

Nepal Health Sector Support Programme

Phase 1: Final Report



December 2013

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Acronyms and Abbreviations

4ANC	4 Antenatal Care Visits
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ANM	auxiliary nurse midwife
AWPB	annual work plan and budget
BCC	behaviour change communication
BEONC	basic essential obstetric and neonatal care
BIA	benefit incidence analysis
BMI	body mass index
BTS	blood transfusion services
CAC	comprehensive abortion care
CAPP	consolidated annual procurement plan
CB-IMCI	community-based integrated management of childhood illness
CEONC	comprehensive essential obstetric and neonatal care
CHD	Child Health Division
CMYP	comprehensive multi-year plan
COPP	Certificate of Pharmaceutical Production
CTT	core technical team
DHO/DPHO	district health office/district public health office
DFID	UK Department for International Development
DG	director-general
DoHS	Department of Health Services
DSF	demand-side financing
DUDBC	Department of Urban Development and Building Construction
EPI	expanded programme of immunisation
EAP	Equity and Access Programme
EDP	external development partner
EHCS	essential health care services
EOC	emergency obstetric care
FCHV	female community health volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FY	fiscal year
GAAP	Governance and Accountability Action Plan
GBV	Gender-based Violence
GESI	gender equality and social inclusion
GHWA	Global Health Workforce Alliance
GIS	geographic information system
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GMP	good manufacturing practice
GoN	Government of Nepal
HF	health financing

HFOMC	health facility operation and management committee
HHS	household survey
HIIS	Health Infrastructure Information System
HIV	human immunodeficiency virus
HKI	Helen Keller International
HMIS	Health Management Information System
HPP/HSG	health policy and planning/health systems governance
HR	human resources
HRH	human resources for health
HSIS	Health Sector Information System
HURIS	Human Resource Information System
ICB	international competitive bidding
IEC	information, education, and communication
IMCI	integrated management of childhood illness
IPAS	International Pregnancy Advisory Services
IUCD	intra-uterine contraceptive device
JAR	Joint Annual Review
KIG	key informant group
LATH	Liverpool Associates in Tropical Health
LHGSP	Local Health Governance Strengthening Programme
LMD	Logistics Management Division
M&E	monitoring and evaluation
MBBS	Bachelor of Medicine, Bachelor of Surgery
MD	Management Division
MDG	millennium development goal
MDGP	medical doctor/general practitioner
MIS	management information system
MNCH	maternal, neonatal, and child health
MNH	maternal and newborn health
MoGA	Ministry of General Administration
MoHP	Ministry of Health and Population
MPDR	maternal and perinatal death review
NAGA	nutritional assessment and gap analysis
NCP	Newborn Care Programme
NDHS	National Demographic Health Survey
NHIP	National Health Insurance Programme
NGO	non-governmental organisation
NHEICC	National Health Education, Information, and Communication Centre
NHRC	Nepal Health Research Council
NHSP-2	Second Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NOL	no objection letter
NPHL	National Public Health Laboratory
NRCS	Nepal Red Cross Society
NUTEC	Nutrition Technical Advisory Committee
OCCMC	one-stop crisis management centre
OPM	Oxford Policy Management

OT	operating theatre
PEER	Peer Ethnographic Evaluation and Research
PFM	public financial management
PHAMED	Public Health Administration and Monitoring and Evaluation Division
PHN	public health nurse
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
PMIS	Population Management Information System
PNC	postnatal care
PP	procurement plan
PPICD	Policy, Planning, and International Cooperation Division
PPMO	Public Procurement Management Office
QI	quality improvement
RA	rapid assessment
RHCT	regional health coordination team
RHD	regional health directorate
SBA	skilled birth attendant
SC	steering committee
SHP	sub health post
SNP	state non-state partnership
SOLID	Society for Local Integrated Development
SPA	senior procurement advisor
SSU	social service unit
STS	service tracking survey
SWAp	sector-wide approach
TA	technical assistance
TABUCS	Transaction Accounting and Budget Control System
TAG	technical advisory group
TB	tuberculosis
TC	technical committee
ToR	terms of reference
TWG	technical working group
UNICEF	United Nations Children’s Fund
VCAT	value clarification and transformation workshop
VDC	village development committee
VfM	value for money
WB	World Bank
WDO	women’s development office
WFP	World Food Programme
WHO	World Health Organisation
WRHD	Western Regional Health Directorate

1. Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit this final report for phase 1 of the programme which ended on 23rd August 2013. The report comprises a summative report against the outcome and output indicators of the programme log frame plus brief activity updates for the period 1st July – 23rd August. The achievements of all consortium partners are captured within the main body report while appendices 3 and 4 comprise supplementary reports from Helen Keller International (HKI) on nutrition and IPAS on abortion related services. Appendix 2 contains a series of learning notes prepared by TA assigned to Nepal's five regional health directorates – work that will be discontinued under phase 2.

NHSSP is a programme of Technical Assistance (TA) to the Ministry of Health and Population/Department of Health Services (MoHP/DoHS), managed by the UK Department for International Development (DFID) on behalf of the pool partners in the Second Nepal Health Sector Programme (NHSP-2). Options leads a consortium of its partners: Crown Agents, Liverpool Associates in Tropical Health (LATH), Oxford Policy Management (OPM), Helen Keller International (HKI), and International Pregnancy Advisory Services (IPAS). The inception period for NHSSP was between September and December 2010. During that time, the consortium carried out a series of capacity assessments covering each output of NHSSP described from Section 3 onwards. The capacity assessment reports, which included proposals for the focus of TA, were approved by government in December 2010.

The purpose of this report is to provide an update on the activities and results delivered by NHSSP between 1st July and 23rd August 2013, the closing date of NHSSP phase 1, and to describe overall progress made against outcome and output indicators of NHSSP's log frame. The intention here is to set the stage for the phase 2 inception period which will set new directions for each thematic area.

The work of NHSSP advisors is based on: the requirements of NHSP-2; the on-going activities and plans of the various divisions, departments and centres; the capacity assessment reports prepared by NHSSP in December 2010 outlining their strengths and needs, and the work plans of the advisors. All work plans have been agreed with each advisor's counterpart who is commonly the head or director of a division or centres, such as the Family Health Division (FHD), Policy, Planning, and International Cooperation Division (PPICD), Logistics Management Division (LMD) and so on. All NHSSP activities are designed to enhance the capacity of MoHP/DoHS to deliver NHSP-2. Enhancing capacity, for NHSSP purposes, is defined as: *the changes in organisational behaviour, skills and relationships that lead to the improved abilities of organisations and groups to carry out functions and achieve desired outcomes.*

2. Summary of Progress

Overall Context:

The principal focus for MoHP's divisions, departments and centres in the reporting period 1st July to 23rd August was the finalisation of budgets for 2013/14. MoHP's budget increased from NPR 20.24 billion in 2012/13 to NPR 30.43 billion in 2013/14, a rise of 50.3% but with the bulk of this increase being earmarked for salary and pension increases for MoHP's 31,000 staff. NPR 500 million was allocated for community health insurance and modest increases were seen in programme budgets for FHD and Child Health Division (CHD).

NHSSP's advisors made the completion of phase 1 work plans their main priority, although these efforts were occasionally hampered by the time needed to brief the recently appointed heads of PPICD, Public Health Administration and Monitoring and Evaluation Division (PHAMED), Curative Services and DoHS on sector priorities and adviser work streams.

Brief Narrative Updates on Key Activities in July-Aug 2013:

Significant progress was made in the following areas:

In **Essential Health Care Services (EHCS)**, Phase 1 of an analysis of barriers to maternal, neonatal and child health (MNCH) services in remote areas was completed. TA carried out an assessment of the mainstreaming of gender equality and social inclusion (GESI) in FHD's and CHD's annual work plans and budgets (AWPBs) over the last two years. This report highlighted the good progress made in improving levels of GESI awareness and in GESI sensitive programming and budgeting.

The FHD-led evaluation of the integration of family planning (FP) services in expanded programme of immunisation (EPI) clinics in Kalikot district was completed. This showed an increased uptake of FP services among vulnerable groups, including Dalit women. Importantly, the evaluation also found that EPI performance did not suffer as a result of the integrated FP/EPI service, which had been a major concern for the government. A value for money study on the use of FP was also completed.

Operational research on strengthened postnatal care (PNC) was also carried out. This showed that integrating FP and EPI services is likely to be highly cost effective in terms of disability adjusted life years (DALY's) averted. The government has subsequently committed to rolling out service integration nationally based on evaluation findings. A summary of lessons learned and recommendations to be taken forward to increase access to safe abortion services in two remote districts was also prepared (see Annex 4.)

In **Gender Equality and Social Inclusion**, a review of GESI mainstreaming in the health sector was completed together with assessments of a) the performance of social service units (SSUs) in two hospitals; b) one stop crisis management centres (OCMCs), and c) the implementation of MoHP's comprehensive social audit guidelines. The latter suggested that improvements in service quality, availability, attitudes of health workers and the responsiveness of Health Facility Operation and Management Committees (HFOMCs) and health staff to feedback had resulted, even if concerns over

levels of ownership, implementation of agreed action plans and contracts for local NGO facilitators remained.

In **Health Policy and Planning/Health Systems Governance (HPP/HSG)**, a financial regulation framework for GoN hospitals was prepared and a process report and templates for performance based contracting of seven private hospitals were completed. The English translation of MoHP's District Health Planning Guidelines was also finalised.

In **Human Resources for Health (HRH)**, workforce planning and staffing projection scenarios based on the World Health Organisation's (WHO's) HRH planning and projection tool were completed, as was a mapping of HRH functions in MoHP, structural arrangements and responsibilities for identifying gaps and bottlenecks in the human resources (HR) system. Preliminary findings of the HRH profile study were produced together with phase two of a capacity assessment of the National Health Training Centre (NHTC). The latter provides guidance on NHTC's proposed transition from a training to a training management body.

Phase 1 of a functional assessment and organisational review of MoHP, including data collection and analysis was completed. It is envisaged that a design stage and the action planning stage will follow under phase 2 of the programme.

In **Health Financing/Public Financial Management (HF/PFM)**, TA facilitated the preparation of MoHP's Business Plan for 2013/14, including supporting individual divisions, departments and centres with work planning and budgeting. Piloting of the Transaction Accounting and Budget Control System (TABUCS) continued in 11 cost centres across the country and, importantly, the tool was linked into MoHP's e-AWPB. Draft operation and training manuals for TABUCS were also prepared.

Round 7 of the Rapid Assessment (RA) of the Aama and 4 Antenatal Care Visits (4ANC) demand side incentive programme was finalised.

In **Procurement**, details of bid results continued to be published on line on dgMarket and United Nations Development Business (UNDB) Online. This is seen as an development in terms of transparency and public disclosure related to procurement practices. The LMD's Operations Manual (Procurement) was updated and a further bidders' workshop held.

In **Infrastructure**, a study on infrastructure planning, procurement, monitoring and maintenance which was recommended during the joint annual review (JAR) of 2013 began with the approval of the health secretary. The original terms of reference (TOR) were revised to include a closer focus on the role played by the Department of Urban Development and Building Construction (DUDBC). Management Division's (MD's) Health Infrastructure Information System (HIIS), which now includes a google earth geographic information system (GIS) interface, went live on MoHP's website.

In **Monitoring and Evaluation (M&E)**, the draft Service Tracking Survey (STS) and Household Survey (HHS) for 2012 were submitted for government review. Plans were also made for the training and scale up across the country of the upgraded HMIS including indicators, recording and reporting tools.

Twenty-two publications, including four Pulse reports were produced in this quarter with all non-sensitive documents uploaded to the NHSSP website (see Annex 1). Traffic to NHSSP's website reached 9800 hits (since Jan 2012) and the programme recorded 50 followers on Twitter.

3. Progress against Logframe

Outcome Indicator	Progress to date
<p>Indicator 1: % of districts with at least one health facility providing all CEONC signal functions 24/7 (100% of districts = 75)</p> <p>2013 Milestone: 68%</p>	<p>Progress: Fully met</p> <p>By July 2013, 54 out of a total of 75 districts (72%) had a functioning comprehensive essential obstetric and neonatal care (CEONC) service at the hospital (source: DoHS Annual Report)</p> <p>Comment: NHSSP has supported improvements in the availability of CEONC services by working closely with the FHD to increase CEONC fund allocations in the AWPBs; by supporting the FHD to develop plans to expand caesarean section training sites; and advocating for an increase in the number of sanctioned posts in hospitals where there is limited availability of CEONC posts. NHSSP has also funded a CEONC mentor to work directly with CEONC providers to overcome barriers to service provision. In some cases this has involved providing mentoring and training to clinicians, in other cases, it has involved working to overcome management and staffing challenges. However, challenges still remain</p> <ul style="list-style-type: none"> • The absence of multi-year contracting profoundly affects the functionality and continuity of CEONC services; • The availability of trained CEONC providers, including doctors and anaesthesia assistants, is still an obstacle for relatively remote districts; • The training of MBBS doctors in advanced skilled birth attendant (SBA) skills and CEONC mentoring interventions greatly enhanced the availability of CEONC services.
<p>Indicator 2: % of health facilities that have undertaken a social audit as per MoHP guidelines in the last FY</p> <p>2013 Milestone: 15%</p>	<p>Progress: Not met</p> <p>Harmonised Social Audit Guidelines, developed with support from NHSSP, were approved in June 2013 by the Minister. Social Audits were conducted in 236 health facilities (out of 4010 - excluding hospitals) of 22 selected districts in 2012/2013 (2069/2070). This represents 6% of Nepal's total public health facilities (source: PHCRD monitoring data).</p> <p>Comment:</p> <ul style="list-style-type: none"> • The practice of social auditing is now accepted and recognised by districts, communities and health service providers. • The social audit pilots in Palpa and Rupandehi have been evaluated with support from NHSSP. The evaluation showed that implementation of the social audit action plans was mixed but that in facilities where plans had been implemented, improvements in service quality and availability were evident. • MoHP plans to conduct Social Audits in 552 (14%) health facilities in 40 selected districts during 2013/2014 (2070/2071). MoHP is also planning to organise coordination meetings with external development partners (EDPs) to harness their support in conducting audits in more health facilities.

