Project Completion Review - Top Sheet

This Top Sheet captures the headlines on the programmes performance over the course of its lifetime. Teams should attach summary sheets from each annual review over the life of the programme.

Review Date:	**14 August 2017**

Title: Transition and Recovery of Nepal's Health System		
Programme Code: 203413	**Start Date: 30 June 2015**	**End Date: 31 May 2017**
If programme was closed >1 month early please describe in a few words why.		

Summary of Programme Performance

Year	**2016**	**2017**
Programme Score	**A**	**A**
Risk Rating	**Moderate**	**Moderate**

Financial Position

Original Programme Value	£10,000,000 plus £353,000 co-financing by USAID
Extensions/ amendments	End Date extended from July 2016 to May 2017 with cost extension of up to £850,000
Log-frame revisions (with dates)	Original: July 2015, revised in October 2016
Total programme spend	£10,691,924 (not including £33,714 design costs)

Follow up actions required following closure

1. **For DFID:** in order to fast-track the mobilization of support in case of emergencies in disaster-prone countries, to consider the inclusion of an earmarked budget allocation to respond to disaster situations in all health sector operations. Such budget could be re-allocated before programme closure in case no emergencies arise.
2. **For DFID:** given the familiarity and success of the combined Financial Aid and Technical Assistance aid modality in Nepal, both in the regular support to the health sector and the earthquake response programme, a similar aid modality should be considered for future disaster recovery and relief operations.
3. **For MoH and DFID:** to limit the number and severity of permanent disabilities resulting from spinal cord injuries during future earthquakes, ensure that a public awareness campaign is launched on the safe transport and correct referral process of people possibly having injured their spinal cord. Such campaign should be targeted at the public, rescue workers, para-medical personnel and health workers. This action would also reduce the risks for people injured during other accidents, especially in road traffic accidents and accidents in the construction sector[1].
4. **For the TA team:** to continue monitoring the progress and quality of the unfinished infrastructure work initiated under the programme.
5. **For MoH and DFID:** to maximize the durability of the infrastructure financed under the programme, permanent as well as semi-permanent (the pre-fabricated structures), advocate with the National Planning Commission and the Ministry of Health for a reasonable budget in the Annual Work Plan and Budgets for maintenance.
6. **For DFID and TA team:** to elaborate a module for the prevention of gender-based violence and physical abuse (e.g. awareness and anger management counselling) to be used in the immediate aftermath of possible future earthquakes or other disasters.
7. **For DFID and the TA team**: in order to be able to again respond effectively in case of any future disaster, to engage with the government and other External Development Partners (EDPs) on changing disaster preparedness modalities as the devolution in Nepal evolves and changes in decision making, operational structures and procedures, and communications channels materialize. For instance, the role

[1] Such a campaign could be conducted by MoH in close co-operation with the Spinal Injury Rehabilitation Centre as a lesson learned from the earthquake with wide coverage in national media.

of the District Officer of Health may change under the upcoming provincial structure and support to her/his office may have to be re-directed to provincial and/or municipal structures.

8. **For MoH, DFID and External Development Partners:** to build on progress made in mental health in terms of the institutional arrangement, treatment protocols and people trained in both the diagnosis and treatment of mental health problems and provide resources for its sustainability and scale-up.

