Nepal Health Sector Support Programme III

(NHSSP – III)

Quarterly Report
January to March 2018

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ABBREVIATIONS

AWPB	Annual Workplan and Budget
BC	Birthing Centre
BEONC	Basic Emergency Obstetric and Neonatal Care
CAPP	Consolidate Annual Procurement Plan
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD	Child Health Division
CSD	Curative Services Division
DFID	Department for International Development
DHO	District Health Office
DLI	Disbursement Linked Indicator
DUDBC	Department of Urban Development and Building Construction
eAWPB	Electronic Annual Work Plan and Budget
e-GP	e-Government Procurement
FHD	Family Health Division
FMR	Financial Monitoring Report
FP	Family Planning
GIZ	German Corporation for International Cooperation
GON	Government of Nepal
HIIS	Health Infrastructure Information System
HQIP	Health Quality Improvement Plan
HRFMD	Human Resource and Financial Management Division
IAIP	Internal Audit Improvement Plan
JAR	Joint Annual Review
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MOHP	Ministry of Health and Population

NDHS	Nepal Demographic Health Survey
NHEICC	National Health Education Information and Communication Centre
NHFS	Nepal Health Facility Survey
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHSS	Nepal Health Sector Strategy
NHTC	National Health Training Centre
OCMC	One Stop Crisis Management Centre
PCU	Project Coordination Unit
PD	Payment Deliverable
PHAMED	Public Health Administration Monitoring and Evaluation
PHCRD	Primary Health Care Revitalisation Division
PPICD	Policy, Planning, and International Cooperation Division
PPMO	Public Procurement Management Office
RANM`	Roving Auxiliary Nurse Midwife
RDQA	Routine Data Quality Assurance
SBA	Skilled Birth Attendants
SSU	Social Service Unit
STTA	Short Term Technical Assistance
TA	Technical Assistance
TABUCS	Transaction Accounting and Budget Control System
TARF	Technical Assistance Response Fund
TSB	Technical Specification Bank
TWG	Technical Working Group

CONTENTS

EXECUTIVE SUMMARY

Precis

This report is one of a number of Quarterly updates that intend to update the progress of the Nepal Health Sector Support Programme. The period covered by the report is from January 2018 to March 2018. The report explores the heuristic features in capacity development, in particular, the use of proximal, embedded, and intermittent technical assistance and funding support in the attainment of specific objectives. It concludes with evaluative comments.

The development context

The sector development context has changed through the quarter, characterised by unexpected decisions emerging from quickly convened, high-level meetings. The Ministry of Health and Population has reassigned several senior departmental positions in restructuring towards a new devolved model in alignment to Federalisation. The Ministry stays committed to the No One Left Behind agenda aimed at increasing services to vulnerable or excluded populations. Several external development partners retained commitments to aiding the Ministry in addressing capacity needs, prominently the United Kingdom Department of International Development. There are three dynamics at play 1) the capacity of the sector to meet population health demands, 2) institutional changes associated with devolution, and 3) protecting and or advancing gains relating equity of services access. These matters frame the delivery of technical assistance in the programme. The alignment of these dynamics will determine the relevance of support.

The Programme

The Programme is implemented by a consortium led by Options, with HERD International, Oxford Policy Management, and Miyamoto; and coordinates with three other DFID suppliers and external development partners.

The Quarter in retrospect

The Programme provided technical and financial assistance along five streams 1) Health Policy and planning, 2) Public finance management and procurement, 3) Service delivery, 4) Evidence and accountability, and 5) Health Infrastructure. Advisors deployed either by a) embedded within key departments of the Ministry or b) placed nearby for easy access by government personnel. A capacity development model that addresses the interconnection of organizations, systems and people framed the technical assistance approach. Most planned activities were undertaken. The Service Delivery workstream experienced significant delays in several activities. Most delays are linked to changes in personnel in Ministry. Financial support has been provided through funding of specific short-term technical assistance, meetings, workshops, training events and field visits. A grant fund, the Technical Assistance Response Fund, remained available to support special initiatives.

Conclusions and strategic implications

The Programme has made notable technical contributions to improving population health and to related management and programmatic delivery systems. The teams have developed and maintained solid counterpart and partner relationships. Contributions to an enabling policy environment are significant, including the transition to Federalism in the sector. There have been numerous examples where progress was brokered by the teams engaging with the counterparts and catalyzing the required counterpart actions. The teams have championed change, leveraged the transition to Federalism and promoted the principle of *Leave No-on Behind*. Value for money targets was exceeded in the period. It would be strategically advantageous to build on the successes of this quarter through 1) continued working on the existing plan, 2) continued emphasis on strengthening of capacity towards sustainability, 3) further empowering the Ministry to lead sector reform, through conceptualizing and advancing better structures and systems; and 4) building the skills for national health sector stewardship.

1 INTRODUCTION

1.1 OVERVIEW

This document apprises the Nepal Ministry of Health and Population (MOHP) and the United Kingdom's Department for International Development (DFID) on the progress of the Nepal Health Sector Support Programme (the Programme) from **January 2018 to March 2018.** The Programme, commencing in March 2017 and scheduled to December 2020, is a part of the United Kingdom's assistance to the health sector. It is aligned to Nepal's National Health Sector Strategy 2015-2020 and focuses on supporting the key interventions defined in that document.[1]

The Programme is implemented by a consortium led by Options, with HERD International, Oxford Policy Management, and Miyamoto. The Programme coordinates with three other DFID suppliers supporting DFID's Nepal Health Sector Programme 3 and with other external development partners and provides technical and financial support along five streams 1) Health Policy and planning, 2) Public finance management and procurement, 3) Service delivery, 4) Evidence and accountability, and 5) Health Infrastructure.

Advisors are deployed either by being a) embedded within key departments of the Ministry,[2] b) placed nearby for easy access by government personnel. Intermittent short-term arrangements are also deployed to provide responsive and proactive high-level technical assistance. A capacity development model that addresses the interconnection of organizations, systems, and people frames the technical assistance approach. Financial support is provided through funding of specific short-term technical assistance, meetings, workshops, training events and field visits. A Technical Assistance Response Fund is available to support special initiatives.

This report explores the heuristic features in capacity development including technical assistance arrangements and funding support in the attainment of specific objectives. It concludes with evaluative comments on how the Programme might stimulate more government engagement to encourage greater sustainability of its activities.

1.2 THE MINISTRY OF HEALTH AND POPULATION

Nepal continues on the path to full Federalisation; the legal framework for three tiers of government is established. Public sector institutions, including the MOHP, are now in devolution to align to the political structure.

1.3 THE PROGRAMME TEAM

The recruitment processes of new Team Leader was completed in this quarter and the new Team Leader joined the Programme in early March. The Senior Management Team continued to provide steerage to the programme and provided an intensive induction to the new Team Leader. An interim Team leader worked with NHSSP team until February and handed over to new Team Leader as part of his induction in March. The Programme revised the contractual terms with Miyamoto to better match technical supply and demand.

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[1] NHSSP spans March 2017 to December 2020,

[2] Implies much more than just physical location.

2 PROGRESS BY WORKSTREAM IN THE QUARTER

This section highlights the key achievements of the Programme in the reporting period grouped by each respective workstream.

2.1 THE HEALTH POLICY AND PLANNING WORKSTREAM

TARGET BENEFICIARIES AND STRATEGIES GUIDING TECHNICAL ASSISTANCE

The Health Policy and Planning team primarily provides assistance to Policy, Planning, and International Cooperation Division (PPICD), Curative Services Division (CSD), Federalism Implementation Unit and Public Health Administration and Monitoring and Evaluation Division. General challenges include an ongoing transition in terms of reorganizing the MOHP structure, adjustment of staff at three levels of government and frequent change in the MOHP leadership.

TA OBJECTIVE 1:   THE MOHP HAS A PLAN FOR STRUCTURAL REFORM UNDER FEDERALISM

A plan for structural reform under Federalism will contribute to a smooth transitioning from a unitary system of governance to the Federalism as per the assigned functions of three levels of government engaged in the sector.

Provide strategic support for structures and roles for central and devolved functions

On-time: Adjustment and reorganising of the existing structures under the MOHP are near finalisation at the three levels of the government. NHSSP was technically engaged in drafting and revising the structure, terms of reference, and human resources need for Federal units, as well as provincial and local level governance structures. Cabinet has endorsed the organisational structure of the MOHP. NHSSP guided the development of the Transition Plan that incorporates issues raised during the Joint Annual Review. Continued next quarter.

Enhance the capacity of the Planning and International Cooperation Division and respective divisions to prepare for Federalism

On-time: NHSSP engaged with PPICD for inter-ministerial discussion and coordination regarding the fiscal transfer for the health sector in relation to the planning and budgeting for FY 2018/19. Similarly, NHSSP, with other development partners, supported the MOHP to develop brief orientation package for the provincial governments on the health sector. The package was delivered in each of the provinces targeting key decision makers at the provincial level on Health Service Day (February 26). Similarly, with the support of NHSSP and other partners, an induction package for local governments is also developed. Continued next quarter.

Develop guidelines and operational frameworks to support elected local governments planning and implementation

On-time: NHSSP contributed to developing the new guideline for the Health Facility Operational and Management Committee. The Ministry is discussing the draft guideline. Further technical assistance will be provided to finalise the guideline based on the feedback. There is uncertainty in defining operational frameworks for the local level as the future role of the district health offices is still unclear. The new governance structure of the health sector at all levels is yet to be approved. Continued next quarter.

TA OBJECTIVE 2:   DISTRICTS AND DIVISIONS HAVE THE SKILLS AND SYSTEMS IN PLACE FOR EVIDENCE-BASED BOTTOM UP PLANNING AND BUDGETING

Evidence-based bottom-up planning and budgeting is crucial to effectively address local needs as per the overall thrust of universal health coverage as envisioned in the Nepal Health Sector Strategy.

Support the Ministry of Health and Population to consolidate and harmonise the planning and review process

On-time: NHSSP engaged in discussion with the program divisions, centers and central hospitals to review the progress on Annual Work Plan and Budget (AWPB) implementation. The discussion focused on budget absorption, challenges in program implementation and its implications for the next year's planning and budgeting. This addresses the existing hurdles in budget implementation and improves the budget absorption rate by transferring budget from one program head to another based on the programmatic need. Continued next quarter.

Implement the Learning Lab approach to strengthen local health planning and service delivery in selected sites and document evidence of effectiveness and value for money

On-time: NHSSP supported Pokhara Lekhnath metropolitan city, which is one of the learning lab sites, to identify priority areas in the health sector and for the drafting of the Metropolitan Health Policy including from Gender Equity and Social Inclusion perspectives. The Assembly of the metropolitan city has endorsed the health policy. A draft profile for planning and budgeting in learning lab sites was developed. NHSSP facilitated the discussion between DFID Advisors on Governance & Service Delivery and Health with PPICD regarding the scope and implementation modality of the learning lab. Continued next quarter.

Develop budget markers on Leave No-one Behind at national and local level

On-time: A draft terms of reference has been completed to initiate the development of guidelines on budget markers for *Leave No-one Behind*. Continued next quarter.

TA OBJECTIVE 3:   PPICD IDENTIFIES GAPS AND DEVELOPS EVIDENCE-BASED POLICY

Evidence-based policies based on the identified gaps are important in the Federalised context to have a coherent approach to setting health priorities at each level of government.

Review existing policy and regulatory framework for quality assurance in the health sector

On-time: NHSSP engaged with the CSD through the technical working group to agree on a framework for the development of minimum standards for hospitals. NHSSP worked with the Management Division in the Department of Health Services in developing the implementation plan based on patient safety assessment findings of 2017. NHSSP provided technical assistance in reviewing the Safe Motherhood and New-born Health (SMNH) programs towards developing the SMNH Roadmap 2030. Technical inputs to the Primary Health Care and Revitalisation Division assured the finalization of the basic health services package. Continued next quarter.

Undertake policy stock take for the health sector and disseminate findings

Completed: NHSSP developed a framework for the review of health sector policies in consultation with the PPICD. A draft report of the review was prepared based on the agreed framework. Preliminary findings of the policy stock take were shared at a workshop and with the MOHP Working Group for the development of the new National Health Policy. Interviews were held with the former Chiefs of PPICD considering the preliminary findings of the policy review to garner their insights and feedback on challenges, implementation aspects of the policies and recommendations. The policy review report is being updated based on the feedback from the workshop and from the interviews. The final report is a payment deliverable due for April 2018.

TA OBJECTIVE 4:   THE MOHP HAS CLEAR POLICIES AND STRATEGIES FOR PROMOTING EQUITABLE ACCESS TO HEALTH SERVICES

Developing policies and strategies for promoting equitable access to health services is crucial for creating enabling environment to address the equity gaps at each level of government.

Revise Health Sector Gender Equity and Social Inclusion Strategy

On-going: NHSSP has provided technical assistance to MOHP to finalise the Gender Equity and Social Inclusion Strategy. This is a payment deliverable due in June 2018. During this quarter, after the rounds of consultative meetings with MoHP and EDPs, the GESI Strategy revision framework was finalized. Likewise, the review of key policies and strategies to support the revision process has begun since this quarter.

Revise national mental health policy and develop a mental health operational plan

Completed: Technical inputs were provided to the MOHP and External Development Partners during the drafting and finalization of the National Mental Health Policy. The policy has been shared with other Ministries for their feedback before submission to Cabinet for approval. The Sr. GESI Advisor participated in the conference organizing committee, responsible for ensuring successful organisation of the Mental Health Conference Nepal 2018, 16 – 17 February 2018, under the theme "Coming Together for Mental Health".

Develop guidelines for disabled-friendly health services

On-going: Inputs provided to the Ministry of Women, Children and Senior Citizen (MWCSC) for the development of the 10-year National Policy and Action Plan on Disability 2018 - 2028. NHSSP convened a joint meeting of multisector stakeholders along with Leprosy Control Division and provided feedback to MWCSC to finalise regulation on disability.

Revise Social Service Unit guidelines

Not scheduled: Technical assistance has been provided to MOHP to lead the mentoring support for the effective functioning of Social Security Unit (SSU) through the development of standard checklists, guidelines, and presentations. In addition, orientation/training to selected hospitals/municipalities was provided to better coordinate with partners and enhance their capacity to advocate with local government for resource mobilisation and ensuring quality service delivery.

Develop Standard Operating Procedures for National Integrated Guidelines for the Services to Gender-Based Violence Survivors

Postponed: This activity has been postponed until December 2018 by MWCSC in consultation with MOHP due to delayed state restructuring. Continued next quarter.

TA OBJECTIVE 5:   THE MOHP IS COORDINATING EXTERNAL DEVELOPMENT PARTNERS TO ENSURE AID HARMONISATION

Since many health sector programmes are being implemented with the support of External Development Partners (EDPs), and since a Sector Wide Approach (SWAP) is followed in the sector, harmonization with EDPs is a must.

Support the establishment and institutionalisation of Health Sector Partnership Forum

On-time: The Health Sector Partnership Forum is already established. No specific schedule or period is fixed for the meeting of the Partnership Forum. The HPP team is continuously engaged with PPICD/MoHP to strengthen and institutionalise the forum. In this quarter, no specific activity was planned.

