) Implant	**Planned**	251,416	No milestone planned	333,466	407,310	470,078	No milestone planned

	Achieved			300,249					
	Source								
	HMIS								
Output Indicator 4.3		**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)**		OCMC Status update report published on March 2018' shows that 8958 people were served by OCMC from October 2013 to mid-July 2017. Annual disaggregation is not available in the system. Now the system has been established to generate the annual data.
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		
	Achieved			4,214					
	Source								
	OCMC reports								
Output Indicator 4.4		**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)**		
Number of women benefited from Aama	**Planned**	315,355	No milestone planned	321,356	327,355	333,355	No milestone planned		

			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)		
	programme (disaggregated by ecological region and Province)	**Achieved**			288,008					
		Source								
		FHD record, HMIS, TABUCS								
	Output Indicator 4.5		**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)**	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 Value (Mid July 2015 - Mid 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 innovative interventions evaluated and disseminated	**Planned**	NA	No milestone planned	No milestone planned	No milestone planned	2	No milestone planned		
		Achieved								
		Source							**RISK RATING**	

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

INPUTS (HR)	DFID (FTEs)	

OUTPUT 5	Output Indicator 5.1		Baseline Value (Mid July 2015 - Mid 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)	Mileston e Y4 (Mid July 2019-Mid July 2020)	Target (Mid July 2020-Dec 2020)	Assumptio ns	
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		
		Achieve d			Equity monitoring dashboard based on HMIS data has been developed and published in MOHP website. The number of local governments using the dashboard will be monitored from August 2018					
		Source								
		HMIS								

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Output Indicator 5.2		Baseline Value (Mid July 2015 - Mid 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)		
% of government health facilities achieving benchmark on RDQA in LL sites	Planned	RDQA benchmark not set	No milestone planned	No milestone planned	20	50	80		
	Achieved			Web-based RDQA developed. This will set a benchmark and will be used from FY 2018/19					
	Source								
	NHSSP periodic progress report, review report of LL sites								
Output Indicator 5.3		Baseline Value (Mid July 2015 - Mid 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)		In agreement with DFID, the assessment of inter-facility free referral support is post-poned for 2018/19
Number of assessments conducted on priority programme areas and results shared with stakeholders	Planned	Not applicable	No milestone planned	No milestone planned	3 (Free referral system, OCMC and Social Audit)	No milestone planned	No milestone planned		
	Achieved								

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		Source						
		Assessment reports						
Output Indicator 5.4		**Baseline Value (Mid July 2015 - Mid 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)**	Themes will be determined based on MoHP priorities
Number of policy briefs produced based on MoHP priorities and shared to inform policy	**Planned**	na	1	3	4	5	2	
	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	Working on three policy briefs in the following areas: 1. An analysis of DLI 12 indicators 2. NCDs from Global Burden of Disease (GBD) 3. Socioeconomic inequalities in institutional deliveries in Nepal			
IMPACT WEIGHTING (%)	Source							
	Policy briefs produced annually							**RISK RATING**

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

OUTPUT 6	Output Indicator 6.1		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)	Assumptions	
MoHP has the capacity to ensure health infrastructure is resilient to environmental shocks	Number of health infrastructure related policies endorsed by MoHP									
	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	MoHP priorities for retrofitting and rehabilitation continue, and are not diverted by the move towards federalism	
		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)						

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	Process defined and necessary steps identified to get legal status of the Nepal health infrastructure earthquake retrofitting and				

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			submitted to DUDBC	rehabilitation standards from concerned authorities				

Source
Health infrastructure related policies and standards endorsed by MoHP

Output Indicator 6.2		**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)**	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

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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 MOHP, DUBDC							
Output Indicator 6.3		**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)**	Government continues to prioritize roll-out of resilient health facilities with funds allocated and effective programme management.
% 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			100				
	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 Value (Mid July 2015 - Mid 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)**	Timely agreement between MoHP and DFID on hospitals to be retrofitted, timely release of fund and procurement of
Number of health facilities/hospitals retrofitted or rehabilitated with support from DFID's	**Planned**	Retrofitting of two priority hospitals proposed using DFID FA	No milestone planned	No milestone planned	No milestone planned	2	No milestone planned	