<p>Indicator 3: Absorption rate of committed funds for the health sector</p> <p>2013 Milestone: 86%</p>	<p>Progress: Fully met</p> <p>The provisional absorption rate from the budget book of FY 2013/14 was 96.87%. (source: MoHP's Expenditure against Budget spreadsheet)</p>
<p>Indicator 4: % of sanctioned posts that are filled</p> <p>2013 Milestone: 88% of sanctioned doctor posts at district hospitals filled 88% of sanctioned nurse posts at district hospitals filled</p>	<p>Progress: Not Met</p> <p>Data from 2012 STS shows:</p> <ul style="list-style-type: none"> • 63% of sanctioned doctor posts at district hospitals filled (down from 69% in STS 2011), and • 83% of sanctioned nurse posts at district hospitals filled (no change from STS 2011) <p>Comment: Data from the current HR database (HuRIS) are not deemed to be sufficiently accurate to track this indicator, but data from STS 2011 and 2012 suggest that no progress has been made. Data from the HRH assessment are not yet ready. The delay in approving the Health Services Act has affected the recruitment of all GoN health staff. As a result, 65 doctors have been recruited of whom only 6 have been posted to district hospitals. NHSSP has continued to take a macro approach to improving HRH systems. However, recruitment strategies included in the new HRH Strategic Plan have not yet had an impact on recruitment numbers.</p>
<p>Indicator 5: % of health facilities with no stock-outs of listed free drugs in all four quarters</p> <p>2013 Milestone: 80%</p>	<p>Progress: Not Met</p> <p>Only 23% of facilities sampled for the 2012 STS had not experienced a stock out in the previous year (source: 2012 draft STS).</p> <p>Comment: Primary health care centres (PHCCs) were least likely to have had no stock outs in the previous year (13%), followed by SHPs (21%), health posts (25%) and hospitals (38%). The drugs most commonly out of stock at all levels of facilities were ferrous sulphate and folic acid, hyoscinebutyl bromide and amoxycillin at all level of facilities. NHSSP has focused on improving the availability of essential drugs primarily by seeking to strengthen central procurement systems and procurement planning.</p>

Output One: Essential Health Care Services



Output One: DoHS/regions have capacity to deliver quality and integrated essential health care services (EHCS), especially to women, the poor and underserved

Results to date	Challenges	Responses to challenges
In partnership with the FHD, CHD and the World Bank, NHSSP conducted a comprehensive study and helped develop a set of recommendations to assist the DoHS improve the health status of women and children in remote areas of Nepal. NHSSP trialed and evaluated several strategies to increase service quality and availability in remote areas (see indicator 1.2)	Lack of policy guidelines and focus on remote areas.	Facilitate the inclusion of a remote area health policy in the revised National Health Policy.
NHSSP has supported FHD to improve availability of Blood Transfusion Services (BTS) and improve CEONC functionality in facilities and respond to factors contributing to overcrowding in referral hospitals (see indicator 1.1).	See Indicator 1.1	See Indicator 1.1
Support has been provided to improve the effective delivery of key services: <ul style="list-style-type: none"> Immunisation: An immunisation coordinator supported the CHD to improve the use of 		

Output One: DoHS/regions have capacity to deliver quality and integrated essential health care services (EHCS), especially to women, the poor and underserved		
Results to date	Challenges	Responses to challenges
<p>routine immunisation and supervision / monitoring data in low coverage districts with the aim of increasing coverage;</p> <ul style="list-style-type: none"> • Increased availability of SBAs in post to provide services: An SBA coordinator contributed to an improvement in the quality of training observed in 14 SBA training sites (based on self-assessment using quality improvement tools). 		
<p>The Health Sector Strategy to Address Maternal Undernutrition is being forwarded by CHD to MoHP for endorsement. It has not yet been approved. A high level meeting to discuss it will be held on September 15, 2013.</p>	<p>Delay in developing implementation guidelines.</p>	<p>High level meeting arranged for Sept. 13</p>

Results to date	Challenges	Response to challenges
<p>Indicator 1.1: Districts have improved tools, skills and systems to provide functional CEONC services</p> <p>2013 Milestone: Strategic options to reduce overcrowding of CEONC referral hospitals agreed with FHD and actions included in the 2013/14 AWPB.</p>		
<p>Progress: Achieved</p> <p>NHSSP supported a study to assess the effects of increased demand for institutional delivery care in tertiary facilities in 2012. The study identified several factors affecting overcrowding in some hospitals and proposed strategic options for responding to high case loads. FHD has subsequently been supported to plan and budget activities to overcome overcrowding in 10 referral hospitals. This budget may be used for local staff recruitment, improving infrastructure and maintenance and procurement of equipment.</p> <p>Comment:</p> <ul style="list-style-type: none"> • FHD's AWPB includes extra beds and staff for these hospitals. • The infrastructure procurement plan should include plans for the expansion of wards using Ministry of Finance (MoF)'s grants to these hospitals. 	<p>Poor quality of care at referral hospitals.</p> <p>Referral hospitals do not always plan logically for the use of MoF grant funds.</p>	<p>Work with MD and PPICD to include MoF grants in the infrastructure procurement plan to ease the overcrowding situation.</p>

Indicator 1.2: Evidence generated for strengthening maternal, neonatal and child health service delivery, including outreach to underserved groups. 2013 Milestone: AWPBs aligned for implementation of strategic guidelines for under-served and unreached populations in 10 districts.		
<p>Progress: Achieved</p> <p>FHD included a budget for scaling-up the integration of FP services in EPI clinics in four districts, micro-planning for improving FP services in six districts, providing rural antenatal ultrasound in 14 districts, and continued referral funds for emergency obstetric care in 16 districts.</p>		
<p>Comment: NHSSP supported innovations to strengthen service delivery for underserved groups in four areas;</p> <p>1) Integration of FP with EPI service provision: The integration of FP services in EPI clinics was successful in increasing the use of FP methods among women during an extended post-partum period (women with infants under one year old) without negatively impacting the functionality and use of EPI clinics and primary health care outreach clinics. Based on the study findings, the government has committed to rolling out the integration of services more widely.</p>	<p>Absence of vaccinators in a number of village development committees (VDCs).</p> <p>Absence of multi-year contracting.</p>	<p>Provide HR and task mapping before implementation. Improve staff commitment and motivation.</p>
<p>2) Strengthening district referral systems: 29 health facility in-charges were trained in obstetric first aid. FHD plans to provide this training to a further 100 health workers (paramedics).</p>	<p>DHOs and NHSSP were unable to monitor the effects of this training except through informal discussions with health workers. These discussions suggested improved confidence in dealing with complicated deliveries and working as a team with SBAs.</p>	<p>Ensure FHD develops monitoring tools for referral of obstetric complications.</p>
<p>3) Strengthening the delivery of PNC: Women interviewed on their PNC experiences indicated that most check-ups were completed and that they were able to recall the information and advice provided. The</p>	<p>Shortage of staff, especially in Banke hospital.</p>	<p>Continue QI of PNC during the next phase by using audio-visual information,</p>

<p>interventions were found to have bolstered the PNC process at participating facilities by supporting health workers to provide more systematic and comprehensive PNC counseling.</p>	<p>Language problems.</p> <p>Lack of understanding of family members on the need for PNC information and advice.</p>	<p>education and communication materials, and a nationwide campaign to increase awareness of the importance of PNC.</p>
<p>4) Strengthening the availability of comprehensive abortion care (CAC) The focused set of activities undertaken by the programme has resulted in substantial improvements in access to quality safe abortion services in the two pilot districts. This is evidenced by the increased number of women receiving services during the project period, the absence of serious post-abortion complications and the high levels of acceptance of a post-abortion contraceptive method.</p>	<p>Poor capacity of the training sites.</p> <p>Frequent transfer of trained staff.</p> <p>The need for tailor made monitoring.</p>	<p>The lessons learnt from this project have wider implication for all programmes in remote areas. Examples, recommended modifications and approaches that suit the specific needs of remote areas are required instead of the blanket approach used at present.</p>

Output Two: Human Resources



Output Two: MoHP has capacity to develop and implement an effective HRH Strategy		
Results to date	Challenges	Response to challenges
<p>An HRH Strategic Plan was developed and approved (see indicator 2.1)</p>	<p>The length of time to get the Strategic Plan approved was excessive.</p> <p>How to ensure the Strategic Plan is adequately reflected in the AWPB so that activities get funded?</p>	<p>Encourage all team members to move the process along by supporting translation, approval processes, dissemination, the writing of policy briefs for different audiences, etc.</p> <p>Work with TWG and other stakeholders over two annual AWPB cycles to ensure the Strategy is taken forward.</p>

Output Two: MoHP has capacity to develop and implement an effective HRH Strategy		
Results to date	Challenges	Response to challenges
An HRH profile, covering both public and private sector health workers, was completed. A total of 54,177 health workers were identified across the public and private sectors, and Nepal was found to have 0.167 doctors and nurses per 1,000 population – significantly fewer than the WHO recommendation of 2.3 doctors nurses and midwives per 1,000 population.	The consultants contracted to prepare the profile did not comply with the ToR resulting in poor quality and missing data.	Improve management of consultants through continuous technical support, backstopping and monitoring.
Workforce plans and projections were developed to inform decisions about the design of services, staff training, and to inform strategic engagement with the private sector (see indicator 2.2)	Delay in getting HRH assessment data on which to base workforce plans and projections.	Formation of a TWG and a Core Technical Team (CTT) comprising senior MoHP officials and development of planning assumptions and scenarios while awaiting data. Use of an international workforce planning consultant to use available data to familiarise CTC members with the projection process, modelling tools and software.
HRH activities taking place across DoHS and MoHP were mapped to identify bottle necks, gaps and overlaps between departments and functions. Recommendations on how to improve current arrangements were also identified.	Incomplete data and lack of clarity of role descriptions in MoHP documentation.	Supplemented official documentation with other data sources including AWPB analysis and key informant interviews.
An institutional assessment of NHTC was completed to support its strategic development as the identified body supporting all in-service training in Nepal. The assessment sets a baseline to inform and direct future capacity building inputs to NHTC. This will be critical in supporting the improved capacity of NHTC to direct and manage in-service training for the health sector effectively.	Vested interests within NHTC constrained objective analysis. Perceived threat within NHTC related to impending disruption of the status quo.	

Results to date	Challenges	Responses to challenges
<p>Indicator 2.1: HRH Strategic Plan developed and used to guide annual work plans and regularly updated.</p> <p>2013 Milestone: Evidence of implementation of strategies for the recruitment of nurses at hospitals and doctors at PHCC in all five regions.</p>		
<p>Progress: Partially achieved</p> <p>An HRH strategic plan was approved by the MoHP and the Cabinet in 2012 (2011 logframe milestone) and has been used to influence planning and budgeting in the AWPB (2012 logframe milestone). However, the 2013 target (strategies implemented for recruitment of nurses and doctors to PHCCs) was based on the assumption that if the relevant activities of the HRH Strategic Plan were implemented, they would impact not only on the total number of health workers deployed across the country but also on their distribution, thereby potentially improving equity of access to services. Good progress was made in developing interconnected strategies and related activities to facilitate this, primarily through better recruitment and deployment systems, but little implementation actually took place and there was limited recruitment.</p> <p>Comment:</p> <p>Though it was a long time from the initial workshop to approval of the Strategic Plan, the time was well spent in engaging important stakeholders and educating them and core team members about strategic approaches to HRH. Discussions and thinking about HRH are now much better informed. The MoHP owns the plan and many stakeholders recognise that new HR initiatives need to be in line with the plan.</p>	<p>Translating priority activities into the AWPB on an annual basis.</p>	<p>Continuous monitoring through the STS and other HR information systems will be needed to encourage MoHP to address the challenges of translating recruitment plans into action. This, in turn, should lead to improvements in staffing levels of doctors at PHCCs and nurses at district hospitals, as well as other key health staff.</p>
<p>Indicator 2.2: Staffing projections available to inform training plans.</p> <p>2013 Milestone: Projections completed and agreed and used to inform planning for pre-service training</p>		
<p>Progress: Fully achieved</p> <p>In 2011, a clear plan for developing projections was developed and subsequently a plan and projections for Nepal's health workforce were developed HRH profiles have been completed for the government to use in designing services and planning staff training.</p> <p>Comment: This activity was clearly dependent on the availability of data on the health</p>	<p>See above</p>	

Results to date	Challenges	Responses to challenges
<p>workforce. MoHP decided it wanted to carry out a full workforce survey. The work on projections was seriously impacted because of delays with producing the HRH assessment data. Nevertheless, the delay provided an opportunity for the TWG to consider various future scenarios and how they would affect the demand for health workers. These can then be matched with supply-side scenarios to contribute to the development of a realistic workforce plan.</p>	<p>Delays in receiving the HRH assessment data and concerns over quality</p>	<p>Additional consultants hired to clean and analyse data</p>