List of Acronyms			
ANC	Antenatal Care	HTRP	Health Transition and Recovery programme
BEONC	Basic Emergency Obstetric and Neo-Natal Care	JAR	Joint Annual Review
CEONC	Comprehensive Emergency Obstetric and Neo-Natal Care	JFA	Joint Financing Arrangement
DFID	Department for International Development	mhGAP	Mental Health Gap Action Programme
DHO	District Health Officer	MoH	Ministry of Health (formerly Ministry of Health and Population)
DoHS	Department of Health Services	NFPP	National Family Planning Project
EDPs	External Development Partners	NHSP-1/2/3	Nepal Health Sector Programme 1/2/3
EHCS	Essential Health Care Services	NHSS	Nepal Health Sector Strategy 2015-2020
EQ	Earthquake	OAG	Office of the Auditor General
FA	Financial Aid	OCMCs	One Stop Crisis Management Centres
FCA	Foreign Currency Account	PFM	Public Financial Management
FMIP	Financial Management Improvement Plan	SBA	Skilled Birth Attendant
FMR	Financial Monitoring Report	SIRC	Spinal Injuries Rehabilitation Centre
FRA	Fiduciary Risk Assessment	SWAp	Sector Wide Approach
FY	Financial Year	TA	Technical Assistance
GAVI	Global Alliance for Vaccines Initiative	TABUCS	Transaction Accounting and Budget Control System
GBV	Gender Based Violence	TPO	Transcultural Psychosocial Organisation
GESI	Gender, Equity and Social Inclusion	UNICEF	United Nations Fund for Children
GIZ	German Technical Cooperation	UNFPA	United Nations Fund for Family Planning & Population
GoN	Government of Nepal	USAID	United States Overseas AID Programme
HI Nepal	Handicap International Nepal	VfM	Value for Money
HMIS	Health Management Information Systems	WB	World Bank

A. Introduction and Context

DevTracker Link to Business Case:	https://devtracker.dfid.gov.uk/projects/GB-1-203413/documents
DevTracker Link to Log frame:	https://devtracker.dfid.gov.uk/projects/GB-1-203413/documents

Outline of programme and what it has achieved

In April and May 2015, there were a series of catastrophic earthquakes and aftershocks in Nepal that resulted at an estimated 8,702 deaths, over 22,000 people injured, extensive damage to health infrastructure and referral systems and a major shock to health care delivery systems. Many of those injured suffered fractures, amputations and other serious injuries and needed ongoing care and rehabilitation. Stronger support services were also required for the people suffering from psychological trauma. Re-establishing a functioning health service was essential in order to deal with any localised outbreaks of disease, and to ensure that day to day health needs, were met. The health needs of women and girls were also flagged as a priority, including safe maternity and family planning services and prevention of gender-based violence (GBV).

The Health Transition and Recovery Programme (HTRP) was developed and agreed with Government of Nepal and donors, to restore health services in the 31 earthquake affected districts, with an emphasis on the 14 worst affected districts with a particular focus on three hard hit districts - Ramechhap, Dolakha and Sindupalchowk - aiming to: a) repair damaged Government health facilities; b) re-establish vital hospital and primary health care services, including immunisation, safe delivery services and family planning; c) provide additional support for rehabilitation, physiotherapy and psycho-social support services; and d) establish a tracking system to ensure that resources are available on time and used appropriately by those who need them.

The DFID programme initially provided up to £10 million over a 12-month period to ensure that the delivery of essential health services would continue or be restored as quickly as possible. Approximately £6 million was to be provided in the form of earmarked financial aid to the Health Sector Integrated District Health Programme (IDHP) budget line to support District Health Offices in up to 31 earthquake affected districts. The remaining £4 million was to support a combination of service contracts to provide rehabilitation, physiotherapy and psycho-social support services and technical assistance (TA) to track implementation and enhance the delivery of the earmarked financial aid (FA) and its assurance. An additional £353,000 was provided by USAID for the implementation of Family Planning activities, delivered through the HTRP TA, resulting in a total budget of £10,353,000 over the 12 month period.

Given the humanitarian context and need for rapid mobilisation of support, the TA and service delivery was procured through a single source contract with the existing health TA service provider for DFID's National Health Sector Programme II, Options Consultancy Services, partnering with Oxford Policy Management (OPM), HI Nepal, TPO and SIRC. The contract was output-based with a total of 51 output deliverables-aligned to the DFID HTRP log frame.

HTRP's implementation plan was approved by MoH on 2nd September 2015. Later that month Nepal's new Federal Constitution was approved but protests related to new state boundaries and ethnic representation led to a five-month unofficial blockade and a fuel crisis. This impacted on the delivery of the programme, most notably concerning the progress against the infrastructure objectives. These difficulties eased around March 2016 allowing the pace of programme implementation to increase. A no-cost extension was provided up end Oct 2016, including for HI Nepal, TPO and SIRC. At the same time approval of the Nepal Health Sector Programme 3 had been delayed, partly due to the earthquake, with a subsequent knock on affect for the procurement of the new TA suppliers. To ensure continuity in embedded TA at such a critical time, a costed extension of up to £850,000 until end March 2017 was agreed, with an additional 12 payment deliverables.