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	earmarked Financial Aid				Design for retrofitting of two priority hospitals and preparation of procurement document have been completed and submitted to DUDBC and DFID on Feb 2018.				contractor. Design and preparation of tender documents will be completed in year 1; and contract awarded and mobilized in year 2.	
		Achieved								
IMPACT WEIGHTING (%)		**Source**								
		Standards and retrofitting completion certificate from FMoHP							**RISK RATING**	
INPUTS (£)	**DFID (£)**		**Govt (£)**		**Other (£)**		**Total (£)**	**DFID SHARE (%)**		
INPUTS (HR)	**DFID (FTEs)**									

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Appendix 2 Payment Deliverables approved in this Quarter

Workstream	Milestone No	Description of Milestone	DFID approval date
HPP	56	Gender responsive budgeting guidelines developed	31-Jan-19
Management	57	Quarterly report 6 Oct - Dec	01-Mar-19
RHITA1	68	Policy for Health Sector Infrastructure Development, Upgrade and Maintenance produced and adopted	06-Mar-19
SD	32	Report on the process of Safe of Safe Motherhood and Neonatal Health (SMNH) Programme Review and the development of the SMNH Roadmap 2030	19-Mar-19
HPP	49.1	PEA of private sector engagement in health care provision in Nepal	28-Mar-19
HPP	42	MCH Guidelines for disabled-friendly health services developed	14-Mar-19

Workstream	Milestone No	Description of Milestone	DFID approval date
HPP	56	Gender responsive budgeting guidelines developed	31-Jan-19
Management	57	Quarterly report 6 Oct - Dec	01-Mar-19
RHITA1	68	Policy for Health Sector Infrastructure Development, Upgrade and Maintenance produced and adopted	06-Mar-19
SD	32	Report on the process of Safe of Safe Motherhood and Neonatal Health (SMNH) Programme Review and the development of the SMNH Roadmap 2030	19-Mar-19
HPP	49.1	PEA of private sector engagement in health care provision in Nepal	28-Mar-19
HPP	42	MCH Guidelines for disabled-friendly health services developed	14-Mar-19

NHSSP Risk Matrix Assessment (Updated on 8th April 2019)

The overall risk factors remain at the same level as previous Quarter, other than R12 which we suggest deleting as it is no longer relevant.

General Health TA matrix												
Risk No	Risk	Gross Risk		Risk Factor RAG rated	Current controls	Net Risk		Risk Facto r RAG rated	Net Risk Acce ptabl e?	Additional controls / planned actions	Assigned manager / timescale	Actio ns
		Likelih ood	Impa ct			Likeli - hood	Impac t					
	Contextual											
R1	Weak coordination between EDPs and MOHP.	Mediu m	Medi um		NHSSP Team support FMoHP to work with EDPs; Team Leader supports DFID in coordinati on	Low	Mediu m		Yes	Continue to Facilitate FMoHP and EDPs for the implementation and monitoring of transition plan and agreed action points	Team Leader/Strategic adviser	Treat
R2	Change in Team Leader may affect the stewardship of the team,	Mediu m	Medi um		NHSSP Deputy Team Leader step in as acting Team leader and SMT with strong support from Options UK is strengthe ning the team managem ent.	Low	Low		Yes	Options UK placed the interim Team Leader to bridge the gap	Interim team Leader, DTL,	Treat
	Political											
R3	Inadequate political will to drive key reform processes for example procurement reform	Mediu m	High		NHSSP advisors work closely with senior staff in FMoHP to advocate, build understan ding and buy in to planned reform processes .	Medi um	Mediu m		Yes	Pace of changes will be carefully planned. Regular meeting of CAPP monitoring committee.	Team Leader /PPFM lead Adviser/Strategic Advisor	Treat

R4	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 the NHSSP adviser for on-going work.	High	High		Yes	NHSSP team will work closely with FMoHP and take flexible and adaptive approaches	Strategic Adviser and HPP Team Lead	Treat
R5	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 EDPs	High	Medium	Y	Yes	Regular engagement with the FMoHP in planning processes to recognise if changes need to be made	Concerned Advisers	Treat
R6	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	High	Medium	Y	yes	NHSSP will support FMoHP in developing minimum service standard and implement HQIP at different level health facilities.	Service Delivery Adviser	Treat