Output Three: Gender Equality and Social Inclusion



Output Three: MoHP and DoHS have systems, structures and capacity to implement the GESI Strategy		
Results to date	Challenges	Responses to challenges
<p>Institutional Structure Guidelines to oversee the leadership and coordination of GESI approved and established: (see Indicator 3.2). The approval of the Institutional Structure Guidelines by the Minister provided the mandate for various institutional structures/mechanisms to be established and made functional.</p> <p>GESI Operational Guidelines developed: GESI operational guidelines to support the implementation of MoHP's GESI strategy were developed through a participatory process. These support the application of GESI principles in key processes including planning, programming, monitoring and service delivery.</p> <p>Capacity development: Understanding of GESI concepts, principles and application of the guidelines improved through a comprehensive capacity building programme for staff at MoHP, DoHS, Regional Health Directorates (RHDs), and DHO/DPHOs.</p>	<p>Adequate resourcing to implement Institutional Structure Guidelines (see 3.2)</p> <p>The sheer scale of rolling out of the Guidelines across the country and capacity building while</p>	<p>Provision of regular budget for the roll out of guidelines proposed.</p> <p>Create partnerships and coordinate with EDPs in project districts for</p>

Output Three: MoHP and DoHS have systems, structures and capacity to implement the GESI Strategy		
Results to date	Challenges	Responses to challenges
	retaining an adequate focus on skills training and the use of GESI tools.	capacity building at facility level. Ensure adequate provision of GESI TA.
<p>Mainstreaming GESI: Progress was made in mainstreaming GESI within the health system including in health worker training:</p> <ul style="list-style-type: none"> • An inventory of training courses provided by health sector institutions under MoHP, including an assessment of GESI related content was completed. • GESI training modules and behavior change communication (BCC) materials were integrated into the curricula for female community health volunteers (FCHVs), HFOMCs and senior auxiliary health workers and SBAs. Draft documents were submitted to NHTC for pre-testing and finalisation. • GESI was also integrated into AWPBs (see indicator 3.1) 	Eliciting sufficient internal support for the revision of training curricula to include GESI and their roll out through training institutions.	<p>Provide GESI TA and an adequate budget to support roll out through NHTC and other training institutions.</p> <p>Lobby EDPs to support NHTC for roll-out. Strengthen trainers' skills in GESI so they are better able to deliver the revised curricula.</p>
GESI related programmes and services piloted, reviewed and strengthened		
<p>1) One-stop Crisis Management Centres (OCMCs): OCMCs were established and made operational in 15 district hospitals with support from NHSSP. Staff were appointed and trained, including in psychosocial counseling and integrated service provision improved. An impact assessment was commissioned with the report due for submission in October 2013.</p>	Insufficient functional coordination across ministries and with EDPs and civil society at both the central and district levels.	<p>Updated guidelines from cabinet to clarify the roles of various stakeholders and reduce duplication.</p> <p>Improved OCMC coordination mechanisms at central</p>

Output Three: MoHP and DoHS have systems, structures and capacity to implement the GESI Strategy		
Results to date	Challenges	Responses to challenges
<p>2) Social Service Units (SSUs): SSUs were established and made functional in five hospitals with support from NHSSP. A road map for establishing and strengthening SSUs was produced in 2012 and the revised SSU Establishment and Operational Guidelines were approved in 2012. SSU piloting was undertaken in six hospitals and a report published in August 2013.</p>	<p>Hospital management is reluctant to accept SSU-related service provision as a core responsibility.</p> <p>Resistance among some hospital staff to support SSUs due to strong accountability mechanisms that may limit opportunities for irregular fund use and nepotism.</p> <p>Hospital staff have not adequately internalised the importance of providing SSU services to the poor and marginalised.</p> <p>Limited availability of suitable non-governmental Organisations (NGOs) to facilitate SSU services.</p>	<p>and district levels.</p> <p>Ministry level directive to hospitals to increase the priority to be given to SSU service provision.</p> <p>Awareness raising and coaching of hospital staff.</p> <p>Train and issue multi-year contracts to local NGOs.</p>
<p>3) Equity and Access Programme (EAP): MoHP continued to fund and manage EAP in 21 districts, including selected remote districts. It also submitted a file memo to the Finance Ministry for the approval of multi-year contracting of local NGOs to enable facilitation of the full EAP programme under a single service contract. This promises to help prevent the fragmentation of inputs reported in the October 2012 Strategic Review of the EAP</p>	<p>The inability to issue multi-year contracts with EAP NGOs fragments inputs and compromises the quality of</p>	<p>Support Primary Health Care Revitalisation Division (PHCRD) for EAP implementation</p>

Output Three: MoHP and DoHS have systems, structures and capacity to implement the GESI Strategy		
Results to date	Challenges	Responses to challenges
conducted by NHSSP.	programme implementation.	and NGO capacity building esp. in remote districts.
<p>4) Social Audit: Drawing on the collective experiences of sector agencies, draft Social Audit Guidelines were developed and piloted in 29 facilities of two districts in 2011/12. In addition, non-pilot social auditing was carried out in 170 facilities of 21 districts in 2011/12, and in 236 facilities in 2012/13. Based on the results of the pilot, MoHP revised and finalised the guidelines in June 2013 and the approach is now being mainstreamed across the country using AWPB and EDP funding.</p>	<p>Maintaining the quality of social audits including ensuring that the full process is completed.</p> <p>Insufficient skills of NGOs to conduct social audits with the correct level of understanding and motivation.</p> <p>Reluctance on the part of some health staff and workers to accept social auditing as an effective means by which to improve health services.</p> <p>Responding to 'high level' issues including those related to human resources, infrastructure, and supplies.</p>	<p>Provide specialist TA and a budget for capacity building of local health staff and facilitating NGOs.</p> <p>Improve dissemination on the impact of social auditing on service availability, quality and client satisfaction.</p> <p>Advocate at central level to address strategic concerns that lie beyond the control of health facilities.</p>

Output Three: MoHP and DoHS have systems, structures and capacity to implement the GESI Strategy		
Results to date	Challenges	Responses to challenges
<p>Peer Ethnographic Evaluation and Research (PEER): An in-depth PEER study was conducted to identify the socio-cultural, economic and institutional barriers to accessing health services experienced by poor and excluded women and men in Nepal. The findings were used to inform the AWPB preparation of CHD and FHD.</p>	<p>How to use the insights and findings of the PEER study to inform GoN priorities and programmes.</p>	<p>Share the findings of the PEER study widely including with FHD, CHD and the National Health Education, Information and Communication Centre (NHEICC). Ensure that district level planning and programming include interventions to address the barriers identified.</p>
<p>OTHER:</p> <ul style="list-style-type: none"> GESI integration was reflected in policy documents such as the Health Policy Review, HRH Strategic Plan, Urban Health Policy and NHSP-2 Implementation Plan. A GESI section was included in the Joint Annual Review (JAR) report. Training on Inclusive Governance for Training of Trainers was delivered to GESI trainers. 		<p>Advocate for and facilitate the integration of GESI in all MoHP policy documents.</p>
Results to date	Challenges	Responses to challenges
<p>Indicator 3.1: AWPBs integrate GESI, reflecting the GESI strategy. 2013 Milestone: AWPBs show increased resourcing for GESI activities.</p>		
<p>Progress: Fully achieved</p> <p>The Population Division, PHCRD, FHD and CHD made significant investments in GESI-related programming in 2013/14 as follows:</p> <ul style="list-style-type: none"> Population Division allocated NPR 229 million (£1.5m), including an increase of +240% on SSUs; +7064% on GBV and GESI orientation, and +1062% on GESI Institutional structures compared with 2012/13. 	<p>How to ensure a continuing focus on GESI in successive AWPBs?</p> <p>How to ensure that GoN fully</p>	

Output Three: MoHP and DoHS have systems, structures and capacity to implement the GESI Strategy		
Results to date	Challenges	Responses to challenges
<ul style="list-style-type: none"> PHCRD allocated NPR 95 million (£0.6m), including an increase of +135% on social audits and +150% on GESI research on 2012/13 levels. FHD allocated NPR 372 million (£2.5m), including an increase of +1853% in reaching remote women Of CHD's total budget of NPR 2,617 million, 25% (NPR 654 million (£4.4m)) was earmarked for malnourished children and other children living in remote areas, an increase of 1397% on 202/13 levels. <p>Comment: MoHP's business plan format proved invaluable in ensuring that GESI-related activities were identified, planned and budgeted, thus providing an effective entry point for GESI. TA worked with individual divisions to help staff identify how GESI could be integrated into their programmes.</p>	owns and adopts the business plan format during AWPB preparation.	Continue advocacy and TA facilitation to incorporate GESI within AWPBs using the business plan format.
<p>Indicator 3.2: A leadership and coordination structure in place to drive implementation of the GESI strategy. 2013 Milestone: A GESI district coordination structure established with TOR and membership in 20 Districts.</p>		
<p>Progress: Fully achieved</p> <p>Comment: The Institutional Structure Guidelines for mainstreaming GESI were approved by the Minister in 2012. The GESI Steering Committee was formed in October 2011 with the Health Secretary as chair and meetings to be held twice a year. A DoHS GESI Committee was formed in December 2011 to meet once a year. One official was nominated as the GESI focal person by each division and centre. TWGs were formed in all five regions in 2012 and oriented on their roles. Each met 1-3 times. TWGs were formed in 70 districts, with meetings held at least once in all districts and more than three times in many districts. In 2013, a GESI Section was established in the Population Division, reflecting the growing level of commitment to institutionalising GESI seen across the Ministry.</p>	<p>How to make the institutional structure for mainstreaming GESI fully functional?</p> <p>How to strengthen the skills needed to apply the GESI framework down to health facility level.</p>	<p>Provide a regular budget for TWG meetings and the implementation of GESI Operational Guidelines in order to keep the GESI institutional structure fully operational.</p> <p>Ensure the adequate provision of TA.</p>

Output Four: Health Financing



Output Four: MoHP and DoHS have the capacity to develop and implement a transparent and sustainable supply and demand-side financing framework.

Results to date	Challenges	Responses to challenges
<p>Management and oversight of Demand-side Financing (DSF) schemes was strengthened (see 4.2).</p>	<p>Maintaining the quality of the DSF rapid assessments (RA) conducted by FHD.</p> <p>Institutionalisation of the RA process and implementation and use of the integrated M&E framework.</p>	<p>Engaged FHD staff members in designing, implementing and analysing the DSF RA.</p> <p>RA of DSF schemes included in the Red Book for FY 2013/14.</p> <p>Supported FHD in generating quarterly reports on DSF schemes from routine reporting.</p>

<p>Piloting of TABUCS was completed (see 4.3).</p>		
<p>Improved and more efficient budgeting systems were implemented</p> <ul style="list-style-type: none"> • A web based AWPB system was introduced to increase the ease and efficiency of budget development • The NHSP-2 Logical framework was incorporated in the e-AWPB enabling the MoHP to analyse the budget by output indicators and NHSP-2 objectives. This is an important step towards output based budgeting • TABUCS was linked with the e-APWB 	<p>Delay in planning the AWPB.</p> <p>Errors consolidating the AWPB.</p> <p>Lack of involvement of districts in the AWPB planning processes.</p>	<p>Supported MoHP in revising the eAWPB through the concerned divisions and centres.</p> <p>Kept a history of all revisions and if revision was required, worked on the most recent version.</p> <p>Included NHSP-2 result framework indicators in the eAWPB. Improved clarity on the AWPB through budget analysis.</p>
<p>GoN transparency on financial issues was improved and the availability and accessibility of financial information increased.</p> <ul style="list-style-type: none"> • NHSSP supported MoHP to design a summary format for its AWPB, which was uploaded to MoHP's website 	<p>Weak involvement of the audit committee in transparency promotion.</p> <p>PFM issues often not discussed with EDPs.</p> <p>No internal financial information system in place.</p>	<p>Reactivated the audit committee, including preparation of ToR and regularisation of meetings.</p> <p>Formed PFM committee with the participation of EDPs.</p> <p>Designed and piloted TABUCS to ensure the availability of appropriate financial information.</p>
<p>NHSSP supported GoN to improve audit practices.</p> <ul style="list-style-type: none"> • NHSSP supported MoHP to re-activate its audit committee with a TOR. • An Audit Clearance Manual has been drafted to help resolve outstanding audit issues. 	<p>High number of audit queries.</p> <p>Delays in clearing audit queries.</p> <p>Unavailability of internal control guidelines.</p>	<p>Prepared audit clearance guidelines.</p> <p>Supported MoHP in clearing audit queries.</p> <p>Prepared internal control guidelines.</p>

Results to date	Challenges	Responses to challenges
Indicator 4.1: Functional Health Financing expertise in MoHP and DoHS.		
2013 Milestone: Consensus built with MoHP and key stakeholders on core components of the HF strategy.		
<p>Progress: Fully achieved MoHP and EDPs agreed to develop a HF strategy and the World Bank prepared an outline. NHSSP provided technical inputs through the Benefit Incidence Analysis (BIA), Budget Analysis Report and Household Survey.</p> <p>Comment: MoHP prioritised the implementation of the National Health Insurance Programme (NHIP) which slowed the process of preparing the HF strategy.</p>	<p>Delay in preparing the HF strategy.</p> <p>How to achieve national consensus on finalising the design of NHIP?</p>	<p>Provided technical inputs to prepare the HF strategy.</p> <p>Provided a draft actuarial analysis to MoHP from which it then defined the contribution amount.</p>
Indicator 4.2: Implementation of systems to provide regular monitoring and information of DSF schemes.		
2013 Milestone: Analysis of the effect of free care and Aama on service utilisation trends.		
<p>Progress: Fully achieved</p> <p>The institutionalisation of RA in FHD has advanced with FHD including a budget line in its AWPB. In addition, the FHD director served as the principal author of the last two RA reports.</p> <p>An integrated excel database for the Aama and 4ANC schemes and a separate excel database for Uterine Prolapse data were created at FHD to record expenditure and progress of these DSF schemes. The databases were updated regularly and information used for planning, budgeting and policy level decision making.</p> <p>An integrated M&E framework of DSF schemes including Aama with 4ANC, Uterine Prolapse and FP was also developed.</p> <p>Comment: The recently developed M&E framework needs to be rolled out across the country. The capacity of regional and district level health facilities to implement the framework needs to be strengthened.</p>	<p>Institutionalisation of the RA in subsequent years.</p> <p>Effective analysis of the excel databases.</p> <p>Generation of quarterly reports based on an integrated M&E framework.</p>	<p>Provide continuous support to FHD in conducting RAs.</p> <p>Provided technical support in updating and analysing the excel databases.</p>

Indicator 4.3: Improved systems to ensure timely and accurate reporting of expenditure.
2013 Milestones: e-AWPB expanded to a further 1-2 regions.