Support the preparation and coordination of partnership meetings (three Joint Consultative Meetings, one mid-year review and one Joint Annual Review annually)

On-time: The Joint Annual Review (JAR) was organized on Jan 31st –1st Feb 2018. The JAR was scheduled for this quarter and is a joint review between GoN and EDPs, HPP supported the PPICD to organise pre-JAR field visits; produce a pre-JAR report; organize the JAR meeting, and draft the post-JAR report. Since the JAR reports were a payment deliverable, both the pre- and post-JAR report were submitted to DFID and duly approved. The approved reports are already uploaded to the NHSSP

website. The role of NHSSP is to capacitate the MoHP to convene the partnership meetings such as the JAR to further strengthen the partnership and dialogue between MoHP and EDPs. The HPP team has been advocating with PPICD to budget the JAR expenses in next year's AWPB. We hope, eventually MoHP will be able to organize the JAR meetings independently.

The Joint Consultative Meeting (JCM) is scheduled for 1st quarter of year 2. The mid-year review is also expected to be organized in this quarter by MoHP. The HPP team will closely engage with the PPICD in organizing both of these meetings.

EMERGENT OR UNPLANNED TECHNICAL ASSISTANCE DEMANDS

- The HPP team provided technical inputs to the Department of Sociology, Tribhuwan University, and MOHP to review questionnaires for a study on "State of Social Inclusion in Nepal" to include Gender-Based Violence, Women Empowerment and Health Issues related to Social health security.
- The HPP team provided technical assistance to DFID to design and facilitate the Blue Sky Thinking workshop to identify strategic interventions on gender-based violence as per the changed context.

2.2 THE PUBLIC FINANCIAL MANAGEMENT AND PROCUREMENT WORKSTREAM

TA OBJECTIVE 1:   TARGET BENEFICIARIES AND STRATEGIES GUIDING TECHNICAL ASSISTANCE

The Public Finance Management and Procurement team provides the technical inputs to MOHP's Human Resource and Financial Management Division (HRFMD) and the Department of Health Service's Logistics Management Division (LMD). The low absorptive capacity, use of cash advances, weak compliance with procurement standards and lack of monitoring are the key challenges. Through the joint consultative meetings, the team has identified knowledge gaps and poor institutional home as the key capacity issues. The team has utilized joint consultations and workshops to develop the systems; formulate the policies; and develop the training curriculums.

Electronic Annual Work Plan and the Budget system being used by the MOHP spending units for the timely release of the budget

On-time: The main purpose of this activity is to enhance the skill of MOHP staff and improve the use of Electronic Annual Work Plan and Budget (eAWPB), which will contribute to improving absorptive capacity.

Develop AWPB Improvement Plan and report Quarterly on

On-time: NHSSP has provided the onsite coaching and mentoring to use the eAWPB. The eAWPB manual is now uploaded to the website. MOHP's monitoring section has used the output table while submitting the Quarterly progress to the Health Minister and Office of Prime Minister. In the next quarter, we will continue to provide our technical inputs in updating the current eAWPB system, which can be used by the provincial and local government. NHSSP will engage the Transaction Accounting and Budget Control System (TABUCS) Implementation Unit while updating the system.

Conduct budget analysis using eAWPB

On-time: MOHP officials have insufficient knowledge to conduct a detailed budget analysis. NHSSP organized a consultative workshop in January to provide the knowledge to officials. MOHP is currently using the budget analysis report developed by NHSSP and submitted as a payment deliverable in the previous quarter while presenting the budget and expenditure status to its counterparts. The detailed budget analysis report was uploaded on the MOHP and NHSSP websites in January 2018.

Analysis of Aama programme in the eAWPB

On-time: Previously, there was no electronic system to analyze the Aama budget and expenditure. NHSSP developed a sub-system and included it in the eAWPB. The MOHP now can analyse the Aama budget using the eAWPB. This has contributed to saving the time of planners and mangers. In the next quarter, we will assess the technical requirements and proposes a system to be used by provincial and local governments.

Prepare a framework for the annual business plan

On-time: The team has prepared a framework for the annual business plan and shared this with the MOHP's planning section. A consultative workshop was organized to prepare a draft framework. In the next quarter, the PPFM team will further improve the current framework to cover the business plan of Federal, Provincial and Local Government.

Package evidence into advocacy materials

On-time: A standard PowerPoint presentation has been prepared to share the MOHP's budget scenario to stakeholders. HRFMD has made the presentations at national and international meetings. This has contributed to advocating the need for more budget for Nepal's health sector. In next the quarter, we will conduct the consultation meetings with MOHP officials to develop the further advocacy materials i.e. policy notes and budget scorecard.

TA OBJECTIVE 2:   TABUCS IS OPERATIONAL IN ALL MOHP SPENDING UNITS INCLUDING THE DEPARTMENT OF URBAN DEVELOPMENT AND BUILDING CONSTRUCTION

The main objective of TABUCS is to capture the basic accounting transactions at source level and enforce budgetary control procedures so that no expenditure can take place without an approved budget.

Revise TABUCS to report progress against NHSS indicators and Disbursement Linked Indicators

On-time: This will help MOHP and EDPs in tracking the progress against the NHSS indicators and disbursement-linked indicators. A sub-system has been developed in consultation with the TABUCS Implementation Unit. In the next quarter, we will provide a training to MOHP officials, which will enable them to use the system. NHSSP may need to update the current sub-system if MOHP decides to add or delete some indicators.

Support MoH/the Department of Health Services to consolidate and harmonise the planning and review process

On-time: NHSSP has utilized the findings from the budget analysis in the planning and review process. NHSSP will repeat this exercise in next fiscal year.

Support the MOHP to update the systems manual, training manual, and user handbook of TABUCS and maintenance of the system

On-time: The systems manual, training manual, and user handbook of TABUCS have been updated. Based on these manuals, three batches of training were conducted in this quarter. The manuals are now uploaded to the TABUCS website. These can be used by the MOHP officials at all level. The MOHP has included a training budget in its AWPB, which ensures the funding sustainability of this training. In the next quarter we will continue to provide technical inputs in updating the system manuals to incorporate the requirements of the devolved structures..

Update TABUCS to be used in the DUDBC

On-time: In the absence of the TABCUS, DUDBC officials were not able to submit timely expenditure reports to the MOHP. A training of trainers was undertaken to senior finance officials from DUDBC in March 2018. In the next quarter, the PPFM team will continue to update systems to fulfill the evolving requirements of DUDBC.

Support annual production of Financial Monitoring Report (FMR) using TABUCS

On-time: The monthly expenditure reports using TABUCS are being produced. MOHP officials are now capable of producing the report. In next quarter, the PPFM team will prepare the FMR-2 for DFID.

Support the MOHP with the further development of TABUCS to capture the NPSAS report

On-time: The system and manuals have been uploaded on the TABUCS website. This has enabled the MOHP to prepare a timely central expenditure report. Since this is a new initiative, we will provide training to MOHP officials in the next quarter.

Share TABUCS with other countries

Delayed: NHSSP had planned to share the TABUCS with interested countries in order to contribute to the development of a country-specific system. Before we present TABUCS to other countries, however, the MOHP decided to upgrade TABUCS so that it can address the requirements of devolved structures. NHSSP will discuss with DFID and make the decision in the next quarter.

Update TABUCS to include data on audit queries

On-time: NHSSP has developed the system to capture the audit quires from 308 spending units. The system has been shared in the meeting of TABUCS Implementation Unit and uploaded on TABUCS. This will support the MOHP in analyzing the audit status and taking specific action to reduce audit queries. In the next quarter, we will provide the training to MOHP finance officials.

TA OBJECTIVE 3: REVISE, IMPLEMENT, AND MONITOR THE FINANCIAL MANAGEMENT IMPROVEMENT PLAN

The main objective of Financial Management Improvement Plan is to strengthen the MOHP's current practices on financial planning, accounting procedures, internal control systems, financial reporting, monitoring, auditing, audit query clearances and transparency measures.

Update the internal control guidelines

On-time: The guideline provides the specific roadmap to address the delay in decision making. In this quarter, the PPFM team have updated the internal control guideline, which will be discussed in a wider workshop in April 2018.

Conduct a public expenditure review

Discontinued: In consultation with DFID, we have decided not to carry out this activity.

Support the process of institutionalising the internal audit function

On-time: The Internal Audit Improvement Plan (IAIP) was developed in October 2017. The IAIP contributes to preventing the audit queries. The workshop has been organized to finalise the IAIP. In next quarter, we will prepare a status report on IAIP and present at the meeting of PFM committee.

Build capacity of finance officers to reduce audit queries and clear backlog

On-time: The meeting of Audit Committee was held on 21st March 2018. It included a focused discussion on clearing audit backlog. NHSSP will conduct training of MOHP officials on reducing audit queries in the next quarter.

Support MOHP in designing, updating, and rolling out Performance Based Grant Agreement in Hospitals

On-time: In this quarter the PPFM team has initiated discussions with stakeholders from the MOHP, the Department of Health Services, districts, local government, and Performance-Based Grant Agreement implementing hospitals. NHSSP has also organised the Performance-Based Grant Agreement learning group meetings with Netra Jyoti Sangh and Naya health (Bayal Pata Hospital)-

January through March. This will help to improve the practice related to the performance-based budgeting in the public sector. In the next quarter, we will organize a workshop where MOHP, external development partners, and hospitals will participate.

TA OBJECTIVE 5:   LMD IS IMPLEMENTING STANDARDIZED PROCUREMENT PROCESSES

This activity intends to improve the procurement process by updating of the standardized systems, which are in line with the existing Act and Regulations

Reassess and build on the Organisation and Management Survey and disseminate findings

Delayed: The restructuring report has not been completed by MOHP. After finalisation of the organisational structure of health facilities in Federal, Provincial and Local Government levels, organisation and management survey assessment report will be relevant, This is expected to be completed by end of June 2018.

Revise and update the procurement improvement plan and support its implementation

On-time: the Procurement Improvement Plan (PIP), prepared at the end of Quarter 2, has been endorsed by MOHP. NHSSP has been supporting LMD to implement the PIP. The challenge remains for the MOHP and its departments to successfully implement the PIP. NHSSP will support LMD and MOHP to enhance their capacity in monitoring the PIP through the designated section. In the next quarter, we will organise a workshop to present an update on the implementation of the PIP.

e-CAPP preparation using Standard Operating Procedures and establishment of CAPP monitoring committee

Completed: A concept note relating to the e-CAPP system design was prepared in March 2018. Preparation of CAPP is as per Standard Operating Procedures will be made easy by using an electronic program developed which is expected to be designed and tested by June 2018. The CAPP monitoring committee established in previous quarter is functioning well. The second CAPP Monitoring Committee meeting was organised and progress in the implementation of the PIP, CAPP and other issues were discussed in this quarter. The meeting decided to expedite the procurement process, revise the CAPP and for LMD to take the lead role in facilitating and supporting the procurements of health sector goods by the provinces and local governments through several printed materials and instructions.

Preparation of standard bidding documents for Procurement of Health Sector Goods

Partial completion: The standard bidding documents for the procurement of Health Sector Goods was prepared and submitted to PPMO for endorsement during the first quarter but PPMO wanted to take more time to review. However, PPMO has decided that a separate standard bidding document for Health Sector Goods was required. Therefore, it is expected that a separate standard bidding document for Health Sector Goods will be approved by the end of the next quarter. NHSSP will lead discussions with PPMO for approval.

Capacity building on Procurement System in Federal, Provincial and Local Government

Completed: Standard Operating Procedures to support the standardization of procurement of drugs was finalised with the involvement of the Department of Health Services staff. On this basis, the Handbook of Procurement and Supply Chain for the Local and Provincial level was prepared and printed in March 2018. The handbook will be sent to all Local Governments and health institutions by April 2018. Similarly, the session plan for a training program on procurement management for officials working under Local/Provincial Government was prepared in March 2018. Training will be conducted gradually in all the provinces throughout the year.

LMD specification bank is used systematically for procurement of drugs and equipment

The objective of using a specification bank is to maintain transparency and fairness in procurement through the standard technical specification.

Develop coding of specification bank and orient all the Department of Health Services divisions' staff on their use, monitor its use

Completed: Technical Specification Bank (TSB) was designed and updated in close engagement with LMD's information technology section. More than 300 users have access to the TSB (January through March). While it is risky to keep the TSB rigid, it also needs to be protected from unauthorized changes. Therefore, Standard Operating Procedures have been prepared to guide LMD staff in the functioning and regular updating of the system. An introductory brochure on the use of the TSB was prepared to promote and facilitate its use by Local and Provincial Government in March 2018. In the next quarter, continuous monitoring of the use of the TSB will be done. Necessary updating will be done addressing the feedback received from the users of TSB.

Specification bank updated by LMD in consultation with External Development Partners annually

Delayed: Updating of the technical specification bank is in process. The delay was due to the local elections and changes in MOHP/the Department of Health Services leadership. LMD is initiating the review of old technical specifications and it is expected to be uploaded in the next quarter.

TA OBJECTIVE 6: PPMO ELECTRONIC PROCUREMENT PORTAL (E-GP) IS USED BY LMD FOR AN EXPANDED RANGE OF PROCUREMENT FUNCTIONS

The objective is to make the procurement information transparent using e-GP-2

Support PPMO on changes needed on e-GP for health sector procurement

Completed: NHSSP facilitated the technical consultative meetings with PPMO for the successful implementation of e-GP-2 at LMD. Some issues relating to instructions to bidders and special conditions of contract on online standard bidding documents have been resolved. In the next quarter, the PPFM team will provide specific guidelines to resolve bottlenecks of e-GP II with respect to Health Sector Procurement.

Develop guidelines to support the use of e-procurement at local levels

On-time: It was planned to prepare e-GP guidelines for supporting local levels in this quarter. The hiring of STTA consultant initiated and the Guideline will be developed and disseminated to all local levels in the next quarter.

Adapt e-GP to be used for handling of grievances

Delayed: PPMO has not yet been able to complete this module in e-GP. In the next quarter, a separate grievance handling mechanism will be adapted by LMD for the health sector.

2.1 THE SERVICE DELIVERY WORKSTREAM

TARGET BENEFICIARIES AND STRATEGIES GUIDING TECHNICAL ASSISTANCE

The service delivery team supports the Family Health Division (FHD), Primary Health Care Re-vitalization Division (PHCRD), Curative Service Division (CSD), National Health Training Centre (NHTC), Leprosy Control Division (LCD), Public Health Administration and Monitoring and Evaluation Division (PHAMED) and Child Health Division (CHD), in planning and delivery for improved access and quality services. During the reporting period, the main challenges are delayed implementations by local councils and transfer of directors.

TA OBJECTIVE 1: THE DEPARTMENT OF HEALTH SERVICES DELIVERS INCREASED COVERAGE OF UNDERSERVED POPULATIONS

The SD team provided technical assistance to better reach under-served communities. Limitations in infrastructure, personnel, and services compounded with geographic difficulties are some of the key challenges faced. Some populations experience discrimination in relation to gender or cast.

Support expansion, continuity, and functionality of CEONC sites

Delayed: Full coverage of CEONC services and recruitment of caesarean section providers is a critical gap. The functionality of CEONC services in remote areas are most affected. NHSSP focused on improving a) C-section services[3]; b) recruitment/ deployment of C-section providers; c) resolving the availability of equipment; and d) selection of doctors to be trained in advanced skilled birth attendants (ASBA). Three CEONC sites re-started C-section services. Reductions in C-sections are evidenced. Further investment is required in poor performing sites. Local Government and hospitals will require ongoing strengthening. Continued in next quarter.