The HTRP outcome and output indicator results indicate that the programme has been successful. The restoration of a functioning health delivery system has been swift and impressive as demonstrated by health care utilization statistics. The programme played a major role in the progress towards repairs, reconstruction and improved standards regarding the health sector's physical infrastructure. The provision of rehabilitation, physiotherapy and psycho-social support services responded to a significant demand

however sustainability of the interventions may be negatively impacted due to the limited implementation timeframe. The quality assurance of the interventions in all areas has been satisfactory with a range of experts assessing the quality and providing guidance.

Stakeholders in the sector asserted that the earmarking of financial aid through the programme did not create distortions. The Financial Aid modality, providing funds to districts through government channels, gave the programme and the TA a justification, legitimacy and significant leverage to be involved in systems strengthening, budget allocations and policy dialogue. In the absence of this modality, it is likely that the MoH may not have been able to implement a number of system/policy initiatives such as financial management improvements though the roll-out of Transaction and Budget Control System (TABUCS) and the Financial Management Improvement Plan (FMIP), the support to the elaboration of the Consolidated Annual Procurement Plan (CAPP), the strengthening of the Health Information Management System (HMIS), the support for the Gender, Equity and Social Inclusion and social audits, and the policy dialogue and progress on the use of Visiting Providers, the mental health programme and the level of coordination of external partners, particularly related to infrastructure.

B: PERFORMANCE AND CONCLUSIONS

Overall Outcome Assessment

The overall outcome is assessed as not having fully achieved the expected outcomes by the end of the programme as one outcome target on health care utilization was significantly exceeded while two other outcome targets were not achieved as per the following table:

Outcome Indicator	Target (March 2017)	Comment
1. Number of women and girls utilizing delivery services from a trained health worker	70,000	**Achieved and exceeded:** 90,648 women and girls had utilized delivery services from a trained health worker in the EQ affected 14 districts during the period July 2015 to February 2017 (Source: HMIS) Note: The service utilization data for the month of March 2017 is not reported to HMIS yet.
2. Number of injured patients receiving physiotherapy and rehabilitation services	3,500	**Achieved and exceeded**: a total of 6381 earthquake affected beneficiaries received support from HI Nepal and SIRC up to October 2016; of which 1351 were earthquake injured- 1,219 and 148 respectively (source: HI Nepal and SIRC).
3. Number of people receiving psychosocial support	10,000	**Target not achieved:** a total of 7,378 people with mental health/psychosocial problems received psychosocial support: 3,991 received psychosocial support from community psychosocial workers; 2,124 received mental health care from a health worker; 688 received counselling; 371 received specialised care; 4 were admitted and 200 with mental health/psychosocial problems were referred. An additional 6,895 participated in community based awareness raising sessions on psycho-social issues and 194 (target 120) prescribers trained on mhGAP HIG and 127 (target 120) non-prescribers trained on psychosocial support. In retrospect the target (10,000) is not considered realistic.

The programme has delivered additional achievements and outputs, in particular helping to rapidly restore the functionality of health services and support systems improvements. At the outcome level it also made some, limited, steps to building the capacity of the Nepal health system to improve mental health issues. Overall the evidence provided justifies an A rating for the programme rating.

The Financial Aid component and the provision of technical assistance, in particular, the employment of district coordinators in the three most affected districts, supported the districts in rapidly restoring the functionality of public health services. Data shows that by November 2015 the use of basic health services in the earthquake affected districts were at levels broadly similar to the national average[2]. The programme has made critical contributions to the planning and budgeting of required civil works through rapid and detailed engineering assessments of all health facilities in the 14 earthquake-affected districts, including structure, utilities and land ownership status.

Subcontracting NGO-delivered psychosocial and rehabilitation services through a well-established key supplier in Nepal has been an effective mechanism for DFID to provide rapid support in an emergency context where there are gaps in existing public health services. However, substantial support to the NGOs and quality assurance of the deliverables has been required from NHSSP. While undoubtedly the project has made steps towards strengthening capacity of the Nepal health system to address mental health issues, there have been significant challenges which have compromised the sustainability of this progress, including the short-length of the capacity building programme.