<p>Progress: Fully achieved</p> <p>MoHP was supported in the preparation of TABUCS to help capture expenditure on programme activities and prepare good quality and timely financial monitoring reports (FMRs). After completing this process, MoHP was supported to prepare a web-based planning and accounting system with the flexibility for use in offline mode. In order to reduce the potential for error, MoHP was supported to pilot TABUCS in 11 selected cost centres. The pilot programme was finalised and draft reports are being prepared.</p> <p>Comment: MoHP needs to be supported to train all planning and accounting officers prior to TABUCS being rolled out in 278 cost centres. Technical support should be provided to address security concerns.</p>	<p>Rolling out TABUCS in 278 cost centres.</p> <p>Issues related to data storage and security are a concern for MoHP.</p> <p>Building the capacity of MoHP officials at all levels.</p>	<p>Prepared the financial proposal to ensure funding support for the roll out.</p> <p>Address storage and security in the rollout plan.</p> <p>Included training in the roll out plan in NHSSP phase-2.</p>
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Output Five: Monitoring and Evaluation



Output Five: MoHP has the capacity to strengthen and effectively use an information system to support planning and delivery of quality EHCS.

Results to date	Challenges	Responses to challenges
<p>NHSSP helped strengthen GoN systems to generate high quality routine health system monitoring data by supporting a revision of the Health Management Information System (HMIS) (see 5.1).</p>		
<p>OTHER: NHSSP helped strengthen GoN systems that utilise data for evidence-based planning by supporting the compilation of key findings of national level surveys and supporting their use in preparing the AWPB.</p>	<p>The standard practice of GoN officials is to simply continue last year's activities rather than analyse available data/information and plan based on the evidence.</p>	<p>Helped concerned divisions, centres and sections discuss and compile data before beginning the planning exercise.</p>

Results to date	Challenges	Responses to challenges
<p>Indicator 5.1: HMIS functioning effectively and informing local area planning and monitoring across Nepal.</p> <p>2013 Milestone: a) Strategies to strengthen HMIS successfully scaled up across all 75 districts. b) The DoHS annual report published within three months of the FY end with improved analysis and interpretation of data.</p>		
<p>Progress:</p> <p>a) Fully achieved</p> <p>The Management Division revised HIMS indicators, recording and reporting forms with support from NHSSP. Field testing of the revised HMIS has now begun and NPR 150,000,000 has been allocated by the GoN for training on implementing the revised HMIS. There was also a strong commitment from divisions, centres and development partners to support implementation of the revised HMIS.</p> <p>The revised HMIS will:</p> <ol style="list-style-type: none"> 1. Bring HMIS in line with the national Health Sector Information Strategy (HSIS) with regard to: <ul style="list-style-type: none"> ▫ enabling ten selected indicators to be disaggregated by caste/ethnicity, ▫ revising the reporting process to enable facility level data reporting, ▫ ensuring that data are collected from all health facilities across the country including police and army hospitals, mission hospitals, teaching hospitals and all non-public facilities. 2. Ensure that indicators and tools meet current needs, including monitoring the logical framework of NHSP-2 and all relevant programmes of FHD, CHD [including nutrition], Epidemics and Disease Control Division, National Centre for AIDS/STD Control, Leprosy Control Division, National Tuberculosis Centre, National Public Health Laboratory and Curative Division). 3. Integrate vertical reporting systems into HMIS (Aama programme, Emergency Obstetric Care [EOC] monitoring, Community Based Neonatal Care Programme, Nutrition, HIV/AIDS and Tuberculosis [TB] programmes). 4. Make the tools more user-friendly. 	<p>Maintaining the quality of national level training of staff, from FCHVs to district managers, over the two month training period.</p>	<p>Put forward a quality assurance plan supporting districts to plan and implement the revised HMIS. DFID gave its approval and allocated a budget to implement this.</p>

Results to date	Challenges	Responses to challenges
<ol style="list-style-type: none"> 5. Ensure that the reporting process is efficient and effective in order to reduce the burden on staff and to avoid any duplication of work. 6. Ensure that the same recording and reporting tools and reporting processes are used in all 75 districts. 7. Enable electronic data entry at the district and the hospital level and web-based reporting to the central level 8. Disaggregate hospital mortality and morbidity data by age, sex and cause 9. Enable reporting on all NHSP-2 log frame indicators for which HMIS is a data source 10. Provide evidence to inform strategic and policy level decisions such as the design of the forthcoming sectoral plan (NHSP-3). 		
<p>b) DoHS annual report: Not met</p> <p>Progress: Some improvement was seen in the quality of the DoHS annual report in terms of its analysis, interpretation and presentation. However, publication of the report within three months after completion of the FY was not achieved.</p>	<p>To publish the DoHS annual report within 3 months of the FY.</p> <p>Changes are made in the data even after the district, regional and national reviews.</p>	<p>The MIS Section prepared an HMIS bulletin that compiled revised indicators, defined the numerator and denominator and showed 5 year trends for each indicator. This bulletin will be shared with all divisions, centres, regions and districts during the 2013 regional reviews in order to help them track their achievements and plan based on the evidence.</p> <p>Ensure that the MIS section publishes quarterly reports in order to increase access to and utilisation of HMIS data.</p> <p>Improve data quality in the MIS section and eliminate the practice of districts making changes in the data submitted to</p>

Results to date	Challenges	Responses to challenges
		the national server.
Indicator 5.2: Additional monitoring data not covered by HSIS generated. 2013 Milestone: Facility survey		
Progress: Ongoing Data collection for STS 2013 was completed and the report is due in December 2013.	Institutionalisation of the STS due to its complexity and cost.	Increase involvement and ownership of the STS by the divisions and centres. Seek institutional home for future surveys within MoHP. Strengthen the capacity of GoN counterparts to manage the STS.

Output Six: Procurement and Infrastructure



Output Six: MoHP and the Ministry of Physical Planning and Works (MPPW) have the capacity to develop and implement procurement in accordance with the procurement arrangements for the health sector during the implementation of NHSP-2

Results to date	Challenges	Responses to challenges
<i>Goods and Services:</i>		
A strengthened process for developing consolidated annual procurement plans increased the quality and timeliness of planning (see 6.2)	See 6.2	See 6.2
Transparency was increased through the development of a complaints mechanism and dispute resolution system (see 6.3)	See 6.3	See 6.3
A standardised process for accepting goods post-shipment was developed.		
A survey of drug pricing was completed		
A bidder database was introduced		

Output Six: MoHP and the Ministry of Physical Planning and Works (MPPW) have the capacity to develop and implement procurement in accordance with the procurement arrangements for the health sector during the implementation of NHSP-2		
Results to date	Challenges	Responses to challenges
An analysis of bid rejections was conducted		
Procurement advisors continued to provide extensive executive support to procurement processes		
Improved office management procedures were implemented		
<i>Building Works: :</i> Basic integrated construction designs were approved		
An Annual Procurement Plan was prepared	See 6.2	See 6.2
Standard bidding documents were produced	See 6.2	See 6.2
An e-bidding system for health facility contracts was introduced	See 6.2	See 6.2
Support was provided to monitor on-going building works		

Results to date	Challenges	Responses to challenges
Indicator 6.1: Recommended standards and procurement documents for best practice adopted and applied		
2013 Milestone: Development of an Operations Manual.		
Progress: Fully met At the time of writing, the Operations Manual is in draft form. Comment: Goods and Services The Operations Manual is dynamic and will need to be updated as necessary.	To ensure that the Operations Manual is taken into use by LMD.	Reminding LMD staff to use this excellent tool.

Results to date	Challenges	Responses to challenges
<p>Comment: <i>Building Works</i> Integrated construction designs were developed and have been used for the last three years by DUDBC. The standard designs were discussed extensively at central and district levels and updated and revised. The updated designs include blood supply units SSUs and OCMCs.</p> <p>The facilities are now designed to suit different levels of population and ecological zones, thus making them more economical and fit for purpose.</p> <p>The standard bidding process for building works prepared by NHSSP was agreed by the WB and will be uploaded to the DUDBC website and printed.</p>	<p>Proper use of standard designs.</p> <p>Proper selection of sites and design types.</p> <p>Adherence to the designs by contracted entities.</p>	<p>Provision of an orientation on standard designs.</p> <p>Encouraged the use of Google based HIIS to locate new health infrastructure.</p> <p>Provided an orientation on the infrastructure bidding process to contractors in coordination with the WB.</p>
<p>Indicator 6.2: Transparency and disclosure measures implemented. 2013 Milestone a: Annual procurement plans published.</p>		
<p>Progress: Fully met</p> <p>At the time of writing, the Consolidated Annual Procurement Plan (CAPP) for 2013/14 - is with the director of LMD for onward transmission to the WB for a no objection letter.</p> <p>Comment: <i>Goods and Services</i> The Plan is not fully consolidated as the MoHP has little appetite for such. However, it does include the majority of the centres' procurement requirements as annexes as agreed with the WB. It does not include any input from NHEICC which failed to provide a return in spite of repeated requests.</p>	<p>To persuade LMD to keep to the plan.</p> <p>To persuade programme divisions not to change their orders and quantities mid-procurement.</p>	<p>Use gentle persuasion on LMD.</p>

Results to date	Challenges	Responses to challenges
Indicator 6.3: Transparency – Complaints & Dispute Resolution		
<p>Progress: Partly met</p> <p>Although a procedure was presented in October 2012, it has not been taken into use.</p> <p>Comment: Goods and Services</p> <p>There seems to be little appetite for introducing the procedure as LMD feels that all bidders are well acquainted with the procedures.</p>	<p>Difficulty in persuading LMD to comply.</p>	<p>Use gentle persuasion on LMD.</p>
2013 Milestone b: 100% of tender notices published on the MoHP/MPPW website.		
<p>Progress: Fully met</p> <p>100% of tender notices were published on LMD’s website.</p> <p>Comment: Goods and Services</p> <p>Additionally, 100% of Bidding Documents, Contract Notices and Reasons for Failure were regularly published on LMD’s website.</p>	<p>To keep the system going.</p> <p>The WB needs to appraise the system.</p> <p>Confusion is still occasionally created by the WB asking DUDBC not to go for e-bidding.</p>	<p>Encourage the WB to make its appraisal.</p>
2013 Milestone c: 50% of bidding documents available for direct download from the e-bidding server.		
<p>Progress: Not met</p> <p>No bidding documents were available for download from the e-bidding server.</p> <p>Comment: Goods and Services</p> <p>LMD was asked by the WB to complete a questionnaire of the current e-bidding server so that the WB could inspect the system for security and accuracy prior to providing a no objection letter to go ahead with e-bidding. This is a new situation because, up until recently, the perceived wisdom was for LMD to await the results of the Public Procurement</p>	<p>To maintain the momentum and introduce e-bidding in FY 2013/14.</p>	<p>Keep pressure on LMD to establish e-bidding.</p>

Results to date	Challenges	Responses to challenges
Management Office's pilot e-bidding projects. These have not yet come to fruition and, at the WB's insistence, the e-bidding now reverts to LMD.		
Progress: Available for all the National Competitive Bidding (NCB) which includes more than 90% of the bids. International Competitive Bidding (ICB) was not done due to the WB's objection to them.		

Output Seven: Health Policy and Planning



Output 7: PPICD has a clearly defined and functional role as the focal point of the planning and policy process for the health sector.		
Results to date	Challenges	Responses to challenges
NHSSP supported a number of initiatives to improve management of the Sector-Wide Approach (SWAp) and to improve donor/GoN coordination:		
A review of reproductive health committees was completed.	The review did not generate sufficient interest in MoHP for the recommendations to be used.	Use the review to feed into the ongoing functional analysis of MoHP and planning for NHSP 3.