Support the FHD and DHOs to upgrade health posts with Basic Emergency Obstetric and Neonatal Care (BEONC) services

Discontinued: The selection and upgrading of strategically located sites to deliver BEONC have been discontinued. The SD team will facilitate planning and implementation of local health plans in 10 selected remote councils.

Support the Primary Health Care Revitalisation Division (PHCRD) to assess Community Health Units and modify guidelines

Delayed: This work is pending approval from the Director-General. The Technical Working Group (TWG) met to finalise the Term of Reference to assess Community Health Units and advertise for contracting out an organization to conduct the Community Health Unit assessment. Follow up and assistance to PHCRD to develop the selection criteria for NGO selection; contracting out to an organization; finalisation of methodology; and monitoring of the assessment process will be provided during the next quarter.

Facilitate design and testing of RMNCAH, FP, and nutrition innovations

On-time: *m-Health intervention to improve Female Community Health Volunteers engagement with the community*: The contracting process with BBC Media Action is in progress. An advisory group from the government will guide the process of implementation.

On-hold: *Physiotherapy skill transfer to paramedics:* This is approved but requires a further meeting with government stakeholders to commence. Delayed due to the absence of NHTC director.

Discontinued: Following an in-depth exploration and consultation, the decision was made not to pursue the two innovations proposed by Save the Children: Foot length card to identify and improve the home care of low birth weight babies; and working with adolescent girls and young women to increase knowledge and practices on reproductive health.

Support the FHD/CHD/PHCRD and DHO to improve access to RMNCAH and FP services in remote areas building on Remote Areas Maternal and Newborn Health Project approach

On-time: *Scaling up access to primary health services in remote areas:* The SD team provides technical assistance to increase skills of rural administrative and health planners towards better utilization of primary health care services in 10 remote councils[4], and microplanning for PNC facilitated in 6 councils. Baseline data collection from HMIS data is planned. Continued in next quarter.

Support the FHD and DHO to scale-up Visiting Providers (VPs) and roving Auxiliary Nurse Midwives (RANMs) and Integration of FP in EPI clinics

Delayed: Some municipalities did not buy into the of the importance of the Visiting Providers and RANM activity. This resulted in a reluctance to release budgets. Recruitment was low due to

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[3] [3] Sarlahi, Dhading, Nuwakot, Sindhopalchok, Sangjya and Dhaulagiri zonal hospitals and Burtibang PHCC
[4] Two councils each from Rasuwa, Ramechhap, Dolakha, Rolpa and East Rukum districts

unavailability of skilled human resources willing to work in remote areas and with Local Governments. The SD team has acted to advocate for and resolve this matter in 40 out of 100 municipalities. Continued next quarter.

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

Delayed: The SD team contacted and interacted with DHOs and district Family Planning Supervisors/ Officers by telephone or during field visits to expedite the implementation of the activity. NHSSP also provided a district health program implementation guide, and program/budget sheets (both soft copy and hard copy) to DHOs, family planning supervisors/officers of respective districts. Continued next quarter.

Support to the MOHP for improving delivery of nutrition interventions

Delayed: The SD team has reviewed the SBA training strategy (and participated in the revision of the SBA training manual including the nutrition component). The alignment of the SMNH roadmap planning process with NHTC's plan to review SBA training strategy will be facilitated during the next quarter. The review and road map planning will continue beyond next quarter.

Strengthening and scaling up of One-stop Crisis Management Centres (OCMCs)

On-time: Five new OCMCs[5] were established and site visits for monitoring, coaching/mentoring in 10 existing OCMCs[6] were completed during this quarter. Orientation was done on the OCMC concept and operational guidelines were disseminated to hospital staff and multi-sectoral stakeholders. Capacity building of OCMC staff and stakeholders and coordinating strategies are of concern. The reluctance of municipalities to transfer OCMC budgets has impacted the functionality and quality of services provided, staff motivation, and raised concerns for the future. From mid-July 2017 to mid-January 2018, 29 OCMCs provided services to 1756 GBV survivors - 40% domestic violence, 38% sexual violence (24% rape and 14% sexual assault) and 15% extreme mental torture. To address these gaps, capacity building activities have been planned by FHD on Basic GBV and Psychological Counseling Training as well as Medico-Legal Training. This includes orientation on GBV clinical protocols at select hospitals to guide service providers of all levels to be responsive in providing health services to GBV survivors and those at risk of GBV in a comprehensive manner.Continued next quarter.

Rolling out the gender-based violence clinical protocol

Ongoing: The government has a plan to upscale hospital-based OCMCs across the country, though it will take several years to achieve this. A critical step to increasing the response of the health sector to gender-based violence is to roll-out the gender-based violence clinical protocol. Training of trainers on the gender-based violence clinical protocol was completed at the 3 OCMC based secondary level zonal hospitals (Koshi, Bharatpur, and Lumbini) selected by NHTC for the development of GBV clinical protocol training sites.

Scaling up Social Service Units (SSU)

On-time: The establishment of 3 new SSUs[7] and site visits to 5 existing SSUs[8] was completed this quarter. Orientation was provided to hospital staff and other stakeholders on SSU concept and

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[5] Tamghas hospital, Gulmi; SandhiKharka hospital, Arghakhachi, Rukum hospital, Rukum and Kalaya hospital, Bara and Trisuli hospital, Nuwakot.

[6] Dhading hospital, Dhading; Bharatpur hospital, Bharatpur; Hetauda hospital, Hetauda, Sindhuli hospital, Sindhuli; Udaypur hospital, Udaypur, Daumali hospital, Tanahu, , Mangal Sen hospital, Achham, Bajura hospital, Bajura and Baitadi hospital, Baitadi.

[7] Chitwan Medical College, Bharatpur; Sindhuli hospital, Sindhuli and Bhaktapur hospital, Bhaktapur

[8] Bharatpur hospital, Lumbini zonal hospital, National Trauma Center, Hetauda hospital and Pokhara Science and Academy

operational guidelines. The launch of the SSU at Chitwan Medical College and the ownership of the SSU concept by Patan hospital (Academy) are positive signals for the expansions of SSUs beyond the government referral hospitals. Inspirational Volunteerism and Humanitarian Approach training for two SSU based in federal level hospitals were completed. Continued next quarter.

Capacity building to put LNOB into practice

On-time: A 2-day workshop was conducted on gender, equity and social inclusion for DHO/District Public Health Office, Police and Women development officers from 8 districts of 7 provinces to strengthen their capacity. Mayors (3), Deputy Mayors (6), Head and Deputy Heads of Palikas were oriented on MoHs' Gender Equity and Social Inclusion framework and targeted orientation sessions were held during the establishment of OCMC and SSUs at different districts were undertaken to raise awareness. Since, there have been changes at all levels, continuous orientation on the Gender Equity and Social Inclusion framework and targeted interventions are required to build capacity and to raise the awareness of stakeholders at all levels. Continued next quarter.

Develop a digital platform for social change

On-time: The SD team worked with the National Health Education Information and Communication Centre (NHEICC) to develop IEC materials and messages. This will contribute to addressing the gaps that persist at different levels in terms of advocacy materials related to gender-based violence-OCMC and information on free health services in the Nepali language. Upon the request of NHEICC, technical assistance will be provided to review the gender-based violence pack in the next quarter.

TA OBJECTIVE 2:   RESTORATION OF SERVICE DELIVERY IN EARTHQUAKE-AFFECTED AREAS

A programme to re-establish service delivery and improve quality of care focusing on RMNH/FP services in two districts – Ramechhap and Dolakha districts was implemented during the Transition and Recovery Programme. Based on the experience of physical rehabilitation and mental health services provided, the transfer of physiotherapy skills and institutionalisation of mental health services were planned under NHSSP. It also is important to continue to support local councils to continue implementation of free referral to establish for learning.

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

Delayed: A delayed appointment of the new director has impacted timing.

Support the institutionalisation of mental health services

On-time: The SD team coordinated with NHTC to finalise and print the training manual based on revised mental health standard treatment protocol for prescribers.

Strengthen the capacity of DHOs and HFOMC in two earthquake-affected districts

Discontinued: This activity is combined with the remote areas activity under support to the FHD/CHD/PHCRD and DHO to improve access to RMNCAH and FP services.

TA OBJECTIVE 3:   THE MOHP/THE DEPARTMENT OF HEALTH SERVICES HAS EFFECTIVE STRATEGIES TO MANAGE HIGH DEMAND (OF MNH SERVICES) AT REFERRAL CENTRES

Improving quality of care and timely provision of referred women required addressing overcrowding of referral hospitals resulting from by-passing of BC service users.

Free emergency referral for obstetric complications

On-time: The SD team provided referral funds to continue free referral of obstetric complications from birthing centres (BC) to CEONC sites. The local council members are aware of the importance

of timely referral and thus almost all municipalities have planned to provide a budget for a free referral. The mechanism to provide this free referral through all municipalities will need to be set up and the approach for coordination through district-level entities or municipalities where the CEONC services are provided will need to be developed. The plan to assess this free referral has been delayed due to concerns about thepropoposed methodology. The revised methodology will be shared with DFID in April.

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

Delayed: Overcrowding of maternity wards at referral hospitals has hampered the provision of good quality maternity care in referral hospitals. The Joint Annual Review (JAR) *aid memoire* 2015 proposed addressing this issue through infrastructure master planning which is being supported by the HI team. Establishing a birthing unit at referral hospitals, as recommended in the NHSSP 2 study[9] has been taken forward by the MOHP. The budget to establish three birthing units at three referral hospitals in 2018/19 is pending approval.

Support the implementation and refining of the Aama programme

On-time: A capacity gap that was observed was that no updates were provided on the status of Aama programme implementation in private facilities in the changed context. Palikas were requesting for additional Aama budget without sufficient evidence relating to the demand. At the same time, Palikas were requesting for Aama programme guidelines to facilitate the implementation process. To bridge the capacity gap this quarter the SD team has done as follows: 1) Updated the Aama programme implementation status in private sector and mapped it with Palika; 2) Carried out an exercise to assess the sufficiency of the Aama budget allocated to Palikas, 3) Developed Aama programme prototype guideline for Palika. The objectives of this quarter were achieved. To be continued next quarter.

TA OBJECTIVE 4: CONTINUOUS QUALITY IMPROVEMENT INSTITUTIONALISED

Providing quality of care at the point of service delivery is a core part of the strategic approach as well as one of the major outcomes of NHSSP "Improved quality of care at point-of-delivery". The SD team focuses on output 2.1 and 2.3 and NHSSP focuses on output 2.2.

Support the Department of Health Services to expand implementation of Minimum Service Standards (MSS) and modular Health Quality Improvement Plan (HQIP)

Delayed: *The SD team plans to facilitate the processes to improve quality of care at three referral hospitals using the Minimum Service Standards tool and action planning for improved quality of care including actions to address overcrowding issues.*

On-time: *Health Quality Improvement Plan*: The FHD lacks the capacity to facilitate the HQIP process at the hospital level. The SD team, along with FHD staff, facilitated a two-day workshop at 10 hospitals[10] to form the Hospital Quality Improvement Committees (HQICs) and to introduce the self-assessment tool and action planning for improving quality of MNH services. Eleven hospitals[11] completed self-assessment and action planning.

Delayed: *Quality dash-board*: The new director and planning/monitoring person at FHD could not give time for discussion.

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[9] Responding to increased demand for institutional child birth at referral hospitals in Nepal: situational analysis and emerging options (FHD 2013)

[10] Kalikot, Dang-RZH, Dailekh, Rolpa, Rautahat, Pyuthan, Siraha, Parbat and Gulmi district and in coordination with OHW in Taplejung. Total 27 hospitals established HQIC and HQIP.

[11] Jiri, Charikot, Sindhuli, SRH Dadeldhura, Prithivichandra, terathum, Mahottari, Rukum, Salyan, Baitadi, Darchula

Support revision of the Standard Treatment Guidelines/Protocols (STP) and roll out of the updated guidelines

Delayed: The planned activity was delayed due to delay in conducting the TWG meeting. As the revision of technical protocol is technically challenging, the PHCRD requested NHSSP to provide a local consultant to revise the STP based on the Basic Health Care Services (BHCS) package.

Support the FHD to scale up on-site mentoring of SBAs

On-time: Skills and knowledge of SBAs at birthing centres were previously very poor and quality assurance of training of clinical mentors is problematic. The SD team assisted in skills development in nine out of 10 districts[12]. A skill lab is considered necessary for practicing clinical skills as well as for coaching by the clinical mentors. NHSSP provided an SBA trainer to ensure the quality of one batch of SBA mentors training.

Support the NHTC (FHD and CHD) to expand and strengthen training sites focusing on SBAs, FP, and new-born treatment

Delayed: Revision of the training management guidelines of NHTC was completed in this quarter. A rapid service readiness assessment of 3 training sites was delayed. This is due to the fact that there are significant structural and programmatic bottlenecks to implementing this activity in three tertiary care hospitals and it may require intensive but coordinated and tactful dealings with multiple stakeholders.

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

On-time: The SD team prepared FHD's 2073/74 (2016/17) Annual Report for FP and MNH sections (Feb-March). The team also support a review of the programme implementation status and prepare AWPB 2018/19 for FP and MNH programmes. Continued technical inputs were provided to the FHD in the implementation and monitoring of AWPB's FP programmes activities including service tracking of DFID FP/FA supported activities.

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

On-time: FHD has limited capacity to provide training on issues such as family planning and Maternal and Perinatal Death Surveillance and Response. The SD team facilitated a two-day training of trainers on the Decision-Making Tool (DMT) and Medical Eligibility Criteria (MEC) wheel of family planning methods. The SD team supported facilitating and providing local level health program implementation guidelines[13]. The team also co-facilitated an orientation programme to locally elected representatives and health coordinators from Province 5.

Support to the FHD and CHD for monitoring of free care

On-time: The CHD is not yet able to establish a system to monitor free newborn care. The SD team is investigating a mechanism to best monitor the free abortion programme.

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[12] Rolpa, Baitadi, Siraha, Bara, Gulmi, Dailekh, Dolakha, Surkhet, Kailali and Dhading
[13] Rasuwa, Dolakha, Ramechhap, Makawanpur, Chitawan, Kailali, Rupandehi, Rautahat, Udayapur, Siraha, Sunsari, Rolpa, Kalikot, Panchthar.

EMERGENT OR UNPLANNED TECHNICAL ASSISTANCE DEMANDS

Improved availability of human resources at all levels with a focus on rural retention and enrollment

Human Resources Policy Documents: The SD team provided inputs to three policy documents, 1) the draft incentive strategy for retention of the health workforce. 2) the deployment strategy including scholarship guidelines for recent MBBS graduates and postgraduate scholarships 3) the standards to recruit Human Resources by HDCs

IMPROVED MEDICAL AND PUBLIC HEALTH EDUCATION AND COMPETENCIES

Preservice Midwifery Course: The SD team provided technical inputs to develop the certificate level, pre-service midwifery course particularly for province six.

TRAINING FACILITATION AND TECHNICAL INPUTS REQUESTS

The SD team provided technical inputs to LMD on IUCD technical specification. The team also participated in the Nepal Demographic and Health Survey (NDHS) further analysis of the safe motherhood.