Financial Aid, backed by TA, has facilitated the Ministry of Health (MoH) to understand the importance of specific programmes and treatments and to include them in the annual work plan and budget[3]. FA has also been instrumental in assisting MoH to develop better systems of managing spending, notably through encouraging the adoption of a FM Improvement Plan (FMIP), with follow-up taking place through a joint

[2] HFS Final report, January 2017.

[3] Examples include: inclusion of psychotropic drugs in the list of free drugs, psychosocial counselling at district level, expansion of one stop crisis centres, a budget for TABUCS training, establishing of a separate entity oversee rebuilding/infrastructure related work.

donor-government finance committee. The expansion of the Transaction and Budget Control System (TABUCS)[4], facilitated by support from HTRP TA, has enabled the more efficient use of MoH funds by expanding its use into a tool used in budgeting and planning.

The focus of HTRP has been support to primary care services. This has clear equity benefits compared to support for secondary and tertiary health care services, given the increased difficulty for the population to access the latter services. The programme has focused on the most affected districts and on the most vulnerable members in the community - pregnant women and newborns, those with serious injury and those requiring psycho-social support.

Overall, the risk matrix as outlined in the Business Case was adequate and the mitigation measures appropriate and well followed. The governance and fiduciary risks, rated as high, were managed well through the active engagement in the Financial Management Improvement Plan, the Procurement Improvement Plan, the roll-out of TABUCS, annual fiduciary reviews and the follow-up of audit queries.

The programme complied with the requirements of the Gender Equality Act. . In the context of the Gender Equality and Social Inclusion (GESI) Strategy, Equity Monitoring was added to the regular HMIS data collection indicating that the increased demands on health services in highly affected and remote areas were managed well by the district response to the earthquake. However, pre-existing issues, such as lack of roads, transportation, availability of staff and drugs were amplified in the immediate aftermath of the earthquake, especially for remote populations.

Output Score and Description

The overall output score is assessed as A. The log frame lists 8 output indicators and targets of which 1 was significantly exceeded, 5 were achieved, 1 partially achieved and 1 not achieved but on track to do so (infrastructure works) by September 2017. Section C provides the details of the output indicators and the results achieved against them.

Remarkable achievements have been made despite delays incurred by force majeure, but the means of measuring these achievements has not been fully captured in the log frame. The most notable achievements include a) the swift assessment of the damage to the health sector infrastructure and equipment; b) the effective support to the MoH, both at central and district level, to coordinate the response from multiple agencies; c) the rapid restoration of health service delivery and utilization within three months after the earthquake through financial and technical assistance and through the mobilization of visiting providers and mobile teams for Family Planning; d) the roll-out of the Transaction and Budget Control System (TABUCS); e) and the initiation of much needed rehabilitation and psychosocial support services[5] and f) the support provided to policy development such as the implementation plan for the National Health Sector Strategy 2016-2020; adaptation of WHO's *Mental health Gap Action Programme Humanitarian Intervention Guide* (mhGAP-HIG) to the post EQ context, updating the free essential drugs list for psycho-tropic drugs and subsequent revision of the standard treatment protocols for psychiatric illness; and support to analysis, policy and planning for health sector governance and service delivery in a federal structure.

In the context of post-earthquake recovery, where specific needs emerge during implementation, the programme has shown that a flexible approach to output-based contracts is needed, allowing modification of deliverables to reflect ground realities.

Key Lessons

The Theory of Change outlined in the Business Case has remained relevant. Although a formal impact evaluation of this programme was not planned, there are numerous attempts to draw conclusions and

[4] Transaction and Budget Control System (TABUCS) infrastructure was restored in 31 districts; a specific module was developed for EQ affected districts to enable better data capture of EQ expenditures, and data entry clerks were supported in the three focal districts.