<p>Support was given to the Local Health Governance Strengthening Programme (LHGSP): The NHSSP supported pilot was completed in Myagdi while other EDPs supported other districts. Assessments were done of the piloting experiences in phase 1.</p>	<p>Centralised planning in MoHP mitigates against the scale-up of this approach to decentralised planning.</p>	<p>Support the central level to guide the overall LHGSP process and assess whether it can be used to move MoHP to adopt decentralised planning approaches.</p>
<p>A TA matrix was produced showing TA support provided to various divisions, departments and centres aligned to the NHSP 2 objectives.</p>	<p>It is not clear that MoHP or EDPs use the TA matrix optimally to harmonise and coordinate TA/Technical Committee (TC) support.</p>	<p>Disseminate the TA matrix and promote its use, especially in the annual planning process.</p>
<p>The health policy environment was strengthened. (see 7.2).</p>		

Results to date	Challenges	Responses to challenges
<p>Indicator 7.1: PPICD led and implemented the JAR process. 2013 Milestone: PPICD staff lead preparation for the JAR and the completion and sign off of the final JAR report.</p>		
<p>Progress: Fully met PPICD led on the JAR 2013 preparation and implementation which resulted in an Aide-Memoire that was signed within weeks of the JAR completion. Pre-JAR field trips organised around health themes were arranged before in 2012 and in 2013 and may become a regular event. Comments: The JAR 2013 was considered by many to be the most successful si far.</p>	<p>PPICD staff are very busy in the months leading up to the JAR due to GoN reviews and find it difficult to do the necessary work to prepare the JAR.</p>	<p>Work with PPICD starting as early as possible to encourage planning the JAR, especially the agenda. Encourage EDPs to present their agenda early so that advisors can work with counterparts to prepare the required inputs for the JAR.</p>

Indicator 7.2 PPICD updated and disseminated the National Health Policy and the nationally agreed Planning Guidelines for Health.

2013 Milestone: National Health Policy disseminated; the Planning Guidelines for Health developed and piloted.

Progress: Partly met

The National Health Policy preparation began under a former Health minister and was taken forward by a new minister who has set a deadline for a draft by mid-November 2013 in time for a new government to review.

Comments: A number of working groups are beginning to prepare their sections of the policy.

Progress: District Health Planning Guidelines were drafted by MD for use by DHOs. All DHOs and some of their partners were oriented on the guidelines which were piloted in one district.

Progress: A Health Facility Operations Manual was produced through the MD by collecting various laws, regulations, standards and guidelines pertaining to the functioning of health facilities and compiling them into a manual.

This schedule does not allow for wide public consultation of the draft policy.

The working groups are unclear on the difference between a policy and a strategy.

It is difficult to convince districts of the utility of district plans when there is no response from the central level to district requirements and plans.

Further experience with the Planning Guidelines is needed followed by their revision.

The manual must be used in order to improve facility functioning and will have to be updated on a regular basis.

Encourage more public consultation before approval.

Work with a policy consultant to clarify for the working groups the difference between a policy and a strategy.

Devise feasible processes to enable the central level to respond to district plans.

Revise the Planning Guidelines after one to two years' implementation experience through consultation with the districts.

Disseminate the manual and orient health facility managers to its existence and utility. Discuss a process for updating the manual with MD and work with the Nick Simons Institute (NSI) as part of its hospital management training programme to disseminate and update the manual.

4. Payment Deliverables

Twenty one payment deliverables were submitted during this reporting period:

- Report on revised SSU Guidelines implemented in two hospitals (26c)
- Preliminary findings of HRH Profile Study (30)
- Value for Money (VfM) report on Integration of the Aama programme with 4ANC Demand Side Financing Incentive Programmes (43c)
- Draft Household Survey (2012) submitted to GoN for review (46)
- Report on Increasing Access to Safe Abortion Services Including Medical Abortion in Remote Areas (49)
Draft STS (2012) report for circulation to GoN (55)
- Report on GESI Operational Guidelines reflected in work plans and budgets of FHD and CHD (56)
- Analysis of Barriers to MNCH Services in Remote Areas (57)
- Draft Value for Money case study on the Integration of FP and EPI (59)
- Performance based contracts prepared in 7 hospitals (61)
- Draft lessons and recommendations from operational research on strengthened PNC and integrating FP and EPI shared with stakeholders (62)
- Draft assessment of the Implementation of the Comprehensive Revised Social Audit Guidelines in Pilot Districts (65)
- Draft Progress Review and Process Documentation on GESI Mainstreaming into the Health System (66)
- Web based HIIS manual with Google interface available for use by DUDBC and DHOs with provision for updating the construction procurement plan and progress reporting by each district (68)
- Draft Rapid Assessment of the Aama Programme (70)
- Draft Business Plan of MoHP and DoHS for FY 2013/14 (71)
- Procurement bid results published on dgMarket and UNDB Online identifying: (a) bids and lot numbers; (b) names of each bidder who submitted a bid; (c) the bid process as read out at the bid opening; (d) names and evaluated prices of each bid that was evaluated; (e) names of bidders whose bids were rejected and the reasons for their rejection and (f) the name of the winning bidder including the price offered as well as the duration and summary scope of the contract awarded) (73)
- Mapping of HR functions and responsibilities in MoHP and DoHS and other selected external agencies (74)
- Approved TABUCS Operational Guidelines, training manuals and user guides developed for full roll out (T4)
- TABUCS linked to AWPB (T5)
- Quarterly progress report April – June 2013

Annex 1 – Publications Produced

EHCS	Strengthened PNC and integrating FP and EPI
	Report on increasing access to safe abortion services including medical abortion in remote areas
	Analysis of barriers to MNCH services in remote areas
	Draft Value For Money case study on the integration of FP and EPI
GESI	Report on revised SSU guidelines implemented in two hospitals
	Report on GESI operational guidelines reflected in work plans and budgets of FHD and CHD)
	Draft assessment of the implementation of the comprehensive revised social audit guidelines in pilot districts
	Draft progress review and process documentation on GESI mainstreaming into the health system
HPPHSG	Performance based contracts prepared in seven hospitals
HRH	Preliminary findings of HRH profile study
	Mapping of HR functions and responsibilities in MoHP and DoHS and other selected external agencies
	Pulse report: How Dr Awasthi saved the life of Ms Kamala Tamata and her son
Procurement & Infrastructure	Value for Money case study – Technical Specifications Bank
	Pulse report – Technical Specifications Bank of Health Equipment and Drugs
	Web based HIIS manual with Google interface
PFM	Draft RA of the Aama programme
	Draft business plan of MoHP and DoHS FY 2013/14
	Approved TABUCS operational guidelines, training manuals and user guides
M&E	Draft HHS (2012)
	Draft STS (2012) report
Other	Quarterly Progress Report: Apr-June 2013
	Pulse Quarterly Report: Apr-June 2013

Annex 2 – Regional Learning

This annex provides a summary of work, achievements and recommendations from NHSSP's regional advisors in the five regional health directorates under phase 1 of the programme. TA support to RHD's will discontinue under phase 2.

ACHIEVEMENTS

Regional Planning

Regional health sector strategic and periodic plans were developed along with calendars of operations which were used and displayed. Annual and half-yearly review meeting reports were prepared.

For HR, job descriptions were developed for most positions together with quarterly work and supervision plans. HR inventories were carried out and updated. Capacity assessments and training of RHD staff took place. In the Far-western RHD and in Doti district, an analysis of HR by sex, caste and ethnicity was carried out.

Regional health profiles were developed, used and updated; regional HMIS information was used for local planning and priority setting. CEONC planning was initiated and institutionalised in several hospitals. Improved documentation systems were introduced to CEONCs, BEONCs and birthing centres.

Regional OCMC planning and implementation was supported and both OCMCs and SSUs were established. In the Mid-western RHD, action plans for client-centred quality care were developed at the regional hospital. GESI TWGs formed at regional and district levels

District Planning

Several orientation and training programmes were implemented including: district planning (incorporating leadership and governance); GESI mainstreaming; appreciative Inquiry; communications and presentations; website updating and report writing.

District profiles were prepared and several districts developed annual work plans and calendars of operations. All districts in the Far-western Region prepared district health sector strategic and periodic plans.

Interventions in support of priority programmes such as EAP, safe motherhood, immunisation and special vaccination campaigns were initiated and guidelines for mapping hard to reach areas and populations prepared and used. Social audits were carried out in selected VDCs of Doti in the Far-western RHD. The referral system for voluntary surgical contraception was strengthened through FCHV training in several districts of Western Region.

Monitoring and Evaluation

M&E documentation systems improved with written feedback being sent from RHDs to districts following supervision visits. Half-yearly reports and monthly reviews of HMIS reports were published and feedback provided to districts. Need-based supervision visits were introduced and appropriate checklists developed. RHD quality reviews took place at monthly coordination meetings.

In Eastern RHD, a monitoring sheet including major health service indicators was developed and displayed publicly. In addition, a monitoring diary was used to help track programme specific progress in low performing districts and facilities and a grading tool for D/PHOs was developed.

The use of guidelines, such as those for CB-IMCI, the newborn care programme, nutrition, safe motherhood, EAP, and GESI increased. A revised maternal and newborn health checklist to improve EHCS monitoring and supervision was introduced and joint supervision and monitoring visits by RHD staff were carried out. A feedback system on CS services was introduced and a small study on the 'local support and the performance of birthing centres' was carried out in three districts in the Central region.

The Far-western RHD developed a checklist for integrated monitoring and reporting from a GESI perspective, including collecting disaggregated service utilisation data and strengthening supervision and monitoring to improve service delivery in private hospitals.

HSIS

An information and documentation system was established including regional websites and the collection of data from private sector institutions. Disaggregated data on service users was collected and analysed in several districts. Comparisons of physical vs. financial progress were made. The skills of district supervisors in data verification, analysis and use were strengthened.

The following review templates were developed in the Western RHD: EOC programme review, annual health report, half-yearly and annual programme review meeting, and follow-up on implementation report.

Information Management

An electronic HMIS was established. A regional health information bank was established in Mid-western and Far-western RHDs. A BCC tool on Chaupadi and GBV was developed in coordination with the Women's Development Office (WDO). In Central RHD, plans and progress information were displayed on poster presentations.

Coordination System Strengthening

Coordination guidelines were developed and monthly coordination meetings held on issue-based themes with a defined agenda, documentation and follow-up. Regional Health Coordination Teams (RHCTs) were formed with defined TOR and RHCT meetings were held and documented. Coordination meetings were also held with other GoN line agencies, EDPs and international non-governmental organisations.

EDP/(I)NGO mapping was conducted, updated and incorporated in the annual regional health report and a contact list of all D/PHOs, hospitals and EDPs was developed.

Representatives from other GoN offices were included in GESI regional and district committees and the resources of other stakeholders were incorporated into GESI planning.

PROBLEMS AND CONSTRAINTS

HR Issues

Counterparts often lacked computer and other skills. There were many vacant positions and frequent transfers of RHD staff and the actual presence of RHD staff in regional offices was limited. The poor work environment including inadequate physical facilities for RHD counterparts also led to difficulties.

TA and Capacity Building

There were misunderstandings concerning the TA approach due to unrealistic expectations of financial and material support and training incentives. Insufficient time was available for system strengthening.

Decentralisation and Coordination Issues

The quality of leadership among D/PHOs was seen to be variable and there was, in general, a lack of bottom-up planning from the districts. Routine delays in information transfer from the centre were also common with information flows frequently bypassing the RHDs and going direct to districts. The delayed release of programme budgets also slowed implementation activities.

It was evident that RHDs had limited capacity to coordinate with the private sector, (I)NGOs and EDPs.

LESSONS LEARNED

TA and Capacity Enhancement

RHD staff's perceptions on TA support were varied, with the many officials presuming that immediate tangible benefits and personal perks, rather than sustainable health systems improvements, were the main focus. Regular interactions facilitated by TA were necessary to bridge gaps in perceptions and resolve misunderstandings. Further, by encouraging regional health directors to take a leadership role in system strengthening, TA were able to work with officials to enhance the skills needed for planning, implementation and the institutionalization of good working practices, including those related to the monitoring of district activities.

Despite these gains, sustainable regional health system strengthening is seen to require increased authority and resource allocations, including staffing, to RHDs plus 4-5 further years of TA support for technical backstopping, mentoring and coaching.

NHSSP TA also helped to introduce a team approach to management, harmonized working relations, mutual trust and a conducive working environment.

Follow-up from RHDs to DPHO/DHOs enhanced service delivery as did the provision of TA directly to district hospitals, particularly with regard to meeting the needs of poor, vulnerable and socially excluded groups.

Detailed work plans were prepared based on need and gap assessments and these helped stimulate the development of new tools and guidelines including those for onsite technical coaching.

Working Environment

The provision of basic physical facilities such as computers, internet and email services proved critical to helping counterparts perform their roles effectively.

HR Issues

Filling key positions and retaining staff in RHDs and DHO/DPHOs is essential if regional health systems are to improve. Unfortunately, very high numbers of vacancies and generally poor motivation levels limited opportunities for capacity enhancement. HR staffing and transfer issues can only be addressed at central level.

Some RHD programme supervisors were not able to analyse service data effectively and this impacted the quality of planning, monitoring and system strengthening. In some cases, district officials were more skilled and experienced than regional focal persons and supervisors. This led to some line management difficulties.

Decentralisation Issues

Limited autonomy of RHDs due to overly centralised control mechanisms led to incomplete ownership of programme planning, implementation and evaluation. TA believe that RHDs could perform effectively if MoHP and DoHS provided more functional support, delegated authority and maintained better channels of communication and command.

Coordination Issues

Internal coordination in RHDs and external coordination between RHDs and EDPs was seen to improve over time resulting in improved team work and work performance, reduced duplication of programmes and resources and improved planning, implementation and M&E. However, it was noted that service statistics of non-state actors working in health service delivery were not captured in HMIS, leading to understated programme achievements (e.g. Aama).