					planning support in coordination with all supporting partners EDPs							
R7	Frequent 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		Yes	NHSSP will participate in induction processes in the relevant department.	All advisers	Treat
R8	Flux over the MoHP leadership can have implication on AWPB development processes and service delivery.	Medium	Medium		NHSSP TL, Strategic Adviser & DTL will engage with the FMOHP leadership in strategic issues.	Low	Low		Yes	NHSSP TL will schedule regular meeting with Secretary and other senior officials at FMOHP	TL.	Treat
	Programmatic											
R9	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	NHSSP IS engage with FMoHP to develop, AND MONITOR implementation plan	EA adviser	Treat
R10	MoHP priorities/demands are changeable due to external and internal pressures which deflects TA from sector targets	High	Low		The NHSSP team is and will continue to closely collaborate with key counterparts to ensure a shared understanding of work plans. The NHSSP is being flexible and responsiv	Low	Low		Yes	NHSSP team will work closely with FMoHP colleagues and remain flexible and strategic	Concerned Advisers	Treat

					e to make certain that adapting plans will have limited impact on overall quality of delivery of the TA.							
R11	Evolving priorities of FMoHP means that less attention is paid to NHSSP supported activities.	Mediu m	Medi um		NHSSP will engagem ent with FMoHP and provide flexible and responsiv e support within the scope of NHSSP	Low	Low		Yes	NHSSP team will work with other partners for resource leveraging	Concerned NHSSP Advisers	Treat
R12	High staff turnover in key government positions limits the effectiveness of capacity enhancement activities with FMoHP and the DoHS.	Mediu m	Medi um		NHSSP adopts capacity enhance ment at institution al and system level besides individual capacity enhance ment so that institution al memory remains in place	Medi um	Low		Yes	NHSSP works with different cadre of Health Staff.	Concerned NHSSP Advisers	Tolera te
R13	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 enhance ment to improve quality of care will be planned with DHOs and facility managers ; refresher trainings will be offered on a regular basis; focus is on building capacity and the functionali ty of the facility,	Low	Low		Yes	NHSSP will actively encourage on site coaching /training and support training needs identification	Concerned NHSSP Advisers	Tolera te

					not just training.							
R14	Reshaping NHSSP could lead to uncertainty among key stakeholders about how smoothly changes in TA will occur.	Medium	Low		Interim Team Leader with strong support from SMT will work with DFID for the formulation of reshaping processes	Low	Low			SMT to engage in reshaping exercise and proposal writing processes, and clear focus on seamless transition to re-shaped programme.	Interim TL/SMT	Treat
R15	HR adjustment can have implication on service delivery and in AWPB development processes.	High	High		NHSSP team collectively supporting PPMD in the AWPB development support	Medium	Low		Yes	NHSSP advisers continuously engage with the relevant counterpart and facilitate the AWPB processes	HPP & PPFM Adviser	treat
R16	Lack of clarity in the FMoHP structure that ultimately disrupt the SD functions at the local level	High	High		NHSSP continue working with FMoHP and priorities the essential service delivery functions through regular monitoring and support.	Medium	Medium		Yes	NHSSP team working with Secretary and other relevant units to minimise the disruption through continue dialogue and support	Strategic adviser & Lead SD Adviser	Treat
	Climate & environmental											
R17	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 security guidelines will be put in place for all staff.	Medium	Medium		Yes	NHSSP will support MoHP to update disaster preparedness plan	Concerned NHSSP Advisors	Tolerate
	Financial											

R18	The TA programme has limited funds to support the strengthening of major systems components such as HR systems.	Medium	Low	(yellow)	Support policy and planning in the MOHP. Engage with other EDPs who are supporting related areas.	Low	Low	(green)	Yes	Continue to work with FMoHP and WHO and other partners who may have financial resources to support these	Advisers	Treat
R19	Financial Aid is not released for expected purposes.	Medium	High	(orange)	Planning and discussions with FMoHP and MoF. Health Financing TA will support the government in managing release of Financial Aid.	Low	Medium	(yellow)	Yes	Continue with regular and quality monitoring of FMR and regular meeting of PFM committee	Lead PPFM Adviser and PFM adviser	Treat
R20	Financial management capacity of subcontracted local partners is low.	Low	Medium	(yellow)	Carry out a due diligence assessment of major partners at the beginning of the contract.	Low	Low	(green)	Yes	Carry out regular reviews of progress against agreed work plans and budgets.	Deputy Team Leader	Treat
R21	Weak PFM system leads to fiduciary risk	High	High	(red)	To work actively to support the FMoHP in strengthening various aspects of PFM via an updated FMIP, regular meeting of PFM committee, update the internal control guideline and add cash advance module in TABUCS to reduce fiduciary risk and the formulation of procurement improvem	Medium	medium	(orange)	Yes	Continue to monitor risks and mitigate through periodic update of FMIP, CAPP, and PIP, through the PFM and CAPP monitoring committee. Engaging FMoHP Secretary, FCGO and PPMO.	Lead PPFM Adviser and senior 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
		Likelihood	Impact			Likelihood	Impact					
				■ red	ent plan (PIP) and establishment of a CAPP monitoring committee			■ orange				
R22	Further devaluation of the £ reduces the value of FA and TA commitment.	Medium	Medium	■ yellow	Monitor exchange rates and planned spend against these	Medium	Low	■ green	Yes	Strengthen regular monitoring and verification of work plans against budgets	Team Leader/Deputy Team Leader	Tolerate