2.2 THE EVIDENCE AND ACCOUNTABILITY WORKSTREAM

TARGET BENEFICIARIES AND STRATEGIES GUIDING TECHNICAL ASSISTANCE

The E&A work stream provides technical assistance primarily to the 1) Public Health Administration, Monitoring and Evaluation Division, 2) Family Health Division, and 3) Management Division at the Department of Health Services. The key challenges in sector capacity are; data quality, interoperability of systems, and use of evidence in decision-making. Hence these are the main areas of technical investment. The E&A team is also engaged in strengthening and reporting on sector and programme M&E and cooperates with MEOR. Prominently, E&A strategies include introducing the context-specific e-health innovations; leveraging the technical inputs of EDPs, notably GIZ; facilitating engagement; adding technical points; and catalyzing progress with the beneficiary.

TA OBJECTIVE 1:   THE MOH IMPLEMENTS ROUTINE DATA QUALITY ASSESSMENT SYSTEM TO IMPROVE THE QUALITY OF DATA GENERATION AND USE BY THE DISTRICTS AND FACILITIES.

E&A acts to encourage timely progress towards improved data quality.

I5.1.1 Support to develop and implement RDQA system

On-time: The E&A team contributed to Routine Data Quality Assessment (RDQA) development with diagnostic and conceptual design profferings to a GIZ and beneficiary technical collaboration. Efforts have helped to expedite a web-based application being elevated to online trials. The E&A team have focused on ensuring progress and keeping oversight of the development schedule, technical compliance by the vendor and testing of the system. This activity is one of the payment deliverables and will be completed by the end of April.

TA OBJECTIVE 2:   I5.2 MOHP HAS AN INTEGRATED AND EFFICIENT HIS AND HAS THE SKILLS AND SYSTEMS TO MANAGE DATA EFFECTIVELY

The E&A team acts to encourage timely progress towards improved data utilization.

I5.2.1 Support the development of a framework for improved management of health information in the context of federal governance structures in Nepal

Completed: Submitted PD 4.2 (Framework for improved management of health information in the context of federal governance structures in Nepal) in June 2017.

I5.2.7 Support the effective operationalisation of e-health initiatives
E&A is working with MoHP in promoting the use of e-health solutions in programmes and information management; and in addressing the issue of systems interoperability.

On-time: *Unified coding system*: Health facilities do not have a unique identifier code which means that different systems use different codes for the same facilities. The E&A team have given technical inputs towards the conceptualisation of the initiative and in development of the coding structure/schema and in monitoring the progress. . This is led by MoHP and will be completed next quarter.

On-time: *Health facility registry*: The current paper-based system is incomplete and has redundancies. The E&A team have given technical inputs in diagnosing the problem; conceptualization; preparing a concept note and terms of reference for a web-based health facility registry for Local, Provincial and Federal Governments. This health facility registry will maintain the health facility registry codes and facility registry information. All other MISs (e.g. HMIS, LMIS, HIIS etc.) will draw this information from the health facility registry. This will ensure a layer of interoperability from which users will access information from different MIS including the registry via a public interface/dashboard/website. This is led by MoHP and will be completed next quarter.

On-time: *Document (file) tracking system*: The existing paper-based filing and document tracking system at the MoHP is an ineffective and inefficient way of managing data and client information. The E&A team has provided technical inputs to conceptualize, prepare a concept note and develop terms of reference for an electronic system. This activity is led by MoHP and will be completed by the end of July 2018.

On-time: *Digital library:* Policies, strategies, reports, guidelines, tools, important notices and announcements are not stored together in order to facilitate easy access among the MoHP entities and other stakeholders including public on the MoHP website. The E&A team has provided technical inputs to conceptualise, prepare a concept note and develop terms of reference for an electronic repository, accessible through a web-portal. This activity is led by the MoHP and will be completed by the end of July 2018.

TA OBJECTIVE 3:   I5.3   THE MOH HAS ROBUST SURVEILLANCE SYSTEMS IN PLACE TO ENSURE TIMELY AND APPROPRIATE RESPONSE TO EMERGING HEALTH NEEDS

The E&A team acts to strengthen the national surveillance system.

I5.3.1 Support the strengthening and expansion of Maternal and Perinatal Death Surveillance and Response in hospitals and communities
On-time: The MOHP reports issues with the MPDSR system, e.g. incomplete data and delayed submission. Also, Federalisation requires that the system guidelines align with the devolved context including links to M&E. The E&A team has been providing technical inputs towards adapting this system to these changing needs. In the next quarter, the E&A team will work with the MOHP to develop a mobile-based application for FCHVs to notify the deaths of women of reproductive age.

TA OBJECTIVE 4:   I5.4   MOHP HAS THE SKILLS AND SYSTEMS IN PLACE TO GENERATE QUALITY EVIDENCE AND USE IT FOR DECISION MAKING

The E&A team acts to provide quality data analysis for evidence to inform decision-making at all levels.

I5.4.1 Support the development and implementation of harmonised M&E to meet the health sector data needs

On-time: *M&E Gap analysis:* The E&A team is working with MOHP to identify and address the data needs of the three level of governments. This will be completed by end of July 2018.

On-time: *Sector M&E***:** From the functional analysis of the Constitutional provisions, emerges a need to redefine Local, Provincial and Federal Government M&E functions including data needs at each

level and survey plans. The E&A team developed a concept note for the health sector M&E plan, organized a stakeholder workshop (Jan 9-11) and drafted the plan with Monitoring Evaluation and Operational Research (MEOR). This activity is led by the MOHP and will be completed by July 2018.

I5.4.2 Analyse HMIS and national level survey data to better understand and address the equity gaps

Completed: *SMNH Roadmap*: The development of the SMNH Roadmap required further interrogation of available data to understand recent trends in SMNH. The E&A team analyzed the data from the HMIS and the Nepal Demographic and Health Survey (NDHS) to this end.

Completed: *Analysis of national-level survey data: NDHS (1996-2016) and Nepal Health Facility Survey (NHFS) 2015:* To address the need for evidence-based policy, the E&A team provided technical assistance to the MOHP to further analyse the NHFS 2015 (antenatal and postnatal care service) and NDHS 2016 data (postnatal care service). The E&A team has done the equity analysis of the Nepal Health Sector Strategy (NHSS) Results in Framework goal and outcome level indicators using the NDHS series data. These analyses have been accepted for poster and oral presentation at the Fourth National Summit of Health and Population Scientists in Nepal (11-12 April 2018).

I5..4.3 Support the MOHP in improving evidence-based reviews and planning process at all levels
On-time: *Evidence-based reviews:* In addressing data quality and access for use in planning, the E&A team have a) developed a web-based interactive dashboard/portal that presents the Nepal Demographic and Health Survey (NDHS), the Health Management Information System (HMIS) and the Nepal Health Facility Survey (NHFS) data. The dashboard intends to help monitor the Nepal Health Sector Strategy's (NHSS) Results Framework and health-related Sustainable Development Goals (SDG) with an equity perspective in terms of geography, socio-economic and demographic characteristics of the population. The dashboards are hosted on the MoHP website. and b) together with MoHP officials developed abstracts for conferences.

Completed: *Joint Annual Review*: Jointly with the HPP team, the E&A team engaged with the MOHP to prepare and organize the Joint Annual Review (Jan 31-Feb 1, 2018) including the development of the Aide Memoire and action plan.

TA OBJECTIVE 5:   I5.5   THE MOHP HAS ESTABLISHED EFFECTIVE CITIZEN FEEDBACK MECHANISMS AND SYSTEMS FOR PUBLIC REPORTING
The MOHP has limited means and mechanism to receive citizen feedback and report back to the public.

On-time: *Grievance management system:* The E&A team have provided technical inputs to conceptualize and prepare a concept note and terms of reference for an electronic system to improve the current system. This activity is led by MOHP and will be completed by the end of July 2018.

EMERGENT OR UNPLANNED TECHNICAL ASSISTANCE DEMANDS

On progress: *Health policy of Pokhara Lekhnath Metropolitan City*: With the HPP team, the E&A team have been providing technical inputs to Pokhara Lekhnath Metropolitan City to a) finalize the health policy, b) develop a detailed action plan to help translate the policy into action, and c) develop a baseline survey of health facilities. As this is one of the Learning Lab sites, the intention is that this may serve as models for other Local Governments.

On progress*: Assessment of the Free Referral Services for Obstetric Complications in two districts of Nepal:*
Together with the SD work stream, the E&A workstream has been contributing to design of the assessment.

The following activities were not mentioned above because these were **not the prioritized activities for the quarter**. Please find below the details on each activity:

Support effective implementation of Early Warning and Reporting System (EWARS): with a focus on evidence-based response (very important in the current context) NHSSP's support to EWARS initiated particularly in the post-earthquake context. We supported the EWARS system in improving the data collection, analysis and report writing and most importantly in customization of the EWARS reporting system into DHIS2 platform. After completion of the inception phase of NHSSP-III, the intensive support - with embedded officer - was withdrawn as the system was established and WHO was intensively engaged in EWARS. The person supported by NHSSP is still been continuing providing support to EDCD with support from WHO. So NHSSP is engaged on need basis only particularly in the technical discussion/meetings to strengthen EWARS and in post disaster contexts like the terai flood in 2017. There was no specific intervention in the last quarter, so it was not reported in the last quarterly report.

Support the expansion and institutionalization of electronic reporting from health facilities: NHSSP has been one of the key supporter of the MoHP in conceptualization, development and roll out of electronic reporting of HMIS from health facilities. We initiated it in Dolakha and Ramechhap in the post-earthquake context in 2016. We have been engaged with HMIS, DoHS and GIX in planning its expansion in other districts (now it is in 700 plus facilities across the country). We have a plan to support this in the Learning lab sites once we start implementing the NHSSP supported focused interventions in the learning lab sites. We did not support in roll out of this in specific areas in the last quarter, so it was not reported in the last quarterly report. We will include in the quarterly report when we actually do it.

Support the development and institutionalisation of electronic attendance system at different levels: During the post-earthquake context, NHSSP supported the MOHP to conceptualize the development of electronic attendance systems at different levels. MoHP had also initiated the process of developing the system - application - and was in the process of using the existing GoN fund for purchase of the devices for roll out at the PHCC level in the first phase. However, in the changed context of federalism, the MoHP has now with drawn from the concept of developing the electronic attendance system at the central level and rolling it out at the local government level; and limit this initiative at the MOHP level only. Electronic attendance system is operating at the MoHP level. NHSSP has supported in monitoring of the electronic attendance system through dashboard at the MoHP. There was no specific intervention in the last quarter, so it was not reported in the last quarterly report.

Support the Development of the QIMIS: NHSSP was engaged with the DoHS and partners (Health for Life, NSI, WHO, UNICEF) to conceptualize the QIMIS in 2017 and continuously engaged in technical discussions to take this initiative forward. There were no specific interventions in the last quarter, so it was not reported in the last quarterly report.

In the running quarter (May-July) NHSSP (EA and HPP) is now working with the Management Division, QI Section and Curative Service Division, MoHP in establishing QIMIS - pulling the data related to the HMIS and NDHS indicators for monitoring quality of care. The progress on this will be reported in the next quarterly report.

2.3 HEALTH INFRASTRUCTURE

TARGET BENEFICIARIES AND STRATEGIES GUIDING TECHNICAL ASSISTANCE

The beneficiaries of technical assistance are MOHP and DUDBC. Capacity enhancement is at the heart of the strategic approach, building competencies in health infrastructure design, planning, and implementation.

KPA 1: POLICY ENVIRONMENT

The objective is to build a strong policy environment that turns policy into practice.

Production of a policy, standards, and codes gap analysis report

On-time: A gap analysis identified the need for guidelines on designs of HVAC for health infrastructure. Consultation with DUDBC has been established to initiate the issue. The final document on HVAC guidelines is planned. Continued next quarter.

Retrofitting and rehabilitation standards for health infrastructure produced and submitted to the GON for endorsement

Completed: The document is under review by DUDBC. It was decided to be developed in the form of National Standards. A working team has been formed under DUDBC for this purpose. The HI team will work in coordination with DUDBC and national and international experts.

Production of a post-2015 Earthquake Performance Appraisal Report

Completed: This report provides an overview of Disaster Risk Reduction activities and policies in the MOHP. To improve and enhance the coordination mechanism for Disaster Risk Reduction governance in the changed context of federalism, it has been planned to integrate the activities with the NHSSP Learning Labs as a pilot. The mechanism of integration will be finalized in the next quarter.

Production of Nepal Climate Change and Health Infrastructure Framework

Completed: The recommendations from the framework report has been provided to MOHP during different meetings, workshop and events as inputs for the preparation of guidelines for climate resilient healthcare facility. The output of the study will provide evidence in support of output 7 of NHSS, which will be disseminated to Local and Federal Government.

Health facility standards and design guidelines produced and submitted to the GON for endorsement

Completed: The standards and guidelines have been produced and endorsed by the Government. They are published and are planned to be disseminated to Local and Provincial Governments in the next quarter.

Standardization of health facility catchment delineation and upgrading selection criteria produced and submitted to the GON for implementation under the new federal dispensation

Completed: This work has been undertaken and endorsed by the Government. They have been published, and are planned to be disseminated to Local and Provincial Governments in the next quarter.

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

On-time: Reports indicate a gap in the documentation of application of Gender Equity and Social Inclusion and LNOB considerations in different stages of health infrastructure planning, designing and implementation. Existing guidelines were updated to include these issues with a plan to regularly review. The GESI Advisors will help to disseminate these provisions to stakeholders. Continue next quarter.

The NNBC will be updated with appropriate new environmental and natural hazard sections.

Discontinued: NHSSP does not have the authority to update any legal provisions.

Health Infrastructure Information System (HIIS) upgrade and reporting to support evidence-based decision making:

On-time: HIIS is being upgraded to reflect the Federal organizational structure, human resource information, and service availability information. Technical assistance was provided to DUDBC and DOHS for the annual planning of health facility development and upgrade using HIIS. Continue next quarter.

Upgrade HIIS to integrate functionality recommendations

On-time: Agreements have been reached to integrate a data exchange mechanism between the Project Management Information System and the HIIS. A meeting with the health unit in the local authority is yet to occur. This activity is periodic per requirement.

Digitization and update of feature information in the HIIS geo-database. Detailed delineation of service catchment area of health facilities. Avail GIS-based mapping services for other sectors of the programme. Support with information on activities on developing policy, standards and health facilities improvements to address the impact of climate change and environmental hazards

On-time: Digitization and update of feature information in the HIIS geo-database have been carried out and is an ongoing activity. The geo-database features (roads, rivers, bridges, health facilities) have been updated with available data sets and satellite imagery. Updating the catchment areas with more scientific criteria is still ongoing. GIS-based mapping services for other parts of the programme have been provided including the development of various GIS-based maps. This activity is periodic as per requirement.

Integration and database update pertaining to climate change induced hazards and other relevant aspects concerned with climate and hazards.

On-time: An offline database of climate-induced hazards has been created with district-level data. The database is being updated with federal and local authority level data since not all hazard-related data is managed at the national level. Historical and current datasets have been collected and an integrated database is being developed. Such data will be interpreted in relation to the health infrastructure.

Support to MOHP to fulfill information requirements pertaining to reconstruction and recovery of health facilities damaged by the earthquake, regular planning of upgrade of health facilities via data analysis, geospatial analysis and information maintained in HIIS framework.

On-time: Information pertaining to reconstruction and recovery of the health facilities damaged by the earthquake has been maintained in the HIIS framework. Periodic inquiries and data collection from implementing agencies have been performed to derive a current picture of the status of works. Information and analysis data have been provided to the DOHS and DUDBC to assist in regular planning for upgrade and development of health facilities. This activity is periodic as per requirement.

Policy for Health Facilities Prioritization and Selection produced and adopted

Completed: The document has been endorsed by the Ministry in line with the cabinet decision.