RECOMMENDATIONS

For RHDs

Regional and District Planning

- Perform an HR needs assessment at regional and district levels.
- Develop a sustainability plan for work that has already been initiated.
- Reinforce GESI mainstreaming in health planning and service delivery.
- Along with DHOs/DPHOs, focus on enhancing performance in low performing districts and programmes.

- Advocate for improved support and involvement from DDCs and HFOMC in order strengthen local governance and improve sustainability.

M&E

- Continue initiatives in M&E, information management and coordination.
- Maintain a functional performance based evaluation system using rewards and punishments.

Information Systems

- Update health information regularly in order to inform local level planning.
- Regularise joint integrated supervision visits and the use of evidence based feedback, including from the web-based HMIS system, to improve planning and performance.
- Upgrade regional HMIS sections to incorporate operational research capabilities. For example, the HR inventory could be regularly updated and disaggregated.

Coordination

- Continue using guidelines and tools e.g. health planning guidelines, regional health profiles, guidelines for mapping hard to reach areas, etc. and templates for documentation.
- Regularise and strengthen coordination with both internal and external partners (EDPs, (I)NGOs and private sector health organisations) through joint reviews, multi-sectoral meetings, resource mapping and formulation of periodic plans.
- Make existing bodies such as reproductive health coordination committees and GESI TWGs fully functional.
- Strengthen EDPs and RHCTs at the regional level and RHCCs at the district level to improve coordination.

For NHSSP

- Plan TA programming for roughly five years given that health system strengthening is a long term process.
- Continue advocacy for regional health system strengthening.
- Revise the internal structure of RHDs to create a clear chain of command, clarify roles and responsibilities and introduce a performance evaluation system.

For MoHP

- Delegate authority to RHDs for planning, implementation and programme budgeting.
- Authorise RHDs and districts to prepare the AWPB with an annual indicative budget in advance.
- Improve the motivational levels of employees. Implement an appropriate performance based rewards system at all levels.
- Enhance the capacity of RHD and DHOs/DPHOs in effective leadership, analysis, planning and monitoring skills and provide sufficient resources to implement a monitoring and supervision system.
- Ensure sufficient essential equipment, drugs, supplies and a conducive working environment to include staff security, infrastructure, water, sanitation and proper waste management.

Annex 3 – Addressing Maternal Nutrition

Helen Keller International

2011-2013

INTRODUCTION

GoN has expressed a strong commitment to address the complex set of determining factors for improving nutritional status through a multisectoral approach. Nutrition Assessment and Gap Analysis (NAGA) conducted in 2009 by MoHP/GoN provided the impetus to develop a multisectoral nutrition action plan for the next five years (2011-15).

The priority groups for nutrition interventions from MoHP have historically been women of reproductive age and children under five years of age. Traditionally, MoHP has focused on interventions for the prevention of micro-nutrient deficiencies and has been very successful in reducing key micronutrient deficiencies, specifically through the use of vitamin A, de-worming, iron and iodine.

Maternal nutrition is a critical need in Nepal. Low birth weight, poor weight gain during pregnancy, maternal anaemia, excessive intra-household work and inadequate food distribution during pregnancy and after birth are essential issues that must be addressed. The need for maternal nutrition to be mainstreamed within the health system is imperative for supporting both mothers and their babies and is incorporated into NHSP-2.

RATIONALE

A high proportion of women in Nepal suffer from stunting during their early years of life. Low body mass among a high proportion of women, especially in the Terai, results in many having low weight at conception followed by poor pregnancy weight gain, both being important risk factors for poor fetal growth. Pre-pregnancy body mass can predict women at risk of having a low birth weight baby. Recent National Demographic and Health Survey nutritional data (NDHS) 2011 indicate that about one in five (18%) Nepalese women are too thin and more than one-third are anemic. Anaemia among pregnant women in Nepal is 48% according to NDHS 2011. Nutritional deficiencies in women are a result of inadequate intake of nutritious foods, inadequate utilization of nutritional intake, increased nutritional requirements because of parasitic infestation and infections as well as other factors. A strategy that aims to address these and other causal factors will effectively impact both women and their babies. The implications of urbanisation, exacerbated by gender and social exclusion issues, also underscore the importance of a national maternal nutrition strategy that will guide and inform essential nutrition for women during the critical reproductive phase of their lifecycle while prioritizing continuum of care.

The health system can play an important role in addressing the nutritional needs of pregnant and lactating women through contacts with women during antenatal, delivery and postpartum care, child

health visits and family planning servicesⁱ. However, Nepal has yet to develop policies and effective programmes at scale to address maternal undernutrition. Clearly, a review of the existing programmes (both global and national) on the effectiveness of maternal nutrition interventions is needed. More attention also needs to be given to understanding the main causes of maternal undernutrition in Nepal in order to develop and implement programmes that can have an impact on maternal nutritional status.

GOAL AND OBJECTIVES

The goal of the initiative was to provide policy makers with the background necessary to introduce maternal nutrition interventions and actions into existing health programmes.

Based on GoN's and partners' current efforts to gather and generate evidence of successful maternal nutrition interventions, NHSSP's objective was to contribute to the development of an overall strategic approach and key priorities for the health sector in addressing maternal undernutrition issues. HKI was tasked with collating available information on maternal nutrition and designing and developing a strategy to assist the MoHP to effectively address maternal undernutrition in Nepal.

Specific objectives of this assignment were to:

1. Establish the causal factors that lead to maternal undernutrition in Nepal.
2. Identify the gaps and challenges in addressing undernutrition among women in Nepal.
3. Design a strategy for improving maternal nutrition in Nepal.
4. Develop an implementation guide and plan of action with identified priorities for the respective GoN departments so that they can prepare their work plans.
5. Design a manual for maternal nutrition and prepare a team of master trainers in maternal nutrition.

ACTIVITIES

Development of a Health Sector Strategy for Addressing Maternal Undernutrition

The strategy was designed to:

- Enhance the capacity of GoN to design, implement and evaluate programmes at central, regional and district levels with a particular focus on enhancing management and technical skills.
- Integrate maternal nutrition into key health programmes including community based approaches.
- Improve knowledge regarding maternal nutrition, including diet and care practices, through advocacy, community mobilization and behavior change communications.
- Involve appropriate non-health sectors in maternal nutrition services as part of a multi-sectoral approach.
- Strengthen knowledge and contribute to information on best practices for evidence-based planning, implementation and monitoring for effective maternal nutrition programming.

Process

1. Consultations were held with MoHP, FHD, CHD and NHEICC and there were interactions with other key stakeholders. Work was done in close collaboration with the Nutrition Technical Advisory Committee (NUTEC), the nutrition section and the maternal nutrition core group (nutrition section director, FHD/SM director, World Food Programme (WFP), United Nations Children's Fund (UNICEF) and HKI) on the development of a conceptual framework for maternal

undernutrition, a causal analysis and a literature review of relevant maternal nutrition documents and materials (global and national).

2. Work was done with NUTEC, the maternal nutrition working group and an assigned core group from CHD, nutrition section, WFP, UNICEF and HKI to develop a comprehensive maternal nutrition strategy for maternal undernutrition that includes outcomes, objectives, goals and strategic components.
3. A two-day workshop was facilitated with key staff from CHD, FHD and DoHS centres as well as EDPs and other maternal health working members for discussion and review of the conceptual framework and the draft contents of the maternal nutrition strategy.
4. The final maternal nutrition strategy was shared and approved during a NUTEC meeting at Hotel Himalaya in March, 2013. The meeting was attended by the secretary of MoHP, the director general of health services, the director of CHD and the director of FHD.
5. The strategy was circulated for GoN endorsement following fulfillment of the FHD director's recommendation to hold a consultation with the safe motherhood subcommittee.

Preparation of an Implementation Guide and Plan of Action

In order to roll out the specific recommendations outlined in the strategy document for addressing maternal undernutrition, there was a need to develop an implementation guide and a plan of action for use by MoHP and DoHS's divisions and centres as well as other sectoral ministries who are partners in addressing nutrition in Nepal. The implementation guide and plan of action will inform the development of annual work plans over the next few years for the integration of maternal nutrition at all levels of the health system, including the development of pre-service and in-service training curricula and the incorporation of maternal nutrition into all key maternal health programmes.

Process

1. A draft implementation guide and plan of action was prepared by HKI. The draft was directly informed by the maternal nutrition strategy and in particular by the five strategic components outlined in the document.
2. A presentation was made to the maternal nutrition working group at CHD for discussion and planning of a process for collective review and input by maternal nutrition working groups and selected core group members from GoN, EDPs and nongovernment stakeholders.
3. A maternal nutrition workshop was held to review and further refine the implementation guide and plan of action for presentation to and in order to receive comments from the directors.

Maternal Nutrition Manual and Master Training of Trainers

The *Health Sector Strategy for Maternal Undernutrition* highlighted the importance of in-service training for building the capacity of trainers and facilitators at all levels to transfer accurate information, knowledge and skills in maternal nutrition to bring about change in attitudes and behaviours in communities and within families to support improved nutrition for adolescent girls and pregnant and lactating women. Most importantly, the issue of maternal nutrition counselling was highlighted. To initiate the next steps in the maternal nutrition process, HKI assisted GoN by providing expertise for the

development of a maternal nutrition manual for training trainers and facilitators and for training the first batch of maternal nutrition master trainers.

Process

1. A master training of trainers manual for maternal nutrition was drafted and sessions were planned for training.
2. A training of trainers for master trainers selected by DoHS, CHD and nutrition section was conducted.
3. A draft 2 maternal nutrition manual based on refinements made during the master training of trainers was developed.
4. The draft 2 maternal nutrition manual was circulated to maternal nutrition core group members for review and input.
5. A final draft maternal nutrition manual was prepared for a workshop review, refinement and presentation to the directors.

CONCLUSION

This inclusive process, coordinated by CHD, nutrition section and NUTEC and undertaken by NHSSP to initiate maternal nutrition in Nepal, has had a substantial impact in a short time. The meetings, discussions and decision making sessions between division directors and managers have emphasized the important role that nutrition plays in the lives of adolescent girls and pregnant and lactating women in ensuring healthy growth and development, both physical and cognitive throughout the lifecycle. Recent evidence released in the Lancet series on nutrition (2013) focuses on the relationship between nutrition and mortality and further justifies the importance of reaching girls well before they begin child-bearing and in providing optimum nutritional care throughout women's child-bearing years to ensure that their health and the health of their babies is sustained.

The leaders in the health sector at central level have agreed to move forward jointly on the recommendations in the strategy. Making these documents available in English and Nepali to the MoHP and DoHS and to other sectors at national and central levels will put in place the initial tools required to do so. The major tasks of planning and implementing maternal nutrition in the health sector as well as facilitating coordinated efforts in a multi-sectoral approach now lie ahead.

Maternal Nutrition in Nepal

Background

The impressive improvements in child and maternal health in Nepal over the past decade are reflected in significant declines in infant, child and maternal mortality. There has also been a remarkable improvement in levels of nutrition, particularly for the Millennium Development Goal (MDG) indicator for hunger, as the proportion of underweight children (defined as weight for age less than -2SD) aged under five years has declined from 43% in 2001 to 29% in 2011. Women's nutritional status has also improved as the proportion of underweight women of reproductive age (defined as having a body mass index [BMI] of less than 18.5 kg/m²) has decreased from 26.7% in 2001 to 18.2% in 2011.

Despite these achievements, malnutrition rates in Nepal, especially chronic undernutrition, remain among the highest in the world. Stunting currently stands at 41% among children under five years of age. Another concern is that 35% of all women are anaemic. Though this represents a decline over the past ten years, it is still high. The rate is even higher among pregnant women (48%) and breastfeeding women (39%) as compared to non-pregnant and non-breastfeeding women (33%). This is most probably due to the high demand for iron and folic acid, especially during pregnancy according to NDHS 2011.

Efforts to address malnutrition need to be intensified in order to achieve MDG 1 of eradicating poverty. Central to the achievement of MDG 1 is the ability to secure adequate nutrition for women, especially prior to and during pregnancy and while breastfeeding, as these periods have important implications on women's health, pregnancy outcomes and child survival and growth. The risk of complications during birth, including foetal mortality, is higher among women of short stature. Similarly, anaemia poses a five-fold increase in the overall risk of maternal death related to pregnancy and delivery. Furthermore, studies have shown that poor nutrition is associated with increased rates of pre-term deliveries and low birth weight. A low birth weight baby is more likely to be stunted by the age of 2 years, which may prove difficult to reverse, and there is substantial epidemiological evidence that children who suffer such damage have lower educational achievement, reduced adult income, short stature as adults and babies of lower birth weight. The inter-generational cycle of undernutrition then continues. They are also at increased risk of nutrition related chronic illnesses such as diabetes, obesity and cardiovascular disease later in life¹. Additionally, the impact of undernutrition, including anaemia, on a pregnant woman affects her health and well-being as well as her capacity as a mother and a worker. Yet, like many other developing countries, maternal nutrition has received inadequate attention in Nepal. The burden of malnutrition among women has not been well documented and the strategies, approaches and programme options for improving the nutritional status of women have not been clearly defined.