Infrastructure risk matrix

Risk No	Risk	Gross Risk		Risk Factor or RAG rated	Current controls	Net Risk		Risk Factor or 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	■ yellow	Infrastructure Advisors work closely with senior staff in MoHP, 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	■ green	Yes Yes	NHSSP will work closely with the Health Building Construction Central Coordination and Monitoring Committee	Lead Infrastructure Advisor	Treat

ID	Risk				Response				Y/N	Mitigation	Owner	Action
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	(red)	The Team will work closely with MOH 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	(orange)	Yes	We will coordinate with other initiatives under the NHSSP (such as Learning Labs) to develop improved models of service delivery under federalism	Team Leader	Tolerate
R3	Lack of clarity over roles and responsibilities of FMoHP, DUDBC and other related departments in health infrastructure	Medium	Medium	(orange)	Team will support clarification of the roles and responsibilities of departments, and NRA / PCU.	Medium	Medium	(yellow)	Yes	NHSSP will build links and regular communication between MOH 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 work plan and exhaust available resource	High	Low	(yellow)	Close collaboration with key counterparts in the mobilisation phase of the TA resulting in shared understanding of work plans.	Medium	Low	(green)	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	Med ium		The NHSSP capacity enhance ment approach will focus on institution alising approach es and systems, not rely on individual capacity building to ensure sustainab ility				Yes	NHSSP will engage with different level staff to strengthen the institutionalisation processes.	Lead Infrastruc ture Advisor	Tolera te
R6	Local construction companies not responsive/engag ed in capacity building activities.	Low	Med ium		Our team has establish ed working relations hips with local compani es, design of capacity building will respond to identified needs.	Low	Low		Yes	Capacity building will be part of the contractual arrangement.	Seismic Resilienc e 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/G oN data; ensure program me plans are flexible, and re-plan rapidly following any further events.	Mediu m	Medium Medium		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 Infrastruc ture Adviser	Tolera te

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	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 FMcHP and MOF.	Low	Medium		Yes	PPFM and Health Infrastructure teams will continue to support the government in managing release of Financial Aid.	PPFM 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	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	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	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	NHSSP will work with Bhaktapur municipality to settle disputes between parties.	Lead Infrastructure Adviser	Treat
R14	The Independent Review has extended the design timeline, may require extra designs and delay the tender process. This could impact negatively on the construction critical path.	High	High		Strategic dialogue with DFID to facilitate the review processes.	Medium	Medium		Yes	Close engagement with Review Team to support process and share information	Team Leader & Lead Infrastructure Adviser	Treat
R15	Non-inclusion of retrofitting budget line in current AWPB delayed the budget release to DUDBC which impacted delay bidding processes.	High	High		NHSSP work with MOHP to request MOF to create budget line for retrofitting.	Medium	Medium		Yes	NHSSP PPFM team to support and follow up with MOHP for the retrofitting budget line.	PPFM lead 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 the programme has means and plans to further minimise / mitigate as part of programme's key objectives
Transfer	Risk the programme identifies other stakeholders are better placed to minimise / mitigate further
Terminate	Risk beyond the programme control that would render some / some / all the work impossible

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APPENDIX 4: VALUE FOR MONEY (JANUARY 2019–MARCH 2019)

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.

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 £546 for international TA and £177 for national TA. The average unit cost of both international and national STTA is below the programme benchmark of £611 and £224, respectively.