Health Infrastructure Capital Investment Policy produced and adopted

Completed:

KPA 2: CAPACITY ENHANCEMENT

Capacity enhancement is at the heart of our strategic approach.

Policy development and evidence-based planning

The objective the workshop has been achieved with fruitful discussions and finding some issues related to health infrastructure policies. An impact assessment, policy development workshop and training has been planned for each year. The related payment deliverable, "Health Infrastructure Policy Development Workshop" has been submitted.

Infrastructure technical skills programme

On-time: The technical skills training on "Orientation Training on Retrofitting and Tender Process" has been completed and delivered early in March to DFID ((Payment Deliverable, April 2018).

Training Needs Analysis of Construction Contractors & Professionals

Completed: The Training Needs Analysis of Construction Contractors & Professions has been completed (Payment Deliverable February 2018).

Retrofitting and rehabilitation (concentrated on development and dissemination of retrofitting codes, and on-site assessment)

On-time: A consultation workshop on "Nepal Seismic Retrofitting and rehabilitation Standards" was organized inviting national, international, private and public-sector professionals for their feedback and views to make the standard more useful, contextually implementable and legally endorsed. The standard development working team has been formed under the DUDBC with our team members working for review, improvement and approval process together with DUDBC engineers. A series of on-site assessments have been carried out for Bhaktapur hospital, Bhaktapur and Western Regional Hospital, Pokhara jointly with the DUDBC local and central level engineers and architects to have a demonstration effect on them.

Ongoing Technical Assistance for Health Infrastructure Construction to DUDBC and PCU

On-time: The team has been assisting DUDBC for design and implementation of complex health infrastructure projects. The designs are implemented by DUDBC as part of capacity development activities, several tertiary level hospital designs have been developed by DUDBC with technical input from the team, for which joint visits in the site have been organized to resolve any technical complications and issues arising, this is onsite capacity development approach. Similarly, technical backstopping has been made to Project Coordinating Unit (PCU) for understanding the health infrastructure Standards and guidelines and assistance in interpretation of clauses for proper evaluation of tender documents. This is an ongoing process and will continue throughout the programme period.

Infrastructure technical skills programme

On-time: The technical skill development programme will continue into the 2nd year by incorporating the feedback of the impact evaluation. The technical skill developpment training programme will be implemented based on the needs prioritize the target group in the Training Needs Assessment. The training events will continue as required until the end of the programme.

Retrofitting and rehabilitation

On-time: On-site assessment of Bhaktapur hospital and Western Regional Hospital will continue based on the need for designing the retrofitting of those hospitals. The preparation of a training module has been initiated which includes retrofitting design, implementation, contract management use of design software intensive and other related topics in consultation with experts and as per the needs and gaps identified.

KPA 3: RETROFITTING AND REHABILITATION

Retrofitting and rehabilitation standards, codes, and guidelines

Completed: The HI team is providing technical expertise to the MOHP and DUDBC to develop a comprehensive seismic retrofitting and rehabilitation standard requirements for Nepal. An Earthquake Retrofitting and Rehabilitation Standards for Nepal has been submitted to DUDBC for review and approval. A joint working team comprised of representatives from DUDBC and NHSSP is working to review and refine the Standards for approval.

Capacity enhancement

On-time: An orientation training on retrofitting and tendering process for MOHP, DUDBC, and local authority technical staff has been completed. On-site training for MOHP and DUDBC technical staff on retrofitting design and tendering process of the prioritized two hospitals is an ongoing process in

this quarter. There remain gaps in understanding retrofitting construction and the tendering process. There are major challenges in relation to documentation, institutionalization and wider dissemination on a different level and stakeholders

Priority hospitals design and tender phase

On-time: Retrofitting designs of two priority hospitals with tender documents have been completed and submitted to DUDBC (February Payment Deliverable). A joint structural engineer team of DUDBC and NHSSP is working to refine the proposed retrofitting design, drawings, cost estimation, and specification. NHSSP and DFID's consultant are working with DUDBC to finalize the tendering documents and procurement process. The challenges are effective implementation of the retrofitting works without disturbing hospital services with lack of qualified construction professional. The proposed retrofitting approaches and capacity enhancement activities will address these challenges and gaps in order to effectively implement the retrofitting works.

Capacity enhancement

On-time: The capacity enhancement activities relating to retrofitting and rehabilitation for MOHP and DUDBC technical staff, and private sector construction professionals are ongoing. The ongoing retrofitting works of the prioritized hospitals will be a part of the capacity enhancement activities for MOHP and DUDBC technical staff, and private sector construction professionals throughout this year.

Priority hospitals tendering and construction phase

On-time: The construction of decanting space for both of the hospitals will be finished by the end of this year. The first payment shall be made to the contractor of the main retrofitting construction for both of the hospitals.

4 CONCLUSIONS

4.1 KEY ACHIEVEMENTS

Policy and planning

The Ministry of Health and Population finalised structures for the devolved functions of health. Draft planning and budgeting guidelines were developed. A health sector policy review was completed, and draft findings were shared with stakeholders. The Joint Annual Review meeting was held from January 31 to February 1, 2018. Both the pre and post-Joint Annual Review reports were submitted and approved.

The Gender Equity and Social Inclusion Strategy framework were revised. GESI has been incorporated in a number of key policy documents including the draft national health policy; the 10-year national policy and action plan on disability; and new mental health policy. The Department of Sociology, Tribhuwan University, and Ministry reviewed questionnaires to study "State of Social Inclusion in Nepal" enabling gender-based violence, women empowerment and health issues relating to social health security to be included. The MOHP established 4 new OCMCs and 3 new SSUs including one at a private hospital. A training manual based on revised mental health standard treatment protocol (STP) for prescribers was finalised and printed.

Public finance management and procurement

A detailed budget analysis report was posted on the Ministry and Programme websites in January 2018. TABUCS has been rolled-out to the Department of Urban Development and Building Construction, the National Rebuilding Authority, Province 4 and the Home Ministry. The e-Government Procurement II is included in the web portal of government of Nepal's Public Procurement Office. The Logistics Management Division is using the online e-Government Procurement II in all bidding procedures. A total of 30 bids were published this quarter. The procurement improvement plan (2016-2021) has been endorsed by the Secretary.

Service delivery

Local governments have started to implement AWPB funded programmes including the establishment of OCMC, Visiting Providers, Roving Auxilliary Nurse Midwives and micro-planning for Post Natal Care. Training management guideline of NHTC and a draft Aama programme prototype implementation guidelines were completed. The SD team also contributed to the development of important human resource related policy documents. The team received approval to start implementation of two innovations. Signs of institutionalization of HQIP were observed as the majority of hospitals conducted self-assessment and action planning with improved scores in the readiness of MNH services in these hospitals.

Infrastructure

A steering committee was formed between the Ministry of Health and Population and Department of Urban Development and Building Construction. Tender document and retrofitting designs were completed and submitted to the Department of Urban Development and Building Construction. Different capacity enhancement activities were carried out for Department of Urban Development and Building Construction engineers, Project Coordinating Unit engineers and private sector professionals. The Programme facilitated the land dispute resolution in Bhaktapur Hospital between the District Hospital and the Organ Transplant Center.

Technical Assistance Response Fund

No applications were received from MOHP during the reporting period, therefore there no expenditure made in this quarter. Orientation on Technical Assistance Response Fund was made to the PPICD Head and Director General. However, both positions are now replaced by new persons and NHSSP is planning to organize an additional orientation to key officials in MOHP and DOHS about the purpose and the use of Technical Assistance Respond Funds.

4.2 SIGNIFICANT CHALLENGES

Frequent change in the leadership of the MOHP and delays in state restructuring hampered the initiation and approval of some activities. Lack of clarity on budget allocation for hospital-based activities e.g. OCMC budget went to Palikas instead of hospitals which resulted in disruption of services to GBV survivors. The dialogue between the HPP team and high-level officials in MOHP resulted in an agreement to include this as essential health care grant to OCMC implementing hospitals.

Building a common understanding of GESI, and changing the attitudes of people that make up the health system are long-term processes that need to be tackled through institutional and system change, capacity building, and changes in the broader socio-political environment. Further, given the structural changes at all levels, continuous orientation on GESI framework and targeted interventions are required to build capacity and to raise the awareness of stakeholders at all levels. Likewise, private hospitals are run with different principles and objectives with the result that accommodating all twelve types of the target group for free or subsidized services within their corporate social responsibility is proving unworkable.

REFERENCES

Alliance for Health Policy and Systems Research. (2007). *Sound Choices Enhancing Capacity for Evidence-Informed Health Policy.* Geneva: WHO.

Daniels, C. M. (2016). *Organizational Capacity Assessment Tool (OCAT) UserGuide.* The Cash Learning Partnership and the European Union.

Ministerial Leadership Initiative. (2009). *Capacity enhancement tool introduced in Nepal*. Retrieved April 12, 2017, from Ministerial Leadership Initiative: http://www.ministerial-leadership.org/blog/mli-sponsored-seminar-introduces-capacity-enhancement-tool-nepal

Mizrahi, Y. (2004). *Capacity Enhancement Indicators Review of the Literature.* Washington: World Bank Institute.

Nepal Health Sector Support Programme. (July 2017). *Inception Report.* Kathmandu, Nepal: Options Consulting UK.

O'Brien, G. (2004). What are the principles of adult learning? *http://www.southernhealth.org.au/cpme/articles/adult_learning.htm,*

Appendices

APPENDIX 1 UPDATE OF LOG FRAME

NHSSP Logframe: Progress update of year 1									
PROJECT TITLE:		NEPAL HEALTH SECTOR SUPPORT PROGRAMME							
OUTCOME/OUTPUT	**Outcome / Output Indicator**								
Health system is more resilient to environmental shocks and natural disasters	**Outcome Indicator** **1.1**		**Baseline** (2016)	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)		**Assumptions / Remarks***
	% of new health facility buildings (government) timely built adhered to environmental shocks and natural disaster resilience criteria	**Planned**	Not applicable (new standards to be developed)	na	na	100	100		Revised standards are timely endorsed by MoHP. **1st Year update:** A total of 228 new government health facility buildings timely completed adhering to environmental shocks and natural disaster resilience criteria out of total 348 planned.
		Achieved		65.5					
			Source						
			Infrastructure development plan, Construction completion certificate, MoH						
Equitable utilization of quality health services	**Outcome Indicator** **2.1**		**Baseline** (2016)	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)		Regular availability of SBAs at all BCs, BEONCs, and CEONCs **1st-year update:** Target population by local government is expected to be finalized by end of June 2018. So, districts have been considered for this calculation.
	% point reduction in the gap between the average SBA delivery of the bottom 10% and top 10% local governments (disaggregated by Province)	**Planned**	Current HMIS does not report data by local governments	5	10	15	20		
		Achieved		1.3					
			Source						

NHSSP Logframe: Progress update of year 1								

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME							

OUTCOME/OUTPUT	Outcome / Output Indicator							
			HMIS FY 2016/17 (July 2016 - June 2017)					
Improved governance and accountability of the health sector at the three levels of government that leaves no one behind	**Outcome Indicator** **3.1**		**Baseline** **(2016/17)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	*For Province and Local Government, baseline and targets will be set at the end of FY 2017/18; i.e., in year 2 of NHSSP.* *Baseline data for Central level accessed from TABUCS on 10 Aug 2017* **1st-year update:** FY 2073/74 Province and local level data is not available for this year
	% of the expenditure of health budget at: 3.1a: Central level 3.1b: Province level 3.1c: Local level	**Planned** 3.1a: Central	83.07	93.93	87	88	90	
		3.1b: Province	Na	na	tbc	To be confirmed by year 2	To be confirmed by year 2	
		3.1c: Local	Na	na	tbc	To be confirmed by year 2	To be confirmed by year 2	
		Achieved						
		Source						
		AWPB, TABUCS, FMR (						

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME						

OUTPUT 1	**Output Indicator 1.1**		**Baseline** **(2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	**Assumptions / Remarks***
Evidence-based policies and guidelines developed in the	% of local governments adhering to policy/guideline on health	**Planned**	MoH is in the process of defining	na	50	75	100	*Health structures in*

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME					

OUTCOME/OUTPUT	Outcome / Output Indicator					
federal context and endorsed by the respective authorities in MoH	structure in the federal context		health structures in the federal context				*federal context will be defined in year 1.* ***1st year update:*** *The health structures in federal context are expected to be finalized by May 2018.*
		Achieved					
		Source					
		MoHP report on organization restructuring in the federal context					

Output Indicator 1.2		**Baseline** **(2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)
Number of priority health policies, strategies, and guidelines endorsed by MoH 1.2a: Policies 1.2b: Strategies 1.2c: Guidelines	**Planned** 1.2a: Policies	MoH priorities set for Year 1 & 2	1 (Partnership in Health)	1 (AMR)	To be determined based on MoH priority	To be determined based on MoH priority
	1.2b: Strategies	MoH priorities set for Year 2	na	1 (GESI)	To be determined based on MoH priority	To be determined based on MoH priority
	1.2c: Guidelines	MoH priorities set for Year 2	na	1 (National Standard Treatment Guideline)	To be determined based on MoH priority	To be determined based on MoH priority
	Achieved		MoHP has prepared a final	x		

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME						
OUTCOME/OUTPUT	**Outcome / Output Indicator**						
				draft of the Policy on Partnership in health			
		Source					
		MoH endorsed policies, strategies and guidelines					
	Output Indicator 1.3		**Baseline (2017)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)
	% of primary hospitals (government) meeting minimum service standards in learning lab sites	**Planned**	The existing 'Minimum service Standards of Hospitals' needs to be aligned with standards of Integrated Infrastructure Development Plan (IIDP) 2017	na	50	70	80
		Achieved		Na			
		Source					
		Updated Minimum Standards for primary hospitals, NHSSP periodic progress reports					
	Output Indicator		**Baseline** (Mar 2017 -	**Year 1**	**Year 2**	**Year 3**	**Year 4** (Mar 2020-

Minimum service standards for primary hospitals will be updated in line with the standards of IIDP 2017 in year 1.

1st-year update: *MoHP has identified eight local governments as the learning lab sites. The programme implementation will begin from July 2018.*

Assumptions / Remarks*

NHSSP Logframe: Progress update of year 1								
PROJECT TITLE:		NEPAL HEALTH SECTOR SUPPORT PROGRAMME						
OUTCOME/OUTPUT		**Outcome / Output Indicator**						

	1.4			(2016)	Feb 2018)	(Mar 2018 - Feb 2019)	(Mar 2019 - Feb 2020)	Dec 2020)	
	% of MoHP entities met actions recommended by OCAT as per the plan	**Planned**	OCAT not developed	na	100	100	100	*OCAT will be designed, adopted and the first round of assessment completed in year 2.*
		Achieved		Na				
		Source						
		OCAT progress report, NHSSP periodic progress reports						**1st-year update:** The NHSSP is exploring suitable tools and the process of OCAT used in other countries for adaptation in the local context. This will be shared with the MoHP once the health structures are finalized in the federal context.