Current Situation in Nepal

Maternal malnutrition remains an important challenge in Nepal. At the national level, 18.2% of non-pregnant women are undernourished or chronically energy deficient (Body Mass Index [BMI] <18.5kg/m²) and 14% are overweight or obese according to NDHS 2011, an increase of 5% since 2006. At

¹Victora CG, Adair L, Fall C, Hallal PC, Martorell R, Richter L, *et al.* for the Maternal and Child Undernutrition Study Group. Maternal and child undernutrition: consequences for adult health and human capital. *Lancet*. 2008;371:340-57.

particular risk for chronic energy deficiency are adolescent girls (15-19 years), women living in the Terai, western mountains and Far-western Region, women with no formal schooling and women from the lowest wealth quintiles. Women who are most likely to be overweight or obese are older, come from the highest wealth quintiles and live in urban areas. The prevalence of both underweight and overweight among women is indicative of a potential double burden of malnutrition in the country and the need for the health system to incorporate the prevention and treatment of diet related non-communicable diseases such as diabetes in addition to reducing undernutrition and infections.

Women in Nepal are generally of short stature. According to the NDHS 2011, 12% of women in Nepal are less than 145 cm. Risk factors for short height include living in a rural area, having limited schooling and coming from the lowest wealth quintiles. In terms of aetiology, short stature is a likely consequence of the high prevalence of stunting in childhood. Babies who grow poorly and become stunted are likely to continue being stunted, thus perpetuating the intergenerational cycle of malnutrition in the population.

Adolescent girls (15-19 years) in Nepal fair worse. 25.8% of adolescent girls have a low BMI (<18.5 kg/m²) compared to only 18.2% of women of reproductive age. There was no clear trend in low BMI for adolescent girls between 2001 and 2006 and data showed an overall increase of 3% during this period. However, between 2006 and 2011, the rate remained more or less stagnant with 26.3% in 2006 and 25.8% in 2011. This slight decrease is low compared to the 6% reduction in older women during the same time period.

Similarly, the prevalence of anaemia among adolescent girls has remained stagnant at around 39% over the last five years and the NDHS findings from 2006 and 2011 both reported a higher rate of anaemia in adolescent girls than in non-pregnant women. The NDHS 2011 found anaemia among one in three women of reproductive age (35%), with the prevalence having declined by only 1% since 2006. Anaemia rates were also higher among pregnant women (48%) and lactating women (39%) compared to women who were neither pregnant nor lactating (33%). In addition, the anaemia rate among pregnant women increased by 6% between 2006 and 2011 (Table 1). The current rates of anaemia in all groups of women are above the WHO thresholds for moderate ($\geq 20 - 39\%$) and severe ($\geq 40\%$) public health problems.

Table 1: Prevalence of anaemia among women in Nepal in 2006 and 2011 (NDHS 2006 and 2011)

	Prevalence of Anaemia (%)	
	2006	2011
Pregnant women	42.4	47.6
Breastfeeding women	40.3	38.9
Non-pregnant women	28.5	33.0
Adolescent girls	39.0	38.5

The figures above mask important differences. For example, women living in rural areas and those living in the Terai are more likely to be anaemic than women residing in urban areas, hills and mountains. Neither wealth quintiles nor the level of schooling appears to exert a large influence on the risk of anaemia.

Apart from “On Anaemia”, no nationally representative recent studies have been conducted to assess micronutrient deficiencies among Nepalese women. With only a few localised micronutrient studies available, the prevalence of deficiencies is difficult to estimate. Like most developing countries, the bulk of anaemia among women in Nepal is perceived as the result of iron deficiency. A study by Dreyfuss et al. (2000) found anaemia in 73% of pregnant women in the Terai, with 88% of these cases resulting from iron deficiency. In Bhaktapur district, an urban area within the Kathmandu valley, iron deficiency (plasma ferritin <15 µg/l) was found among 20% of relatively healthy non-pregnant women aged 13–35 years (Chandyo et al. 2007).

According to WHO’s definition, vitamin A deficiency may still be a public health problem among women in Nepal despite intensive efforts to address it over the past two decades. The NDHS 2006 reported that 5.2% of women suffered from night blindness during their last pregnancy which is a substantial decline from the 16.7% reported in the 1998 Nepal Micronutrient Status survey (the NDHS 2011 did not report on night blindness among women). This survey also found that 16.6% of Nepali women were vitamin A deficient (serum retinol concentration <0.70 µmol/l) and a study among women in the Terai by Dreyfuss et al. (2000) found that vitamin A deficiency affected 54% of pregnant women in the survey area.

The NDHS 2011 found 80% of Nepali households to be using salt that was adequately iodized which is slightly lower than the 90% coverage required by WHO for national salt iodization programmes to be on track to eliminate iodine deficiency. However, these numbers mask large differences in coverage. For example, while 92% of women living in urban areas had (tested) iodized salt in the home, only 73% of women living in rural households had iodized salt. Other risk factors for low coverage include residence in the Far-western region, no schooling and low wealth quintiles. 55% of women from the lowest wealth quintile had household access to iodized salt compared to 97% of women from the highest quintile.

No national data is available regarding the status of zinc among women in Nepal, however regional studies suggest that zinc deficiency may be significant. Zinc deficiency was reported among more than three quarters (78-90%) of urban non-pregnant women in Bhaktapur district by Chandyo et al. (2009). A previous study by Jiang et al. (2005) found 61% of pregnant women in areas of the Terai to be zinc deficient. Vitamin deficiencies were also found in this same population of pregnant women (vitamin A-7%, vitamin E-25%, vitamin D-14%, vitamin B2-33%, vitamin B6-40%, B12-28% and folate-12%), a further indication of the potential for multiple micronutrient deficiencies.. There is paucity of information on the extent of the problem of calcium deficiency among women in Nepal.

Annex 4 – Increasing access to, and use of, Safe Abortion Services

A Report from International Pregnancy Advisory Services (IPAS)

SUMMARY DOCUMENT

IPAS was tasked to carry out the following piece of work under the maternal and neonatal health thematic area of the programme:

Purpose

To increase access to, and use of, safe abortion services including Comprehensive Abortion Care (CAC) and post-abortion contraception for underserved and unreached populations in Nepal, based on learning from trials in two remote districts (Myagdi and Kalikot) by August 2013.

Objectives and activities conducted

- 1. Improve CAC services (manual vacuum aspiration, medical abortion and post-abortion contraceptive service) available in four health facilities (two hospitals and two PHCs) in two remote districts (Myagdi and Kalikot) by August 2013 by providing trained physicians and auxiliary nurse midwives (ANMs) to serve as CAC service providers.**

In March 2012, a baseline assessment was conducted in four health facilities (one hospital and one PHC in Myagdi and Kalikot districts) to evaluate whether they met minimum requirements for providing CAC services and if they had healthcare providers who would be eligible for training as CAC providers. After assessing the facilities physical and trainings needs, supplies were made available to equip them for CAC service. Twelve providers (one doctor and eleven nurses) received CAC training in April 2012, exceeding the project target of nine providers. In August 2012, eight nurses (four local and four external) participated in a two-day workshop to become clinical mentors to CAC providers which was facilitated by IPAS in coordination with FHD and NHTC. Each of the twelve trained CAC providers in the two districts were visited twice by clinical mentors who performed clinical assessments based on skill demonstrations. However, the clinical mentor from Dhangadi assigned to visit Kalikot PHC did not visit her site and a local mentor replaced her. All activities were conducted as planned and targets were achieved. The CAC training exceeded its target but there is demand for more because of high staff turnover, especially in Kalikot district.

Outcomes: End line findings in August 2013 showed that a 75% target was achieved for output one: three out of four health facilities (one hospital and one PHC in Myagdi district and one hospital in Kalikot district) are providing quality CAC services. However, despite training and health facility upgrading in Kumalgaun PHC in Kalikot district, CAC service is not available due to the transfer of all trained staff to Jumla district.

2. Increase women's access to safe abortion in remote districts by training ANMs to provide MA and establishing MA only service points (health posts that provide medical but not surgical abortion) in seventeen health posts in two remote districts (Myagdi and Kalikot) by August 2013.

A baseline assessment was conducted in sixteen health facilities in Myagdi (eleven health posts and five sub-health posts [SHPs] and fourteen in Kalikot (thirteen health posts and one SHP) to assess their potential for providing MA only services and to identify healthcare providers who would be eligible for training. This exceeded the target of seventeen health posts as all the birthing centres in the district were potential MA sites. Eventually, seventeen health posts were selected based on DHO recommendations and supplied with the minimum requirements necessary to provide high quality MA services. Twenty eight eligible providers (seventeen from Myagdi and eleven from Kalikot) received five days of MA only training at one of three training sites (Dhaulagiri zonal hospital, Baglung hospital and Tikapur hospitals). This exceeded the project target of nineteen providers. Four trained clinical mentors (two from Myagdi hospital and two from Kalikot hospital) visited the twenty eight trained ANMs, with each ANM receiving two visits, one of which was within four months of training. All the activities were conducted as per plan and targets were met as described above. However, there is more demand for MA training in both the districts.

Outcomes: End line findings in July 2013 confirmed that a 76% target (thirteen health posts out of a total of seventeen [Myagdi: seven out of nine and Kalikot six out of eight]) was achieved in providing MA only services in the remote communities of these districts. MAs were not available in four health posts because of the transfer of trained providers.

3. Improve women's reproductive health care in two remote districts (Myagdi and Kalikot) by improving the capacity of FCHVs to properly refer women for FP, ANC and CAC services.

A programme facilitated by IPAS in collaboration with FHD and two DHO/DPHOs was conducted to train FCHVs for early detection of pregnancy and referrals. A total of sixty eight participants (thirty six health facility in-charges, service providers and district supervisors from Myagdi and thirty two from similar cadres from Kalikot) attended two days of training. The trained trainers in turn provided two days of training for FCHVs in all VDCs of their districts, covering a total of 659 FCHVs (369 in Myagdi and 290 in Kalikot), twenty nine more than originally planned. The training focused on skills for confirming pregnancy using the urine pregnancy test, legal provision of safe abortion, family planning, referral for ANC and recording and reporting. Each FCHV received a bag containing a visual counseling flip chart, pregnancy testing kit, referral cards and a safe abortion leaflet. The DHO/DPHOs, medical recorders and public health nurses (PHNs) monitored seven batches of training in Myagdi and eight in Kalikot and provided feedback on improvements needed. The resupply of urine pregnancy testing kits was

addressed by linking the PHNs with a supplier in Kathmandu. All the activities were conducted as per plan and targets were met as described above. However, because of the remoteness of the districts, data were not received on a monthly basis.

Outcomes: This outcome was not included in the end line evaluation. Therefore, for data collection purposes, routine HMIS-11 was used and it was found that during the eighteen month project period (Mar 2012 - Aug 2013) a total of 4,204 regional health referrals (Kalikot: 2191 and Myagdi: 3484) were made by the 659 trained FCHVs. These referrals could not be accurately determined as they were not validated at the health facilities since there was no provision for this in the project. However, it is known from the IPAS mid-line assessment carried out in December 2012, that FCHVs are the first contact person for any health related information in Kalikot district but in Myagdi clients prefer mixed sources for information.

4. Improve CAC services for women throughout Nepal by improving the capacity of district health teams to monitor the services.

The HMIS section chief and his team at the DoHS were oriented on the project which enabled them to act as resource persons for orientation sessions in Myagdi and Kalikot districts. The sessions covered policy on the legal provision of safe abortion services and tools for recording and reporting (HMIS-11, FCHV reporting format and MA quality assessment related forms). There were sixty eight participants (thirty six from Myagdi; thirty two from Kalikot) including DHO/DPHOs, PHNs, supervisors, medical recorders, district statisticians, in-charges and ANMs from health posts and PHCs. Due to limited HR in FHD, the PHNs from the two districts conducted monitoring visits rather than FHD staff as planned. However, debriefing on the status of safe abortion services was done in Kalikot and the CAC site was shown to the FHD director when he visited the district who ensured the minimum requirements and other supply needs were addressed and solved internal issues resolved. Monthly district level meetings took place between December 2012 and April 2013 (four in Myagdi; five in Kalikot) to discuss gaps and problems identified in the HMIS-11 safe abortion logbook. A midline assessment was undertaken in March 2013 and will be followed by an end line evaluation. Data from HMIS-11 are received at the centre. However, there are frequent communication problems due to network related issues, the remoteness of the area and geographical difficulties which result in data not being received on a regular basis. Dissemination was done at the central level at the Technical Committee for Implementation of Comprehensive Abortion Care meeting and will be done at the regional level during the regional review to be conducted in October 2013.

Outcomes: Although 590 clients in Myagdi and 292 clients in Kalikot were served during the eighteen month project period (Mar 2012-Aug 2013) when the district level meetings to review the HMIS-11 log book were organised, it was felt that this was not contributing sufficiently to the strengthening of the health system because the monitoring of safe abortion services is not integrated with the national monitoring system and is always left aside unless the centre intervenes.

Deliverables: One end line report will be submitted by the third week of September 2013 and the dissemination of the findings will be done at the regional level (Surkhet and Pokhara) to coincide with the government regional review as all the concerned stakeholders will be available at that time.

5. Introduce a model for strengthening the post abortion family planning counselling received by women by improving contraceptive counselling skills of CAC providers in Kathmandu Maternity hospital. Use the findings to scale this up throughout Nepal.

A baseline assessment was conducted to assess CAC providers' knowledge and skills in contraceptive counselling. Twenty providers were interviewed using a questionnaire and five counselling materials were reviewed and updated in line with the national medical standard volume-1. The drafts were finalised after consultations with service providers. Pre-testing of the new counselling tools was carried out after orienting providers (seven nurses, one matron and thirteen doctors) on how to use them, which included addressing gaps in skills and knowledge identified during the baseline assessment. Pre-testing took place between October and December 2012 with close monitoring, supervision and feedback meetings. After pre-testing and feedback, a final orientation on the training tools was provided in December 2012, with fourteen participants (six nurses and eight doctors). The tools were implemented from January 2013 starting with an assessment of the providers' counselling skills. In April 2013, eighty three client exit interviews were conducted. The HMIS-11 data was analysed to assess changes across three phases: baseline (July-Sep 2012), pre-intervention (Oct-Dec 2012) and intervention (Jan-May 2013). One dissemination workshop was conducted in the Maternity Hospital in Kathmandu in early August 2013 to share the findings. Implants have been made available at the CAC site in the Maternity Hospital since this time.