International STTA	Actuals to date (March 2017 - March 2019)	Average unit cost to date (GBP), (March 2017–March 2019)	Current Quarter (Jan 2019–March 2019)	Average unit cost (GBP), (Jan 2019–March 2019)
Days	566	552	203	546
Income (GBP)	312,542		110,908	
National STTA	Actuals to date (March 2017–March 2019) Days	Average unit cost to date (March 2017–March 2019)	Current Quarter (Jan 2019–March 2019)	Average unit cost (GBP), (Jan 2019–March 2019)
Days	1,504	156	215	177
Income (GBP)	232,500		37,956	

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

There was a balanced in the use of both National and International STTA in this reporting quarter. The use of International STTA has been considerably increased in this quarter to 48% from 22% in the last quarter. The International STTAs provided technical support on key areas: finalisation of GRB guidelines (PD56), political economy analysis of private sector engagement (PD 49.1), review of internal audit report, and developing guidelines for disabled-friendly services (PD42).

Short Term Technical Assistance Type	In client contract budget*		Actuals to date (March 2017–March 2019)		Current Quarter (January 2019–March 2019)	
	Days	%	Days	%	Days	%
International TA	2,291	44%	565.93	27%	202.63	48%
National TA	2,942	56%	1504.25	73%	215.25	52%
TOTAL	5,233	100%	2070.18	100%	417.88	100%

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

In this reporting period, 21 percent of the budget was spent on administration and management. The key drivers are office running and office support staff's costs which are regular expenditures. In addition, cost was incurred in purchase of laptops for learning lab staff. The percentage of total expenditure on administration and management cost for this quarter is well below the actuals till date (29%).

Category of admin /mgmt. expense:	Client budget		Actuals to date (March 2017–March 2019)		Current Quarter (Jan 2019–March 2019)	
	GBP	%	GBP	%	GBP	%
Office running costs (rent, suppliers, media, etc)	88,550	2%	75,312	6%	9,575	5%
Equipment	26,063	1%	34,719	3%	5,468	3%
Vehicle purchase	120,000	3%	52,875	4%		0%
Bank and legal charges	13,110	0%	2,700	0%	230	0%
Office Set up and maintenance	29,090	1%	37,321	3%	2,958	2%
Office Support Staff	383,318	9%	153,112	11%	15,261	8%
Vehicle Running cost and Insurance	73,998	2%	20,680	2%	2,062	1%

Audit and other Professional Charges	16,000	0%	17,042	1%	4,744	2%
Sub-total admin /management	750,129	18%	393,760	29%	40,298	21%
Sub-total programme expenses	3,385,899	82%	973,009	71%	155,497	79%
Total	4,136,028	100%	1,366,769	100%	195,795	100%

VfM results: Efficiency

Indicator (15): Unit cost (per participant, per day) of capacity enhancement training (disaggregated by level e.g. National and local)

During this Quarter, nine sessions of capacity enhancement trainings were conducted to 538 participants. At the national level, two training sessions were conducted to reach 85 participants. Likewise, at the local level seven training sessions were conducted to 453 participants. The average cost per participant per day incurred for national-level training and local level is £24 and £20 respectively both well below the benchmark cost. The trainings conducted at National level were on standard treatment protocol and retrofitting designs of masonry buildings. At the local level, The Organisational Capacity Assessment (OCA), FWD programme guideline orientation, and orientation of health infrastructure development were amongst the trainings conducted.

Level of Training*	Cost per participant/day Benchmark** GBP	Actuals to date (Jan 2018 – March 2019)***			Current Quarter (Jan 2019 – March 2019)		
		No. of capacity enhancement training conducted	No. of Participants	Average Cost Per Participant/Day (GBP)	No. of capacity enhancement training conducted	No. of Participants	Average Cost Per Participant/Day (GBP)
National	62	17	616	37	2	85	24
Local	39	12	912	21	7	453	20

* 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 N-HSSP (reference for cost taken from N-HSP 2 and TRP programmes)
*** The data for this indicator was collected from Jan 2018 onwards.

VfM results: Effectiveness

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

So for, the programme submitted 57 PDs; 56 PDs have been approved by the Government of Nepal and signed off by DFID.