	Output Indicator 1.5		**Baseline (2016/17)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020-Dec 2020)	**Assumptions / *Remarks***
	% of agreed actions in Joint Consultative Meeting (JCM) completed timely	**Planned**	JCM action monitoring mechanism does not exist	100	100	100	100	**1st-year update:** Of the 6 agreed actions in the last JCM (June 2017) 4 actions have been completed

								timely.
		Achieved		66.67				
		Source						
		JCM note for the record						
IMPACT WEIGHTING (%)		**Source**						**RISK RATING**
INPUTS (£)	**DFID (£)**		**Govt (£)**	**Other (£)**		**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**							

PROJECT TITLE:	**NEPAL HEALTH SECTOR SUPPORT PROGRAMME**							
OUTPUT 2	**Output Indicator 2.1**		**Baseline** **(2016)**	**Year 1** **(Mar 2017 - Feb 2018)**	**Year 2** **(Mar 2018 - Feb 2019)**	**Year 3** **(Mar 2019 - Feb 2020)**	**Year 4** **(Mar 2020- Dec 2020)**	**Assumptions / Remarks***
Financial Management capacity strengthened by supporting the development, implementation and monitoring of Financial Management Improvement Plan (FMIP)	% of MoH spending units conducting an internal audit in line with the internal audit improvement plan (IAIP)	**Planned**	IAIP plan does not exist	na	30	50	80	*IAIP will be finalized and implemented in year 1.* **1st-year update**: *IAIP has been finalized and implemented. Total 307 units conducting an internal audit in line with the internal audit improvement plan.*
		Achieved		na				
		Source						
		IAIP annual progress report						
	Output Indicator 2.2		**Baseline** **(2016)**	**Year 1** **(Mar 2017 - Feb 2018)**	**Year 2** **(Mar 2018 - Feb 2019)**	**Year 3** **(Mar 2019 - Feb 2020)**	**Year 4** **(Mar 2020- Dec 2020)**	Revised eAWPB and TABUCS are in line with the upcoming legal and system frameworks.
	Number of MoHP officials trained on: 2.2a: Revised eAWPB	**Planned** 2.2a: Revised eAWPB	Current eAWPB is not fully used and needs to be updated to include planning at local, provincial and federal level	na	100	150	200	*eAWPB and TABUCS will be revised/ updated in year 1*

	2.2b: Updated TABUCS	2.2b: Updated TABUCS	Existing TABUCS needs to be updated to include expenditure authorisation, payroll, FMR, monitoring, and cash advance modules	na	100	150	200	*The figures in milestones and targets are cumulative.*
		Achieved		na				***1st-year update:*** *eAWPB and TABUCS will be revised/ updated in year 1*
		Source						*Total 20 MoHP officials trained on revised eAWPB and 156 MoHP officials trained in TABUCS in year 1.*
			Health sector eAWPB, Training completion report					
	Output Indicator 2.3		**Baseline** (2016)	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	**1st year update:** Total number of MoH spending units having on recorded audit observation is 139 out of total number of MOHP spending units (307).
	% of MoHP spending units having no Recorded Audit Observations	**Planned**	30	32	34	37	40	
		Achieved		45.28				
		Source						
		OAG Annual Report						

IMPACT WEIGHTING (%)							**RISK RATING**	
INPUTS (£)		**DFID (£)**		**Govt (£)**	**Other (£)**		**Total (£)**	**DFID SHARE (%)**
INPUTS (HR)		**DFID (FTEs)**						

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME							
OUTPUT 3	**Output Indicator 3.1**		**Baseline (2016)**	**Year 1 (Mar 2017 - Feb 2018)**	**Year 2 (Mar 2018 - Feb 2019)**	**Year 3 (Mar 2019 - Feb 2020)**	**Year 4 (Mar 2020- Dec 2020)**	**Assumptions / Remarks***
Procurement capacity enhanced by implementing Procurement Improvement Plan (PIP) that results in the 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	50	60	70	80	*The baseline is taken from NHSS 2015-20, Results Framework*
		Achieved		23				
		Source						
		LMD Report on CAPP						
	Output Indicator 3.2		**Baseline (2016)**	**Year 1 (Mar 2017 - Feb 2018)**	**Year 2 (Mar 2018 - Feb 2019)**	**Year 3 (Mar 2019 - Feb 2020)**	**Year 4 (Mar 2020- Dec 2020)**	Timely monitoring of progress by PFM and CAPP monitoring committees.
	% procurement tender completed adhering to specification bank for: 3.2a: Free drugs 3.2b: Essential equipment	**Planned** 3.2a: Free drugs	Standard specification bank is in the process of revision	na	85	90	95	**1st-year update:** Standard specification bank has been revised.
		3.2b: Essential equipment	Standard specification bank revised	na	75	85	90	20% procurement tender completed adhering to specification bank free drugs in the year 1.
		Achieved						
		3.2a: Free drugs		20				
		3.2b: Essential equipment		na				
		Source						
		LMD Report on the procurement of free drugs and essential equipment, Specification Bank						
	Output Indicator 3.3		**Baseline**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	*Procurement clinic will*

			(2016)	(Mar 2017 - Feb 2018)	(Mar 2018 - Feb 2019)	(Mar 2019 - Feb 2020)	(Mar 2020- Dec 2020)	be established in Year 1.
	% of responses among the cases registered in procurement clinic	**Planned**	na	Na	50	60	70	**1st-year update:** *Procurement clinic has been established.*
		Achieved		Na				
		Source						
		LMD report on procurement clinic, NHSSP periodic reports						
IMPACT WEIGHTING (%)		Source						**RISK RATING**

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

PROJECT TITLE:	**NEPAL HEALTH SECTOR SUPPORT PROGRAMME**						

OUTPUT 4	**Output Indicator 4.1**		**Baseline** **(2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	**Assumptions / Remarks***
MoH expands access to RMNCAH and nutrition services, especially to underserved groups	Number of CEONC sites with functional caesarean section service	**Planned**	75	78	81	84	87	*The figures in milestones and targets are cumulative.*
		Achieved		69				**1st-year update:** *On Feb 2018.*
		Source:						
		FHD report , HMIS						
	Output Indicator 4.2		**Baseline** **(2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	**Assumptions / Remarks***

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME						
A number of current users of: 4.2a: IUCD and Implant 4.2b: IUCD 4.2c: Implant (Disaggregated by provinces and ecological region)	**Planned** 4.2a: IUCD & Implant	420,715	516,998	604,365	679,979	618,664	*The decline in number of users in year 4 compared with year 3 is due to the 10 months programme period in 4th year.*
	4.2b: IUCD	169,299	183,533	197,055	209,901	185,088	
	4.2c: Implant	251,416	333,466	407,310	470,078	433,578	
	Achieved						*1st-year update: FY 2073/74*
	4.2a: IUCD & Implant		4673731				
	4.2b: IUCD		1799529				
	Ecological region						
	Mountain		56071				
	Hill		991241				
	Terai		752217				
	4.2c: Implant		2874202				
	Ecological region						
	Mountain		221267				
	Hill		1602094				
	Terai		1050841				
	Source						

PROJECT TITLE:	NEPAL HEALTH SECTOR SUPPORT PROGRAMME							

		HMIS						
	Output Indicator 4.3		**Baseline (2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	*The decline in a number of users in year 4 compared with year 3 is due to the 10 months programme period in the 4th year.*
	Number of people served by One Stop Crisis Management Centres (OCMC)	**Planned**	3,480	4,320	5,160	5,760	5,000	***1st-year update:*** *Last six months of this fiscal year (mid-Jul 2017-mid-Jan 2018).*
		Achieved		1,756				
		Source						
		OCMC reports						

	Output Indicator 4.4		**Baseline (2016/17)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020-Dec 2020)	**Assumptions / Remarks***
	Number of women benefited from *Aama* programme (disaggregated by ecological region and Province)	**Planned**	315,355	321,356	327,355	333,355	282,796	*The decline in a number of users in year 4 compared with year 3 is due to the 10 months programme period in the 4th year. The disaggregated number of women benefited from Aama program is not available.*
		Achieved		291,711				
		Source						
		FHD record, TABUCS						
	Output Indicator 4.5		**Baseline (2016/17)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020-Dec 2020)	**Assumptions / Remarks***
	Number of SBA trained using revised SBA training manual on	**Planned**	Nutrition component of SBA training manual	na	400	400	400	*Nutrition component of SBA training manual*

nutrition		needs revision					*will be revised in year 1*
	Achieved		na				**1st-year update:** SBA training strategy in process of review after review it will come in revision. Then training manual on Nutrition will be revised.
	Source						
	Revised SBA training manual, training completion report, FHD and NHTC record						

	Output Indicator 4.6		**Baseline (2016/17)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020-Dec 2020)	**Assumptions / Remarks***
	Number of innovative interventions (including nutrition) evaluated and disseminated	**Planned**	na	na	na	1	2	*Two innovative interventions will be developed and implemented in year 1 and 2*
		Achieved		na				
		Source						
		Evaluation report						

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

PROJECT TITLE:	**NEPAL HEALTH SECTOR SUPPORT PROGRAMME**						
Output 5	**Output Indicator 5.1**		**Baseline (2016/17)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020-Dec 2020)	**Assumptions / Remarks***
Availability and use of evidence is improved at all levels	% of local governments using equity monitoring dashboards based on HMIS data	**Planned**	0	na	25	50	80	*The dashboard will be developed in year 1* **1st-year update:** *HMIS is estimating the target population for 753 local*
		Achieved		na				
		Source						

			Year 1	Year 2	Year 3	Year 4	
	HMIS						*governments. Equity dashboards will be generated based on the estimated target population by June 2018.*
Output Indicator 5.2		**Baseline (2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	*RDQA benchmark will be set in Year 1.* ***1st-year update:*** *MoHP has developed web-based RDQA and it will be rolled out at the local level by July 2018.*
% of government health facilities achieving benchmark on RDQA in LL sites	**Planned**	RDQA Benchmark not set	na	20	50	80	
	Achieved		na				
	Source						
	NHSSP periodic progress report, review report of LL sites						
Output Indicator 5.3		**Baseline (2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	*NHSSP conducts 11 assessments/studies on programme priority areas (Annex 11, Table 11.2). These three assessments are taken as tracer priority assessments.* ***1st-year update:*** *Assessment of inter-facility free referral support is planned for 2018.*
Number of assessments conducted on priority programme areas and results shared with stakeholders	**Planned**	Priorities areas set for year 1 & 3	1 (Free referral system in Ramechhap and Dolakha districts)		2 (OCMC and Social Audit)		
	Achieved		x				
	Source						
	Assessment reports						
Output Indicator 5.4		**Baseline (2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 2020- Dec 2020)	*Themes will be determined based on MoHP priorities* ***1st-year update:*** *Policy brief on equity in service utilization has been drafted and shared with*
Number of policy briefs produced based on MoH priorities and shared to inform policy	**Planned**	na	1	3	4	5	
	Achieved		1				

		Source						MoHP counterparts.
		Policy briefs produced annually						
INPUTS (£)	**DFID (£)**		**Govt (£)**	**Other (£)**		**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**							

OUTPUT 6	**Output Indicator 6.1**		**Baseline** **(2016)**	**Year 1** **(Mar 2017 - Feb 2018)**	**Year 2** **(Mar 2018 - Feb 2019)**	**Year 3** **(Mar 2019 - Feb 2020)**	**Year 4** **(Mar 2020- Dec 2020)**	**Assumptions /** **Remarks***
MoH has the capacity to ensure health infrastructure is resilient to environmental shocks	A number of health infrastructure related policies and standards endorsed by MoHP: 6.1a: Policies 6.1b: Standards	**Planned** 6.1a: Policies	Health infrastructure specific policy does not exist	na	1 (Facility prioritization and selection)	1 (Health sector infrastructure development, upgrade and maintenance)	na	MoHP priorities for retrofitting and rehabilitation continue and are not diverted by the move towards federalism
		6.1b: Standards		1 (Retrofitting and Rehabilitation)	na	na	na	**1st-year update:** New health facility construction and upgrading guideline, and land selection for health facility guideline developed.
		Achieved						
		6.1a: Policies		na				
		6.1b: Standards		1				Health facility categorization has developed.
		Source						Nepal Health infracture Development Standards 2017.
		Health infrastructure related policies and standards endorsed by MoH						
	Output Indicator 6.2		**Baseline**	**Year 1** **(Mar 2017 - Feb**	**Year 2** **(Mar 2018 - Feb**	**Year 3** **(Mar 2019 - Feb**	**Year 4** **(Mar 2020- Dec**	Move to Federalism does not result in

		(2016)	2018)	2019)	2020)	2020)	major staff redeployment
Number of people trained in policy development and technical skills: 6.2a: Government staff 6.2b: Construction sector staff	**Planned** 6.2a: GoN staff	No information system to track the trained HR	30	80	90	80	**1st-year update:** Total 29 construction sector staffs trained in policy development and technical skills.
	6.2b: Construction sector		na	50	100	100	
	Achieved						
	6.2a: GoN staff		272				
	6.2b: Construction sector		na				
	Source						
	Training completion reports; Annual Impact Evaluation Reports						

Output Indicator 6.3		**Baseline** **(2016)**	**Year 1** (Mar 2017 - Feb 2018)	**Year 2** (Mar 2018 - Feb 2019)	**Year 3** (Mar 2019 - Feb 2020)	**Year 4** (Mar 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) (disaggregated by Province and types of health facilities)	**Planned**	Hazard resilience criteria to be updated in line with the Integrated Infrastructure Development Plan 2017	100	100	100	100	**1st-year update:** Total 384 new government health facilities designed adhering to hazard resilience criteria.
	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 (2016)	Year 1 (Mar 2017 - Feb 2018)	Year 2 (Mar 2018 - Feb 2019)	Year 3 (Mar 2019 - Feb 2020)	Year 4 (Mar 2020- Dec 2020)	Timely agreement between MoH and DFID on hospitals to be retrofitted, timely release of fund and procurement of contractor.
	Number of priority hospitals retrofitted with support from DFID's Financial Aid	**Planned**	Retrofitting of two priority hospitals proposed using DFID FA	na	na	na	2	Design and preparation of tender documents will be completed in year 1, and contract awarded and mobilized in year 2.
		Achieved		na				**1st year update:** Design for retrofitting of two priority hospital and preparation of procurement document has been completed and submitted to DUDBC and DFID.
		Source						
		Standards and retrofitting completion certificate from MoH						
IMPACT WEIGHTING (%)							**RISK RATING**	
INPUTS (£)	DFID (£)		Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
INPUTS (HR)	DFID (FTEs)							

Note:

na = Not Applicable

tbc = To be confirmed

*Texts in *italics* are Remarks.