[5] The 2008/2009 Nepal Maternal Mortality and Morbidity Study revealed that suicide is the leading cause of death among Nepali women of reproductive age but limited progress had been made in the provision of psychosocial support services since then. HTRP changed that with the training of 938 cadres, the revision of treatment protocols and the revision of the essential drug list to incorporate second generation psycho-tropic drugs.

lessons learned from various aspects of programme design and implementation, including the external review of the programme through this PCR, several in-country lessons learned initiatives organized by the Ministry of Health and NHSSP, and the planned independent compilation of documentation of the experiences and lessons learned - forthcoming.

External verification and evaluation of some of the more innovative approaches, such as the family planning visiting providers and the employment of NGO implementing partners were planned, are either completed (the visiting providers initiative) or in progress (the employment of NGO implementing partners) and part of the lessons learned documentation.

Key lessons are:

Strategic level:

(1) The Financial AID modality, providing funds to districts through government channels, gave the programme and the TA a justification, legitimacy and significant leverage to be involved in systems strengthening, budget allocations and policy dialogue and this modality should be replicated whenever possible. In addition, the familiarity of this modality allowed a swift response with known mechanisms and largely known risks.

(2) A full technical damage assessment is essential to enable sound infrastructure planning and co-ordinated use of resources post-earthquake. It also achieves greater Value for Money as Rapid Assessment techniques from non-technical actors are not adequate, may lead to distorted allocations of scarce resources and has to be repeated to gain additional data for planning and budgetary purposes, thus creating additional costs and time delays.

(3) The perspectives of EDPs interviewed provide a very positive impression of the partnership between the government, the EDPs and the NHSSP TA team. This partnership has matured over many years and is in fact one of the reasons that the programme could respond quickly and effectively. Fundamental was the social capital built between the NHSSP TA team, the MoH and the EDPs that allowed for well-coordinated and well-designed support structures and processes. This was in contrast to the well-meant but often not well coordinated efforts from agents outside of this partnership.

(4) Subcontracting NGO-delivered psychosocial and rehabilitation services through a well-established key supplier in Nepal has been an effective mechanism for DFID to provide rapid support in an emergency context. However, substantial support to the NGOs and quality assurance of the deliverables has been required from NHSSP.

(5) In the context of post-earthquake recovery where specific needs emerge during implementation, a flexible approach to output-based contracts is needed, allowing modification of deliverables to reflect ground realities.

Sectoral/technical level:

(1) The Visiting Provider approach is a cost-effective modality for increasing the coverage of FP services including remote areas (recent evaluation and cost-effective analysis conducted by HERD/Mott McDonald).

(2) The major factors undermining sustained strengthening of Comprehensive Emergency Obstetric Care (CEONC) at district level relate to the entire thematic area of Human Resources, but especially the issue of frequent transfers and, consequently, frequent lack of available of staff.

(3) Approaches used for Quality Improvement at health facility levels (both hospitals and rural health facilities), using self-assessment action planning process, infection prevention demonstration and on-site capacity enhancement of service providers are appreciated by all health workers and management committees and have led to improved Quality of Care within a short period.

(4) The need for mental health services is very high in the community after the earthquake. There is high stigma and low mental health literacy in the community but there is a willingness of primary health care workers and female community health volunteers to provide mental health services. Female Community Health Volunteers (FCHVs) and Community Psychosocial Workers (CPSWs) are very effective at the grass root level in identifying potential cases and referring to health care services.

(5) HMIS data in the three focus districts where the Equity Monitoring was carried out indicated that the increased demands on - and disruptions to - the health services in highly affected and remote areas were managed well by the district response to the earthquake. However, community reports from the Equity Monitoring exercise reflected that strong contextual barriers such as lack of roads, transportation, availability of staff and drugs hinder access to services in remote VDCs, which amplified pre-existing inequities in access, especially for remote populations.

(6) The elaboration of guidelines, standards and specifications for earthquake resistant infrastructure in the health sector in Nepal was crucial to guide all partners responding to the earthquake and is thought to help prevent reoccurrence of recent structural failures.