	Payment Deliverables (March 2017 – March 2019)
Total technical deliverables throughout N-HSSP3	108
PDs submitted to date	57
PDs approved to date	56
Ratio %	98%

Minimum Service Standards for Health Facilities:
A Tool for Evidence Based Planning and budgeting in Health for Local Government

The Ministry of Health and Population, Government of Nepal developed the Minimum Service Standards (MSS) for all level of health facilities. The MSS aspires to ensure the readiness of the health facilities to deliver quality services. In the federal context, the health posts have been handed over to the local government and it is its responsibility to ensure basic health services are delivered to a high standard. For planning and budgeting at local level to be evidence-based, the evidence must be accurate. The MSS helps to quantify the evidence through its scores and determines the status of the health post in terms of its readiness and service availability. This provides a basis for evidence-based local level planning and budgeting to ensure value for money.

Background:

The Government of Nepal is committed to providing quality health services. In order to do so, it has published documents such as the Policy on Quality Assurance in Health Care Services 2007, the National Health Policy 2014, the Nepal Health Sector Strategy (NHSS) 2015-20 and the Public Health Service Act 2018. Understanding that the essence of the health system is about people, shows that its value lies in being equitable, resilient and efficient [20]. Nepal is going through a process of federalism and now has 761 government structures: the federal government, seven provincial governments and 753 local governments, formed with roles and responsibilities clearly defined. The delivery of basic health care services in health posts, and hospitals with up to 15 beds, is now the responsibility of the local government. Therefore, the capacity of local government needs to be built for evidence-based planning and budgeting in order for these responsibilities to be fulfilled.

In line with the NHSS, the UKAid-funded Nepal Health Sector Support Programme (NHSSP) has been supporting MoHP in developing the tools and standards to ensure quality of care. The MoHP has been implementing MSS for district level hospitals and felt there was a need to develop MSS for all levels of health facilities. Therefore, NHSSP supported MoHP in developing MSS for all levels of health facilities, from health posts to tertiary hospitals.

In Nepal, health posts offer community level health services and serve people living in the remote and hard to reach areas. The MSS for health posts focuses on strengthening the overall management of theses health facilities to improve service availability and readiness. In order to assess this, the MSS looks at governance and management, clinical service management and support service (Figure1).
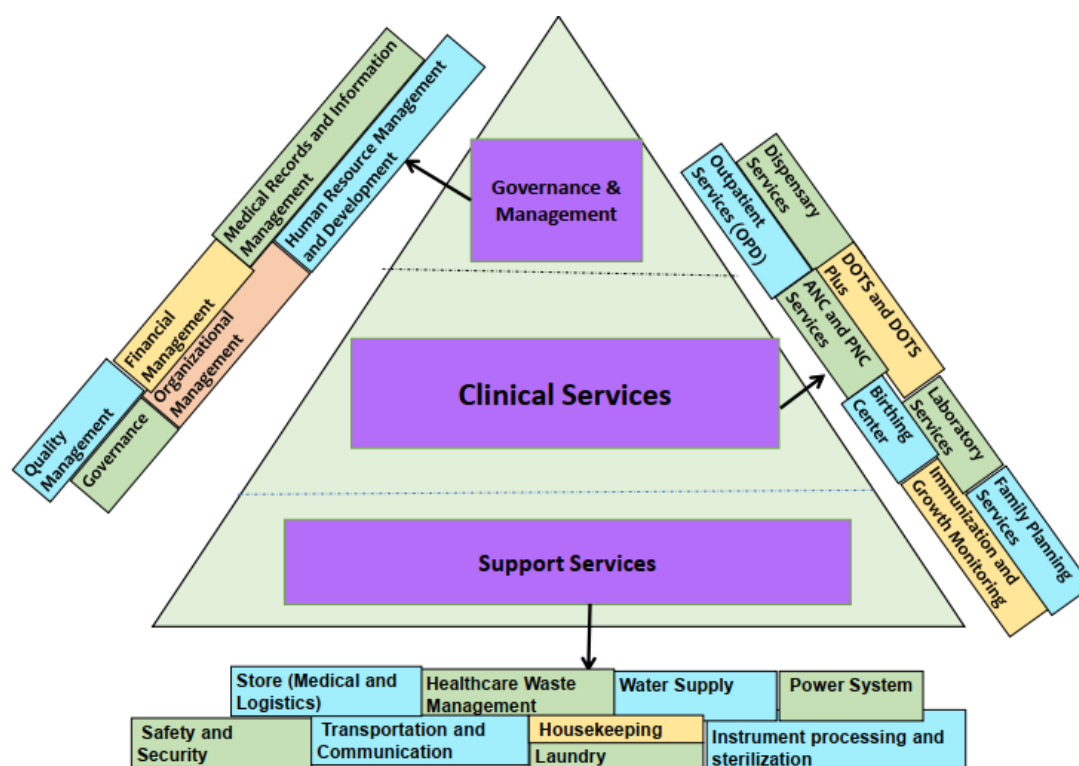