Outcomes: All the activities and objectives were met at the Maternity Hospital. However, a national level guideline cannot be produced based on the findings of one hospital only. During the dissemination, a FHD representative suggested that MA ANM providers in health posts use the same counselling strategy guide.

Deliverables: The draft BCS trainer's guidelines in Nepali language will be submitted by the end of October 2013 and will be used in five more districts before being finalised for the national level scale up.

6. Improve Nepalese women's and men's knowledge about abortion services by providing TA to NHEICC to implement an Information, Education and Communication (IEC) and BCC strategy that raises awareness about safe abortion options in Nepal.

An IEC and BCC subcommittee already existed under NHEICC but was no longer active. In August 2012 it was reactivated under NHEICC leadership and other partners became involved. To date, four meetings have been held. The scope of work agreed includes quarterly meetings, standardisation of safe abortion messages, development of a safe abortion IEC and BCC advocacy plan and the materials needed, provision of technical support and suggestions regarding safe abortion. There is now continuity of this work stream and meetings are being held regularly. In collaboration with NHEICC, a formative/process assessment was undertaken by a consultant in Myagdi and Kalikot districts in order to understand what works, or does not, and what are the preferred methods and options available in these two districts. Information was gathered in selected VDCs through in-depth interviews with key informants and focus

group discussions with women which looked at three broad areas: availability of communication means and services at community level; knowledge and awareness on abortion and increasing access to safe abortion services. As per the recommendation of this assessment, street drama, documentary screening, orientation of social mobilisers and airing of radio spots was done in Myagdi. Interaction programmes in mother's groups and value clarification orientation was done in Kalikot. In coordination with NHEICC and external partners, district specific information was used to prepare district level IEC and BCC guidelines which will be ready in mid-September 2013.

Outcomes: All the objectives were met and assessment findings used to develop district based IEC and BCC implementation guidelines as a part of national IEC and BCC strategy.

Deliverables: The IEC and BCC guidelines are almost in their final stages and will be ready by mid-September 2013.

Overview of the Safe Abortion Program in Nepal

Initiation in Nepal:

Abortion services were legalised in Nepal in 2002 and began in 2004. There has been significant progress in increasing access to safe abortion services since 2004. Under the leadership of FHD/DoHS, along with the Technical Committee for Implementation of Comprehensive Abortion Care (TCIC) partners, IPAS has been instrumental in expanding safe abortion services in Nepal.

By 2008, with the joint efforts of TCIC partners, safe abortion services were made available through the MVA (Manual Vacuum Aspirator) technique in district headquarters of all 75 districts of Nepal. The majority of service providers of this procedure were physicians and service was limited to urban areas. Women residing in remote and hard to reach areas were unable to exercise their reproductive rights. This huge gap led the MoHP to approve an evidenced-based National Medical Abortion Scale Up strategy in 2009. Under this strategy MA began to be provided at periphery level health facilities including health posts and primary health care centres by trained skilled birth attendant trained auxiliary nurse midwives. A rigorous evaluation was conducted to assess the quality of MA services provided by ANMs. Findings suggested that MA provided by the trained ANMs at periphery level health facilities was consistent with the standard defined by the national MA protocol. Complications rate were found to be below 0.1%, and the percent of post abortion contraceptive was above 80%.ⁱ With technical support of IPAS, FHD/TCIC scaled up this approach in 21 districts of Nepal by the end of 2013.

The following strategies have been considered as best practice for SAS scale up:

- **Task shifting:** Mid-level providers (auxiliary nurse midwives and staff nurses) from PHCs/HPs eligible as per National Safe Abortion Implementation Guidelines are trained for MA and MVA (first trimester safe abortion service), while Obygns and MDGPs are trained for specialised skills (second trimester safe abortion service). This approach enables the safe abortion program to use available human resources cost-effectively and at the same time increase access to safe abortion services.

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- **Post training support:** It was learnt that post training support (clinical and programmatic) is critical for service providers. For this purpose DPHO teams with the approximate capacity of 15 members (1 PHN, 3-4 clinical mentors and 8-10 health facility in-charges) per district were developed to provide quality and needs-based support to all trained providers in their district. IPAS' routine monitoring findings revealed that each year 60-80 providers from 40-60 health facilities were trained and on average each received two in-person visits, The needs were mostly related to management and were addressed either by PHN from the district or locally by the health facility in-charges and followed by clinical coaching/mentoring. Twelve months' tracking data on trained providers confirmed that post twelve month training 80% of the trained providers were found to be actively providing services while 85% sites were functioning. Two QI related tools - Client Oriented Provider Efficiency (COPE) and monitoring severe abortion related complications - have been used in selected health facilities.ⁱ
 - **Community intervention to increase awareness on SAS among women and youth:** There are three main community-based interventions that were implemented for creating awareness, and strengthening referrals. They are: (i) FCHVs training in early pregnancy detection and timely RH referral, (ii) mobilization of the Women Development Office (WDO) social mobilizer, and (iii) the radio program "Dojiya". In 2012 a follow up study was conducted in Dhading district to assess the performance of trained 367 FCHVs and the findings revealed that 90% of the FCHVs had performed at least one Uterine Pregnancy Test (UPT) since training and referred women for appropriate maternal health care (Family Planning, Antenatal Care or Safe Abortion). They had also discussed about Safe Abortion Service (SAS) in mother's group meetings.
 - **Monitoring quality:** Quality of safe abortion service provided (by site and provider) has been monitored using the existing HMIS system. Four indicators are used to assess quality: (i) appropriate technology, (ii) % of women who had pain management, (iii) % of women with post abortion contraceptives and (iv) % of women with complications due to induced abortion. The findings from 255 health facilities suggested that 21763 women have already received safe abortion service by 423 trained MA providers in 21 districts. About 75% of the 21763 women received medical and 25% received surgical safe abortion service. Furthermore approximately 83% had accepted post abortion contraceptives, 100% used appropriate technology, 100% received pain medication for the abortion care and only 5 women (0.02%) had severe complications (with severe bleeding requiring blood transfusion and infection requiring IV antibiotics).
 - **Clients perceived quality:** Client exit interviews were undertaken in 2012 with 142 clients and in 2013 with 119 clients. The findings suggested that the majority of the clients received information on safe abortion from their friends and family, followed by FCHVs who were ranked as number one for where to get a safe abortion, followed by the family/friends and others. Hence, the findings suggested that the trained FCHVs are playing a key role in referrals from the community to the safe abortion health facilities. When asked about their levels of satisfaction it was found that nearly 80% of clients were happy with the service quality that they received.ⁱ

Ministry of Health and Population's Target:

The government of Nepal has included safe abortion services as a part of reproductive health services and also considers it as a component of the essential health care service package. In addition GoN has committed to increase access to safe abortion services among poor and disadvantaged populations in remote locations who currently lack effective access (NHSP-II, 2010-2015, page 22). GoN has set the following targets under NHSP-2, 2010-2015.

Indicator	Baseline Year	Target		
		2010/2011	2013	2015
% knowledge of safe abortion sites	19% (2006)		35%	50%
% knowledge of safe abortion legalisation	50% (2006)		60%	75%
Abortion complications	14% (2009)	14%	10%	7%

Source: Ministry of Health and Population, NHSP 2, 2010-2015

Major Achievements:

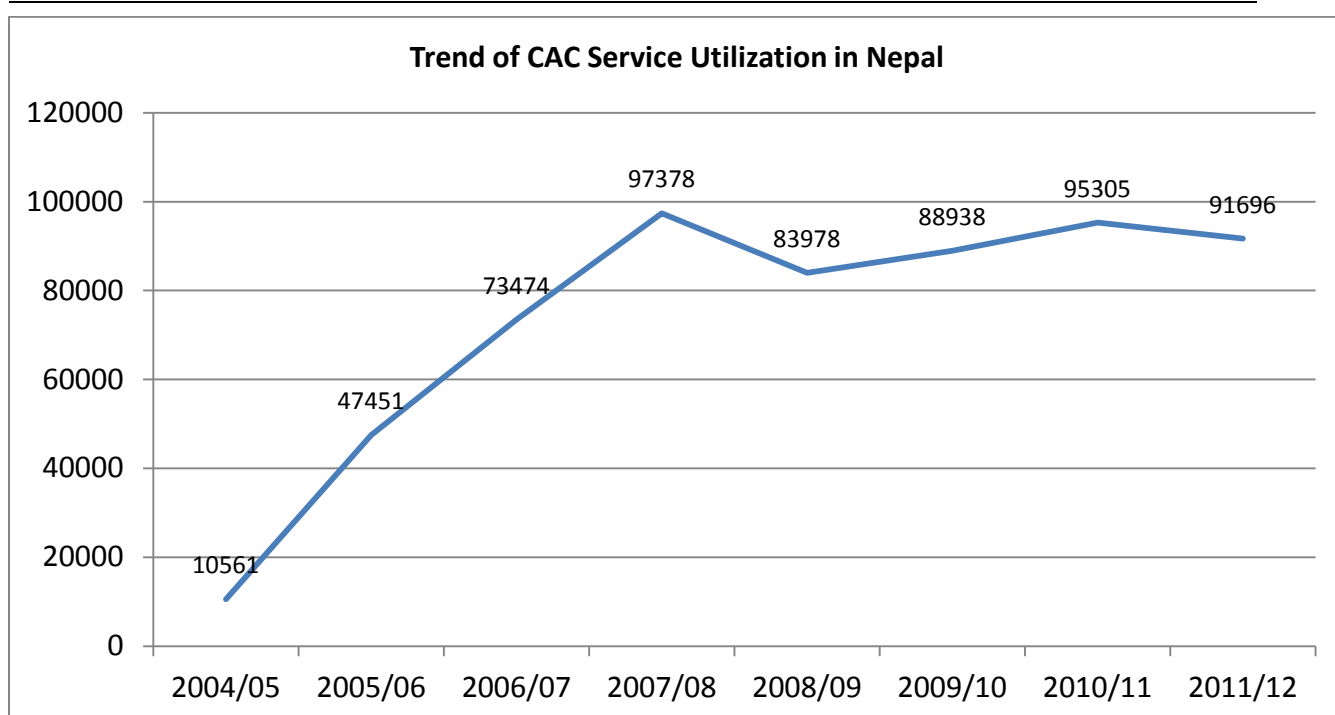
During this reporting period under the leadership of FHD and support provided by IPAS, two policy related documents were developed: the National Medical Abortion Scale Up Strategy in 2009, and Comprehensive Abortion Care Implementation Guidelines, 2012.

Safe Abortion Services through MVA have already been scaled up in all 75 districts (district hospital and selected PHCs). As of June 2013, MA service was available in 254 health facilities of 21 districts. In addition, second trimester abortion services are available in 20 referral hospitals. Safe abortion services are also widely available through private health facilities and medical shops, but the legality of these services is uncertain.

Ecology	No. of SAC sites		
	Ist Trimester	2nd Trimester	Medical Abortion
Mountain	27	0	27
Hill	160	11	160
Terai	144	7	144
Total sites	331	18	331

Source: Family Health Division/Department of Health Services, June 2010

Between 2004 and June 2013 about 588,781 women received safe and legal CAC services by 1764 trained providers working in 634 listed facilities.



Source: Reproductive Health 2012, 9:7: Implementation of Legal Abortion in Nepal: A Model for Rapid Scale-up of High-Quality Care

Issues/Challenges

- Nearly two thirds of women (62 percent) are not aware that abortion is legal in Nepal. Most of them are poor, illiterate and from rural areas according to NDHS 2011.
- Medical abortion is available at periphery level health facilities only in 21 districts of Nepal. This service should be scaled up in Nepal's remaining 54 districts.
- Cost barrier: women are paying 1000 NPR for MVA and 500 NPR for MA while no payment is required for other RH services (ANC, delivery, PNC and FP). The poorest, marginalised and hard to reach women thus experience a barrier to access safe abortion services and tend to opt for unsafe methods.ⁱ
- In the absence of an abortion Act, to date the Civil Code Amendment is the main guiding document for safe abortion services.
- Limited availability of long acting reversible contraceptive methods leads to limited choice of FP methods by abortion clients.
- Due to the long administrative procedure, the purchase of the MA drug is often interrupted and not fully integrated with LMD's logistic supply system.
- MA services have become widely available by unskilled providers and in unlisted sites through medical shops. This has created an unnecessary burden for women. For example, more than three quarters of patients with severe post abortion complications recorded at referral hospitals (for example Kailali Zonal Hospital) are found to have taken the MA drug from medical shops.

Recommendations:

- Develop a five year (2015-2020) National Safe Abortion Plan which will include a strategy to scale up MA services in all 75 districts of Nepal. In addition, this plan will include plans and costing for:
 - Training for service providers
 - IEC/BCC approaches and materials
 - Quality assurance of services
 - Monitoring and use of data
 - Supply of MA drugs and other essential supplies
- Produce evidence based strategies to provide quality safe abortion services through medical shops.
- Integrate safe abortion service costs into the Aama Surakchya Program.
- Develop a Safe Abortion Act and have it approved by GoN.