Appendix 2 Payment Deliverables

AREA	NO	DESCRIPTION OF MILESTONE	DFID SUBMISSION DUE DATE	ACTUAL SUBMISSION DATE	DFID APPROVAL DATE
MANAGEMENT	25	Quaterly reports 2 Oct – Dec	Jan-18	1-Feb-18	8-Feb-18
NHSSP	26	Pre and post JAR reports produced by PPICD	Feb-18	26-Feb-18	20-Mar-18
NHSSP	27	Financial Management Report produced annually by HRFMD using TABUCS	Feb-18	14-Feb-18	26-Mar-18
RHITA 2	28	Training Needs Analysis of Construction Industry Contractors and Professions	Feb-18	27-Feb-18	4-Mar-18
RHITA 3	29	Design phase for retrofitting two priority hospitals complete	Feb-18	27-Feb-18	4-Mar-18
RHITA 3	35	MOHP and DUDBC design and tender training complete	Apr-18	28-Feb-18	9-Apr-18

APPENDIX 3 RISK MATRIX ASSESSMENT

The overall risk factors remain at the same level as previous quarter. *Minor amendment on risk matrix has been done to clarify the roles and to reflect the current risks factor.*The risk level R14 within Retrofitting Health infrastructure TA programme "Potential disagreement between *MOH and DUDBC regarding Bhaktapur Hospital retrofitting plan might cause delay in retrofitting work"* has been added for likely hood of impact. *Forming of steering committee and facilitation by the TA would support to minise this risk.*

NHSSP Risk Matrix Assessment (Updated on 16 April 2018)

Risk No	Risk	Gross Risk		Risk Factor or RAG rated	Current controls	Net Risk		Risk Factor RAG rated	Net Risk Acceptable?		Additional controls / planned actions	Assigned manager / timescale	Actions
General Health TA matrix													
		Likeli-hood	Impact			Likeli-hood	Impact						
	Contextual												
R1	*Slow progress in other areas of GoN policy may affect achievement of NHSS targets*	High	High	🟥	*Close collaboration across ministries, and between EDPs; ensure activities are planned taking into account expected targets*	Low	Medium	🟨	Yes	Yes	*Regular monitoring and feedback / lessons learnt session*	*Strategic Advisor/Team Leader*	*Treat*
R2	*Weak planning and coordination between EDPs and government.*	Medium	Medium	🟨	*Team support MoH to work closely with other ministries; Team Leader supports DFID in coordination*	Low	Medium	🟩	Yes	Yes	*Continue to Facilitate MoH and EDPs joint preparation, implementation and monitoring of transition plan following the NAR and JAR action points*	*HPP Adviser*	*Treat*

	Political												
R3	Lack of political will to drive key reform processes for example procurement reform	Medium	High	🟥	Our advisors work closely with senior staff in MoH to advocate, build understanding and buy in to planned reform processes.	Medium	Medium	🟨	Yes	Yes	Pace of changes will be carefully planned. Regular meeting of CAPP monitoring committee.	Team Leader /PPFM lead Adviser/Strategic Advisor	Treat
R4	Transition planning is still in process, uncertainty over the sub national structure;	High	High	🟥	NHSSP Advisors are supporting the MoH to develop a health sector transition plan, informed by best available evidence. The Strategic Adviser is working closely with MOH and providing regular updates and advice to the NHSSP adviser for on-going work.	High	High	🟧	Yes	Yes	NHSSP team will work closely with MOH and take flexible and adaptive approaches	Strategic Adviser	Treat
R5	Decentralisation of health governance and service delivery will require intensive capacity enhancement at the local/municipal level as PHC may not be the priority of local level government. Threats to RMNCAH service delivery are already appearing both at hospital level and primary health care level.	High	High	🟥	Provision of flexible TA, flexible planning and willingness to change mode of TA support and focus Capacity building of local government including orientation on programme implementation guides and planning support in coordination with all supporting partners EDPs	High	High	🟥	Yes	Yes	Regular engagement with the MOH colleagues in planning processes to recognise if changes need to be made	Concerned Advisers	Treat

R6	Decentralizing authority at local level can lead to a loss of focus and expertise on specific health issues	High	High		NHSSP advisers will actively engage in the reform processes , discussing its potential impact on health services and ways to incorporate health priorities into evolving health care systems	High	High		yes	Yes	NHSSP will support MOHP in developing minimum service standard and engage in orientation processes.	Strategic Adviser & Service Delivery Adviser	Treat
	Programmatic												
R7	Government capacity to implement and the possibility that the TA will be used to substitute capacity gaps	High	Medium		Our TA is embedded in government offices, where appropriate, and is focusing on the development of systems and tools, with a flexible approach	Medium	Low		Yes	Yes	NHSSP team will be strategic as possible in the supporting functions, working to offer sustainable systems solution	Concerned Advisers	Treat
R8	MoH 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 responsive to make certain that adapting plans will have limited impact on overall quality of	Low	Low		Yes	Yes	NHSSP team will work closely with MOH colleagues and remain flexible and strategic	Concerned Advisers	Treat

				delivery of the TA.								
R9	*Competing national and local level priorities and high transfer of MoH staff means that inadequate resourcing is available for other NHSSP activities.*	*Medium*	*Medium*		*Close liaison with the MoH. Our finance team supports effective support to advisers, , tracks expenditure against agreed budgets, and flag any apparent shortfall in resourcing that is likely to affect achievement of the programme deliverables.*	*Low*	*Low*		*Yes*	*Yes*	*NHSSP team will work with other partners for resource leveraging*	*Concerned NHSSP Advisers*	*Treat*
R10	*High staff turnover in key government positions limits the effectiveness of capacity enhancement activities with MoH and DoHS.*	*Medium*	*Medium*		*By institutionalising approaches and systems NHSSP does not rely on individual capacity building to ensure sustainability.*	*Medium*	*Low*		*Yes*	*Yes*	*Engage with mid-level staff of MOH, programming will include orientation of newly transferred officials and staff for better understanding and ownership of TA support.*	*Concerned NHSSP Advisers*	*Tolerate*
R11	*Health workers are not able to complete training/engage in programme activities due to workload, and/or frequent staff turnover, limiting effectiveness of activities to improve QoC.*	*Low*	*Low*		*Capacity enhancement to improve quality of care will be planned with DHOs and facility managers; refresher trainings will be offered on a regular basis; focus is on building capacity*	*Low*	*Low*		*Yes*	*Yes*	*NHSSP will actively encourage on site coaching /training and support training needs identification*	*Concerned NHSSP Advisers*	*Tolerate*

					and the functionality of the facility, not just training.								
R12	***Challenge to retain skills health worker at the local level on the pace of change processes***	***High***	***High***		***NHSSP advisers will work closely with the MOHP and DOHS and encourage them to recruit and retain skills human resource at the local level.***	***High***	***High***		***Yes***	***Yes***	***NHSSP will work with EDPs to provide strategic support to MOHP.***	***Strategic Adviser + HR Adviser***	***Treat***
	Climate & environmental												
R13	*Further earthquakes, aftershocks, landslides or flooding reverse progress made in meeting needs of population through disrupting delivery of essential healthcare services*	*Medium*	*High*		*Continue to monitor situation reports/GoN data; ensure programme plans are flexible, and replan rapidly following any further events. Comprehensive security guidelines will be put in place for all staff.*	*Medium um*	*Medium*		*Yes*	*Yes*	*NHSSP will support MOH to update disaster preparedness plan*	*HPP Adviser*	*Tolera te*
	Financial												
R14	*The TA programme has limited funds to support the strengthening of major systems components such as HR systems.*	*Medium*	*Low*		*Support policy and planning in the MOH. Engage with other EDPs who are supporting related areas.*	*Low*	*Low*		*Yes*	*Yes*	*Continue to work with MOH and WHO and other partners who may have financial resources to support these*	*HRH Adviser*	*Treat*
R15	*Financial Aid is not released for expected purposes.*	*Medium*	*High*		*Planning and discussions with MoH and MoF. Health*	*Low*	*Medium*		*Yes*	*Yes*	*Continue with regular and quality monitoring of FMR and regular*	*Lead PPFM Adviser and PFM adviser*	*Treat*

				Financing TA will support the government in managing release of Financial Aid.						meeting of PFM committee		
R16	Financial management capacity of subcontracted local partners is low.	Low	Medium		Carry out a due diligence assessment of major partners at the beginning of the contract.	Low	Low		Yes	Yes	Carry out regular reviews of progress against agreed work plans and budgets.	Deputy Team Leader	Treat
R17	Weak PFM system leads to fiduciary risk	High	High		To work actively to support the MoH 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 improvement plan (PIP) and establishment of a CAPP monitoring committee	Medium	medium		Yes	Yes	Continue to monitor risks and mitigate through periodic update of FMIP, CAPP, and PIP, through the PFM and CAPP monitoring committee. Engaging MoH Secretary, FCGO and PPMO.	Lead PPFM Adviser and sr Procurement adviser	Treat
R18	Further devaluation of the £ reduces the value of FA and TA commitment.	Medium	Medium		Monitor exchange rates and planned spend against these	Medium	Low		Yes	Yes	Strengthen regular monitoring and verification of wokrplans against budgets	Team Leader/Deputy Team Leader	Tolerate

		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
Infrastructure risk matrix													
Risk No	**Risk**	Likelihood	Impact			Likelihood	Impact						
	Contextual												
R1	*Weak planning and coordination between EDPs and government.*	*Medium*	*Medium*		*Team will work closely with MOH to coordinate with other ministries/departments and EDPs;*	*Medium*	*Low*		*Yes*	*Yes*	*Team Leader, as in previous programmes, will attend EDPs coordination meeting*	*Team Leader*	*Treat*
	Political												
R2	*Lack of buy-in from senior government stakeholders on revising and adopting policies, codes and standards, and drive key reform processes for example procurement reform*	*Medium*	*Medium*		*Infrastructure Advisors work closely with senior staff in MoH, DUDBC and NRA to build ownership of proposed policies, codes and standards and buy in to planned reform processes. Pace of planned*	*Medium*	*Low*		*Yes*	*Yes*	*NHSSP will work closely with the Health Building Construction Central Coordination and Monitoring Committee.*	*Lead Infrastructure Advisor*	*Treat*

				🟨	changes will be carefully considered.			🟩					
R3	Progress towards federalism is slow, creating confusion over what the final sub national structure will look like, and limiting progress in achieving improvements in health infrastructure.	High	Medium	🟥	Team Leader 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	🟧	Yes	Yes	We will ensure close links between RHITA and GHTA, so RHITA is able to draw on support from GHTA engagement in the preparation for federalism	Team Leader	Tolerate
R4	Lack of clarity over roles and responsibilities of MoH, DUDBC and other related departments in health infrastructure. Lack of clarity in set up, roles and responsibilities of PCO and PIUs.	Medium	Medium	🟧	Team will support finalisation of the roles and responsibilities of PCU and PIUs, and develop effective working relationship with the PCU.	Medium	Medium	🟨	Yes	Yes	NHSSP will build links and regular communication between MOH and DUDBC, and take forward recommendations of institutional review	Lead Infrastructure Advisor	Transfer
	Programmatic												
R5	MoH and DUDBC priorities and requests for non-planned TA draw advisors away from agreed work plan and exhaust available resources.	High	low	🟨	Close collaboration with key counterparts in the mobilisation phase of the TA resulting in shared	Medium	Low	🟩	Yes	Yes	We will regularly review workplans with counterparts and adapt flexible approach.	Lead Infrastructure Advisor	Treat

					understanding of work plans.								
R6	High staff turnover in key government positions limits effectiveness of capacity enhancement activities with MoH and DUDBC.	Medium	Medium		The NHSSP capacity enhancement approach will focus on institutionalising approaches and systems, not rely on individual capacity building to ensure sustainability.				Yes	Yes	NHSSP will engage with different level staff to strengthen the institutionalisation processes.	Lead Infrastructure Advisor	Tolerate
R7	Local construction companies not responsive/engaged in capacity building activities.	Low	Medium		Our team has established working relationships with local companies, design of capacity building will respond to identified needs.	Low	Low		Yes	Yes	Capacity building will be part of the contractual arrangement.	Seismic Resilience Advisor	Treat
	Climatic and environmental												
R8	Further earthquakes, aftershocks, landslides or flooding reverse progress made in rehabilitation of existing health infrastructure.	Medium	High		Continue to monitor situation reports/GoN data; ensure programme plans are flexible, and re-plan rapidly following any further events.	Medium	Medium		Yes	Yes	Health and Safety guidelines to be developed and share with staff and to ensure all consortium staff are covered by the relevant insurance scheme.	Seismic Resilience Advisor	Tolerate

R9	Retrofitting not completed in advance of next major seismic event; retrofitting does not prevent significant damage if there is another earthquake.	Medium	High		Insurance will be in place for construction and retrofitting work to cover damage during such events. There will be 1 year defect liability period for the contractor for any defects against the specification to make it correct.	Medium	Medium		Yes	Yes	NHSSP will ensure that retrofitting work will comply with building codes and work is completed as early possible.	Lead Infrastructure Adviser d	Tolera te
	Financial											
R1 0	Financial Aid is not released for expected purposes.	Medium	high		Joint planning and early discussions with MOH and MOF.	Low	Medium		Yes	Yes	PPFM and Health Infrastructure teams will continue to support the government in managing release of Financial Aid.	PPFM Adviser	Treat
R1 1	Financial management capacity of subcontracted local partners is low.	Medium	Low		We will carry out a due diligence assessment of major partners at the beginning of the contract.	Low	Low		Yes	Yes	We will carry out regular reviews of progress against agreed work plans and budgets.	Deputy Team Leader	Treat

ID	Risk	Likelihood	Impact		Mitigation	Likelihood	Impact		Owner?	Action?	Action	Owner	Response
R12	Risk of fraud with locally contracted construction companies.	Medium	Medium		Due diligence processes, quality control and regular monitoring of local subcontracts (including results-based sign-off and payments)	Low	Low		Yes	Yes	We will develop a plan for regular monitoring	Lead Infrastructure Advier	Treat
R13	Further devaluation of the £ reduces the value of FA and TA commitment.	Medium	low		Monitor exchange rates and planned spend against these	Low	Low		Yes	Yes	Strengthen regular monitoring and verification of wokrplans against budgets	Team Leader/Deputy Team Leader	Tolerate
R14	Potential disagreement between *MOH and DUDBC* regarding Bhaktapur Hospital retrofitting plan might cause delay in retrofitting work.	Medium	High		NHSSP will facilitate the formation of steering committee representing both MOH and DUDBC	Medium	Medium		yes	yes	Develop MOU with clear roles & responsibilities between DUDBC & MOH	Lead Adviser RHITA	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 current 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 / all of the work impossible

APPENDIX 4: VALUE FOR MONEY (QUARTER 3)

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

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

The NHSSP VfM Framework has been updated to reflect the inputs of each of the work streams. Detailed below are the indicators that NHSSP has committed to reporting on a quarterly basis. An additional indicator (I5) has been added in this Quarter 3 report.

Quarter 3 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 £576 for internationals and £109 for nationals. The average unit cost of both international and national STTA is below the benchmark of £611 and £224 respectively. In line with the third quarter, the YTD average unit costs of both the STTAs compares well to the benchmark which was calculated based on Options' programmes globally and agreed by DFID under NHSSP2.

International STTA	Total (March 2017- March 2018)	Average Unit Cost (March 2017 – March 2018)	Total Q3	Average Unit Cost Q3
Days	233	548	69	576
Income	127, 631		39,727	
National STTA	Total (March 2017 – March 2018)	Average Unit Cost (March 2017– March 2018)	Total Q3	Average Unit Cost Q3
Days	315	166	195	109
Income	52,195		21,348	

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

Nearly three quarters (74%) of the STTA used in the third quarter are nationals which compares well to the benchmark. The third quarter witnessed substantial inputs from the national STTAs especially to the NHSSP Health Infrastructure team. National STTAs were used for preparing designs, drawings and estimates for retrofitting works of Pokhara and Bhaktapur hospitals. Similarly, national experts were used to review and feedback on structural drawings, and structural analysis of the buildings. As well, the international STTA days were used to provide strategic support to the programme and quality assurance of deliverables. The third quarters' trend is likely to follow in the second year as the programme is in full implementation, and much of the national STTA days are linked to the implementation of programme activities.