Figure 1: Areas addressed by Minimum Service Standards for Health Posts

(Source: MSS for Health Post, Curative Service Division, DoHS, MoHP)

The MoHP, with support from NHSSP, has set up "Learning Labs" to learn and document planning, budgeting and health service delivery in the federal context. There are seven Learning Labs (one in each province) comprising of rural, urban, sub-metro and metro municipalities. One of the tools used in this process is the Organizational Capacity Assessment Tool (OCAT), which has been applied at the local government level to identify the capacity gaps in delivering the functions, and develop an action plan to address the gaps.

Soon after the introduction of the OCAT in two of these Learning Lab sites, Itahari Sub-metropolis (Province 1) and Dhangadhimai Municipality (Province 2), the chief administrative officer, the health coordinator and deputy health coordinator were briefed on the MSS. A team then visited the health posts in these Learning Lab sites and conducted an orientation of the MSS with staff to help them understand the concept, method of self-assessment and how to generate evidence for action planning.

Results and achievements:

The results of baseline MSS assessment of the health facilities (6 in Dhangadhimai Municipality and 4 in Itahari Sub metropolis in these two Learning Lab sites, show that the majority of them score less than 50% overall. There was one health post in Dhangadhimai Municipality which had a score of 64.4% due to better support services provided by this health facility as compared to other health facilities.

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[20] Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, Adeyi O, Barker P, Daelmans B, Doubova SV, English M. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health. 2018 Nov 1;6(11):e1196-252.
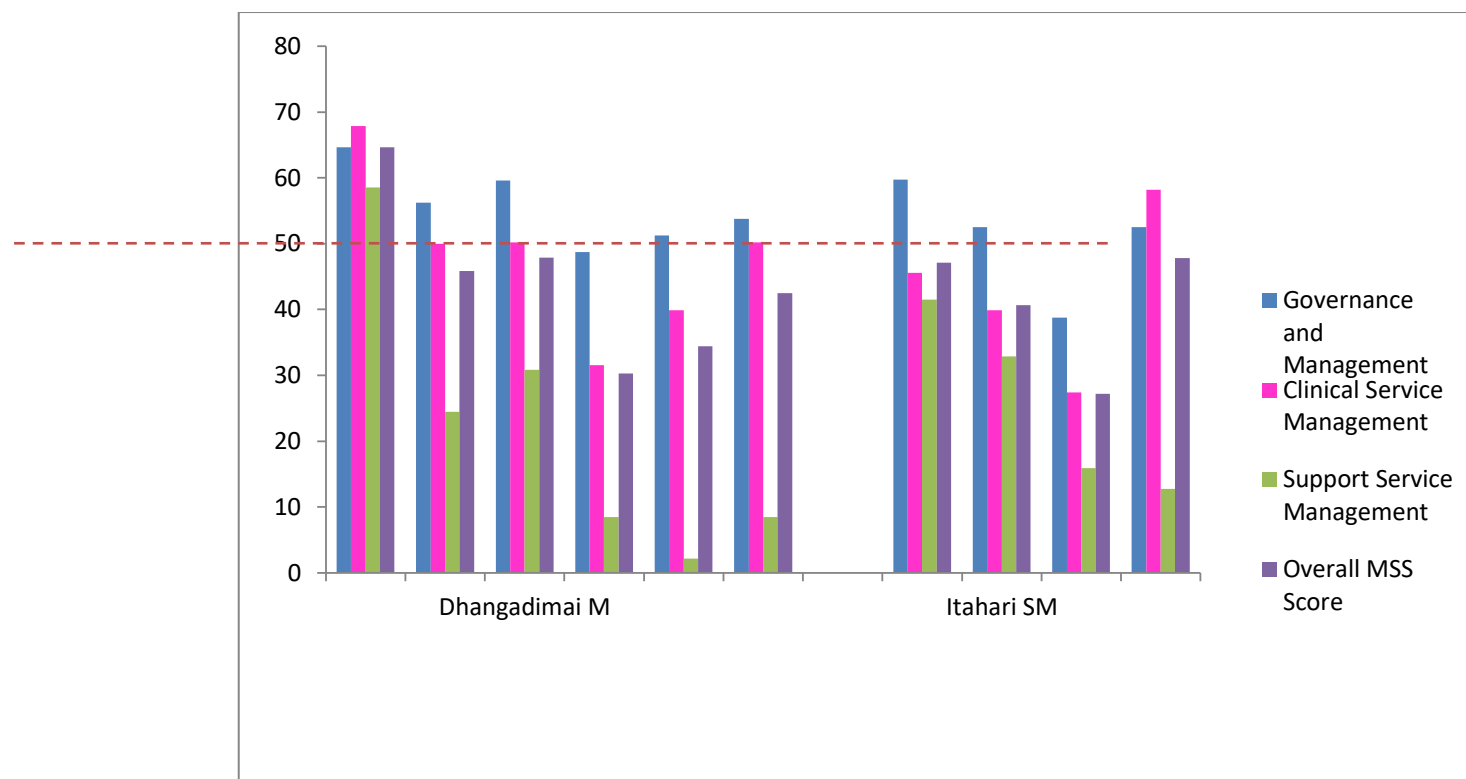
Figure 2: MSS Baseline Assessment Scores of LL Sites