Short Term Technical Assistance Type	In client contract budget*		Actuals to date (March 2017 − March 2018)		Actuals Q3 (Jan − March 2018)	
	Days	%	Days	%	Days	%
International TA	2291	44%	233	43%	69	26%
National TA	2942	56%	315	57%	195	74 %
TOTAL	5233	100%	548	100%	264	100%

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

A total of 18% of the budget was spent on administration and management in the third quarter. The percentage spent in the third quarter decreased significantly when compared with the second quarter (41%). The programmatic expenditure was limited to essential activities in the first quarter followed by contracting suppliers and consultants in the second quarter for full phase implementation, which significantly constrained overall expenditure. In this quarter, however, program activities are in full swing and the proportion of program expense is 82% for this quarter. An important point to note is that the proportion of the overall costs taken up by office running cost decreased significantly in the second quarter to 6% from 32 % of the first quarter and to 3% in this quarter.

Category of admin / mgmt. expense:	Client budget		Actuals to date (March 2017 – March 2018)		Actuals Q3 Jan - March 2018	
		%		%	GBP	%
Office running costs (rent, suppliers, media, etc)	88,550	2%	34,535	5%	5,833	3%
Equipment	26,063	1%	25,873	4%	38	0%
Vehicle purchase	120,000	3%	52,875	8%	5,499	3%
Bank and legal charges	13,110	0%	1,789	0%	270	0%

Office Set up and maintenance	29,090	1%	24,162	3%	3,043	1%
Office Support Staff	383,318	9%	75,772	11%	15,671	8%
Vehicle Running cost and Insurance	73,998	2%	10,936	2%	2,181	1%
Audit and other Professional Charges	16,000	0%	11,986	2%	3,986	2%
Sub-total admin / management	750,129	18%	237,928	34%	36,522	18%
Sub-total programme expenses (see below)	3,385,899	82%	455,888	66%	171,997	82%
Total	**4,136,028**	**100%**	**693,816**	**100%**	**208,519**	**100%**

Quarter 3 VfM results: Efficiency

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

During this quarter nine sessions of capacity enhancement training were conducted. At the national level 99 participants took part in the training, the average unit cost of the training was £ 28 which is half of the benchmark cost (£ 62). Similarly, at the local level 153 participants took part in the capacity enhancement training, the cost per unit incurred for the training was £ 24 which compares well with the benchmark (£39).

No	Month held	Worsktream	Training theme	Level	Cost per participant/day Benchmark*	Training Total Cost	No of participants	No of days	Cost per participant /day
				**National/ Local	**GBP**	**GBP**			**GBP**
1	January	PPFM	TABUCS User Training	National	62	2,332	27	4	22
2	February	HI	Retrofitting and Tender process	National	62	3,142	50	2	31
3	March	PPFM	TABUCS implementing in all spending units of MOH including DUDBC Workshop	National	62	1,328	11	3	40
4	March	PPFM	Workshop on TABUCS	National	62	879	11	4	20
				Average	**62**				**28**

1	February	PPFM	TABUCS User Training	Local	39	2,098	27	4	19
2	February	SD	PNC Microplanning	Local	39	1,613	30	2	27
3	February	PPFM	TABUCS User Training	Local	39	2,407	17	4	35
4	February	SD	FHD Program Orientation and Free referral advocacy meeting	Local	39	3,132	73	2	21
5	March	SD	Implant Training	Local	39	1,002	6	9	19
				Average	**39**				**24**

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

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

Quarter 3 VfM results: Effectiveness

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

So far, all payment deliverables have been approved by the Government of Nepal and signed off by DFID.

	Payment Deliverables **(March 2017 – March 2018)**
Total technical deliverables throughout NHSSP3	105
PDs submitted to date	29
PDs approved to date	29
Ratio %	**100%**

5 NEXT QUARTER WORKPLANS

Health policy and planning

WBS	Activity	Responsible person (lead responsibility)	Start date	End date	Planned technical outputs or PDs
	Continue to support the MOHP towards the finalization of remaining structures of the health sector at Federal, provincial and local level	Kabiraj	Apr		
	Support the MOHP to prepare detailed roles and responsibilities of approved structures.	Ghanshyam	Apr	May	
	Support the PPICD to implement the activities mentioned in the transition plan, once it is approved.	NHSSP	Apr	Dec	
	Support to Federalism Implementation Unit to finalise the guideline for pharmacy registration at local level by May 2018	Kabiraj	Apr	May	
	Support the MOHP in finalizing the AWPB guideline based on the framework provided by National Planning Commission, MoF and National Natural Resource and Fiscal commission (NNRFC)	Ghanshyam	Apr	May	
	Support the MOHP for the development of annual work plan and budget for FY 2018/19 as per the new framework for the planning	Ghanshyam	Apr	Jun	
	Support local level for the development of local health profile and rolling out of the planning and budgeting guideline	Ghanshyam	Apr	Jul	
	Continue advocacy and high level policy dialogue with Provincial Ministries on health planning and budgeting.	Kabiraj	Apr	Dec	
	Develop framework for budget marker on LNOB	Sitaram	Apr	Jul	

	Support to the MOHP/PHAMED in updating the information of private health facilities	NHSSP	Apr	Jul	
	Support the MOHP to document the existing health partnership arrangements in Learning Labsites in order to strengthen this in the changed constitutional context	NHSSP	Apr	Jul	
	Continue support to TWG in developing minimum standards for hospitals	Kishori	Apr	Aug	
	Continue support to the FHD in finalising the Safe Motherhood roadmap	Kishori	Apr	Jul	
	Share final policy stock take report with PPICD/MOHP and submit to DFID	NHSSP	Apr		
	Continue support in finalising the BHS package	Kishori	Apr	Jun	
	Support MOHP to develop "guideline for effective private sector engagement in health"	NHSSP	Apr	Sep	PD
	Finalise the Gender Equity and Social Inclusion strategy revision including translation into English	Sitaram Prasai	Mar	Jun	
	Revise One-stop Crisis Management Center (OCMC) Operational Guideline in the changed context	Sitaram Prasai	May	Jun	
	Revise Social Service Unit (SSU) Operational Guideline in the changed context	Sitaram Prasai	Jun	Jul	
	Technical assistance to finalise the National Policy and Action Plan on Disability led by Ministry of Women, Children and Senior Citizen	Sitaram Prasai	May	Jun	
	Support PPICD to organize health sector development partners forum	NHSSP	May	Jun	
	Support to organize Mid-term review/Joint Consultantive Meeting as agreed between MOHP and External Development Partners	NHSSP	May	Jun	

Procurement and Public Financial Management

WBS	Activity	Responsible person	Start date	End date	Planned technical outputs or PDs
	Support to MoHP to finalization of AWPB for Federal structure/local level will be developed, in the devolved context, in next quarter.	Shiva	April	June	
	Support to MoHP to TABUCS training for MoHP, continuously, will be conduct in next quarter.	Shiva	April	June	
	Support to MoHP to TABUCS training for DUDBC will be conduct in next quarter.	Rajan	April	June	
	Support to finalized the MoHP and DFID to revise the existing FMR format in next quarter.	Shiva	April	May	
	Support to MoHP to prepare FMR-2 of FY 2017/18 for DFID in next quarter.	Shiva	April	May	
	NHSSP will discuss with DFID to Share TABUCS with other countries and make the decision in next quarter.	Suresh	April	June	
	Support MoH to update the status of audit queries in TABUCS.	Bhanu	April	July	
	Support to MoHP to conduct workshop on update the internal control guideline & endorse, printing and publish distribute in next quarter.	Bhanu	April	June	
	Support to MoHP for the Audit Committee and Public Financial Management (PFM) Committee meeting in next quarter.	Bhanu	April	June	
	Support to MoHP for workshop on the framework of Performance Based Grant Agreement (PBGA) in selected 7 Hospitals	Hema	April	May	
	Implementation of SOP for procurement of Drugs	Ram Kaji	May	On going	
	Continuous advisory support in procurement process through Procurement Clinic	Ramesh/Ram Kaji	April	ongoing	
	Support LMD to implement and monitor the PIP through the designated section	Ramesh/Ram Kaji	May	ongoing	

WBS	Activity					
	Meeting of CAPP Monitoring Committee organised for monitoring progress on CAPP	Ramesh/Ram Kaji	May	May		
	e-CAPP system will be designed and consultant will be hired	Ramesh	May	June		
	CAPP of 2018 – 19 developed	Ramesh/Ram Kaji	April	May	PD 37	
	Approval of SBD for Health Sector Goods from PPMO	Ramesh/Ram Kaji	April	June		
	Procurement Management and e-GP Training conducted gradually in all the provinces	Ramesh/Ram Kaji	May	Ongoing		
	Continuous monitoring of the use of TSB and Review of old technical specifications and upload in the TSB	Ramesh/Ram Kaji	May	June		
	Continue support to LMD in using e-GP II across all ICBs, NCBs and SQs	Ramesh/Ram Kaji	April	June		
	Develop guidelines to support use of e-procurement at local levels	Ramesh	April	June		
	Grievance handling mechanism will be adapted in LMD for health sector	Ram Kaji	April	June		

Service delivery

WBS	Activity	Responsible person	Start date	End date	Planned technical outputs or PDs
	CEONC establishment planning workshop at Gukoleswor hospitals	Dr Prajapati	May	May	CEONC services made available by the FHD/DHOs in at least four additional locations in remote sites/areas (August 2020)
	On-site visit and technical capacity building of service providers and troubleshooting at new and poorly functioning CEONC sites	Dr Prajapati	April	June	ditto
	Facilitation to local government for Visting Provider/RANM recruitment Technical skill enhancement of Visting Provider and local councils including orientation, implementation, monitoring and capacity enhancement from selected rural and urban municipalities and also provide TA/field visits	Dr Rajendra	April	June	Provision of Long Acting Reversible Contraceptive-services through Visting Providers scaled-up by DHOs in eight additional remote/hilly districts (November 2018)

	Assist PHCRD in developing Criteria to select organisation to conduct Community Health Unit assessment; selection of the organisation; detailed methodology development	Maureen	May	June	
	Preparation and facilitation of local government of 10 remote municipalities to identify health priority	Kamala	May	June	
	Prepare for contracting out mHealth for Female Community Health Volunteers innovation implementation to BBC Media Action Presentation to FHD new director, NHEICC, Smart Health Section of MOHP on the approach and planned activities; form advisory group (TBC).	Maureen	April	June	An innovation for RMNCAH and nutrition implemented, evaluated, and evidence presented by the MOHP at the JAR (November 2019)
	Monitoring of free referral implementation in Ramechhap and Dolakha districts (3 CEONC sites)	Kamala	April	June	
	Assessment of free referral – - develop ToR, developed detailed methodology, recruit consultants, - sought NHRC approval - start data collection	Maureen	April May June	May May July	Evaluation report on free referral in earthquake affected districts, with lessons learned and recommendations developed (?Sept 2018)
	Identification of physiotherapy skills; contracting of an organisation for implementing physio skill transfer; detailed work plan development	Indira	May	June	Report on innovative approaches to sustaining physical rehabilitation and mental health services in earthquake affected districts and lessons for scale-up (??February 2019)
	Training facilitation to prescribers on the mental health STP based manual.	Rekha	May	June	
	Orientation on Gender Equity and Social Inclusion-LNOB framework and targeted interventions to hospital staff, management committee and local government representative at 5 hospitals. Prepare framework of induction package on Gender Equity and Social Inclusion-LNOB in consultations with NHTC	Rekha	May	June	
	Strengthen capacity of 4 hospitals to establish SSUs including in 2 private hospitals. Site visit to review progress and provide coaching/mentoring at 5 SSUs and distance follow up with remainder.	Rekha	May	June	
	Conduction of OJT on gender-based violence clinical protocol; Orientation on gender-based violence clinical protocol at 5 hospitals. Develop monitoring and reporting framework to assess the OJT and roll out process.	Rekha	May	June	Support to the roll-out the gender-based violence clinical protocol in three OCMC based hospitals that are developed as training sites (August 2018)
	Strengthen capacity of 4 hospitals to establish 5 OCMCs.	Rekha	May	June	the Department of Health Services report on scaling-up of OCMCs that

Visit 7 existing OCMCs to review progress, provide onsite coaching/mentoring and follow up remaining OCMCs from distance. OCMC related coordination meetings with multi-sectoral partners and participation in gender-based violence related meetings held at Office of Prime Minister and Council of Ministers .				provide a comprehensive range of services (February 2020)
Support FHD in selecting third party, provide input in methodology and tools, support training, field implementation and monitoring for Aama rapid assessment round XI.	Hema	May	May	
Finalise the prototype Aama guideline for Palika. Conduct a meeting with stakeholders to share the prototype guideline and changes. Final approval from the Department of Health Services/MOHP, print and disseminate	Hema	April	June	Aama programme implementation status report in public facilities providing evidence for refining Aama (May 2019)
Facilitate HQIP in two new hospitals. Follow up and monitoring of HQIP in 36 hospitals: 9 hospitals due to do self-assessment in next quarter.	Kamala	April	June	Report on the functionality and sustainability of the QI and monitoring system from central to decentralised levels (November 2020)
Minimum Service Standards tool development; testing in one hospital	Indira	Apr	June	
Capacity building of district clinical mentors in four new districts; Follow up of clinical mentoring in 26 districts	Kamala	April	June	
Quality assure SBA clinical mentors training – two batches	Kamala	May	May	
Discussion with FHD (and PHAMED) on Quality dash-board at FHD and establish quality monitoring dash-board as agreed with FHD (and PHAMED)	Maureen (BIshnu)	May	May	
Rapid assessment of service quality at three training sites	Rajendra/ Indira	June	June	Report on progress made upgrading maternity wards/creating maternity units at referral hospitals including opportunities, constraints, and utilisation of services (May 2020) (link activity)
Complete the following documents 1) review/update 2072 MD/MS scholarship guidelines 2) Deployment guidelines for MD/MS graduates with scholarships and 3) local recruitment guidelines	Indira	April	June	
Follow up to develop PCL curriculum for midwifery by MoH/Nursing administration unit Follow up Nurse admin/MOHP to ensure that the draft national policy and nurses &midwives (2074) approved by the government of Nepal	Indira	May	June	

	FHD – AWPB preparation	All	April	May	
	SMNH review and roadmap planning	Maureen	April	June	

Evidence and accountability

WBS	Activity	Responsible person	Start date	End date	Planned technical outputs or PDs
I5.1	Support to develop and implement RDQA system in collaboration with GIZ. Field test and finalize the tool, implementation guidelines, user manual and standard training/learning package and roll out	Mirak	Jan	Jun	PD 20- RQDA tools for different levels developed and rolled out by MoH, April, 2018
I5.4	Support the Development of the QIMIS. Conceptualize and integrate the QIMIS component into the DHIS2 platform of HMIS	Bishnu	Apr	Aug	
I5.2	**Support the effective operationalization of e-health initiatives**				
	Unique facility code application	Pradeep	Jan	Jul	
	Health facility registry	Pradeep	Jan	Jul	
	Document tracking system	Pradeep	Jan	Jul	
	Digital library (Knowledge management portal)	Mirak	Jan	Jul	
	Grievance management system	Pradeep	Jan	Jul	
I5.3	Develop mobile phone application for FCHVs to strengthen Maternal and Perinatal Death Surveillance and Response system	Mirak	May	Sep	
I5.4	Finalize the health sector M&E plan in collaboration with MEOR	Pradeep	Jan	Jul	
I5.3	Analyze MPDSR data and support in translating the evidence	Bishnu	May	Oct	
I5.4	Carry out further analysis of NDHS data (Postnatal care service) in collaboration with MEOR	Bishnu	Mar	Jun	