The self-assessment shows gaps, primarily on the availability and readiness of the laboratory services and support service in the health posts. These gaps are mainly due to lack of managerial skills or lack of basic equipment and human resources. The action plan developed to address the gaps at each health facility, and the capacity development plan provides a case for investment by the local government to further improve the service availability and readiness. The scores of the MSS baseline and the action plan has been shared with the local government and support is being provided to monitor the action plan and to prioritise addressing the gaps through the planning and budgeting process at the health facility and the local level.

Conclusion and Way forward

The MSS is an important tool for assessing the readiness of health facilities. The local government could use the evidence generated through the MSS during the annual work plan and budgeting process to address the gaps identified and strengthen the quality of care. The action plans developed based on the MSS assessment also provide evidence for the local government to advocate to the Provincial and Federal Government for additional resources, like human resources, equipment, and overall infrastructure of the health facilities. The MSS scores could also form the basis for Federal and Provincial Government to provide performance-based grants to the local government.

NHSSP will support the implementation of the MSS in remaining Learning Lab sites and will continue to provide technical assistance to the health facilities and local government in monitoring the action plans developed by the health facilities.

APPENDIX 6: INTERNATIONAL STTA INPUTS IN FIRST QUARTER (JANUARY – MARCH 2019)

S.N.	Name	Date	Purpose
1	Alison Dembo Rath	2 Jan - 10 Jan	Support NHSSP team in workshop planning and provide strategic support to SMT team NHSSP DTL
2	Clare Cummings	6 Jan - 15 Jan	Support HPP team in political economy analysis on private sector engagement (PD 49)
3	Nancy Gerein	13 Jan - 19 Jan	Development of guideline for effective private sector engagement (PD 49)
4	Shanti Mahendra	7 Jan - 18 Jan	Support HPP team and SD team, support Innovations & Learning Lab
5	Deborah Thomas	15 Jan - 24 Jan	Support GESI team to develop Gender Responsive budget guidelines
6	Steve Topham	11 Jan - 26 Jan & 14 Feb – 9 March	Technical assistance to infrastructure team, development of Comms. products, VM land acquisition study. Supporting NHSSP reshaping.
7	Paramita Majumdhar	Jan - Feb (5 days)	Specialist Inputs into Development of GRB operational guidelines (PD 56)
8	Rachel Grellier	19 Jan - 16 March 18 Feb – 16 March	Support acting TL and workstream leads with technical needs including finalisation of PDs, planning for International STTA etc. Support NHSSP team for DFID workshop and reshaping proposal.
9	Jacqueline Boyce	8 Jan - 11 Jan	NHSSP audits
10	Mark O'Donnell	March	Internal audit and TABUCS support
11	Natasha Mesko	Jan - March	Strategic support to Service Delivery and to support in innovations
12	Dr. Geeta Rana	21 Dec - 31 March	Development of Standard Treatment Protocol for service providers to provide the basic health care services
13	Cindy Carlson	19 Feb – 26 Feb	Health sector decentralisation
14	Maria Kett	March	Disability friendly guidelines
15	Peter Drury	March - June	eHealth expert – inputs into development of national eHealth guidelines
16	Tony Bondurant	11 Feb - 15 March	Interim Team Leader