Lessons shared with partners

(i) A meeting for 50 partners that had signed MOUs with the Ministry of Health was held on the 31st January 2017. The reports presented at the meeting are on the NHSP website: nhsp.org.np

Post Disaster Health Infrastructure Documents, Progress Review January 31st 2017

(ii) Safe Motherhood Network Federation Conference 13-15 November 2016

"*Contraceptive discontinuation in Nepal: Implications for quality of care"* Authors: Dilli Raman Adhikari (FHD), Rajendra Gurung (NHSSP)

"Trend and determinants of FP use among married youth in Nepal" Authors: Yuba Raj Paudel, Grishma Pradhan (NHSSP)

(iii) Safe Motherhood Network Federation Conference Kathmandu 13-15 November 2016

"*Functionality & Continuity of Comprehensive Emergency Obstetric and Newborn care (CEONC) services in Nepal: improved access and reaching the unreached"* Authors: Punya Paudel (FHD), Indra Prajapati(NHSSP)

"Improving Quality of Maternal and Newborn Health Services in EQ Affected Districts: Experiences of Quality Improvement at Birthing Center" Authors: Kamala Shrestha, Maureen Dariang (NHSSP)

(iv) A Knowledge Café was held on the 7th December 2016 to get the views of EDPs and INGO/NGOs on holistic care versus support for RH-MNH in the post-EQ setting. This was to respond to the Recommendations of the Annual Review June 2016: Recommendation 7 '*The Project Review (PCR) to consider whether just supporting Birthing Centres rather than a Health Post as a whole was the best approach and make recommendations for future EQ response programmes*'.

Revisions of the log frame

Revisions were finalised in October 2016, as recommended in the annual review of June 2016. The fact that output indicators and milestones for 2.1 and 2.2 are the same as outcome indicators 2 and 3 was not addressed in the October 2016 revision. However, substantial changes to logframes are not usually recommended to short duration programmes and when the logframe was reviewed the psychosocial and rehabilitation components were near to completion and it was agreed not to include additional indicators to measure their performance at such a late stage.

C: DETAILED OUTPUT SCORING

Output Title	**Restore functionality of health facilities to deliver essential health care services**		
Output number per LF	1	**Output Score**	***A***
Risk:	Moderate	Impact weighting (%):	60%
Risk revised since last AR?	N	Impact weighting % revised since last AR?	N

Indicator(s)	**Milestones**	**Progress**
1.1 Number of health facilities meeting basic infrastructure, human resource and drugs to deliver essential health services	Target March 2017: 957	**Not Achieved:** 873 government health facilities were routinely reporting their activities on a monthly basis by March 2017. This compares to 889 in March 2015 [6]. By March 2017, however, all (100%) health facilities above and including health post level were reporting. Lower level facilities (below health post) are not required to routinely report monthly.
1.2 Number of people accessing health services from public health facilities	Target March 2017: 6,000,000	**Target Exceeded:** A total of 9,176,108 people accessed health services from a public health facility during the period July 2015 to February 2017. DFID attribution is estimated at 3,929,209[7] (EQ affected 14 districts) (Source: HMIS) Note: The service utilization data for the month of March 2017 is not reported to HMIS yet.
1.3 Number of health facilities repaired or pre-fabricated facility established to restore service delivery in three focal districts among the earthquake affected areas	Target March 2017: Initially 9 were agreed for the revised logframe. DFID agreed to adjust to 8 in Nov 2016.	**Not achieved by end Mar 2017 but anticipated to be completed by September 2017:** The repair and/or construction of a total number of 5 health facilities had been completed by the end of March 2017, a further 2 by May 2017 and the remaining health facility will be signed off as completed by September 2017

Key Points

Note on the score: The overall A score for this output reflects the fact that the number of people accessing public health services, which is the most meaningful indicator of their functionality, was 50% greater than expected. This balances out the delays in repair/construction and the fact that the target for indicator 1.1 was set at an unrealistic level: all (100%) health facilities including below health post level reporting by March 2017[8].

Restoration of the delivery of essential health services

This activity was a priority in the immediate aftermath of the earthquake and it was designed to accomplish this through financial support and technical assistance. Achievements include:

- There is wide recognition that the availability and use of health services resumed very quickly after the earthquake, in some cases through the deployment of make-shift or semi-permanent structures such as tents and prefabricated units. Supporting agencies such as NHSSP, UNFPA and others (e.g. MSI and FPAN) mobilized visiting providers and mobile service teams that helped to meet FP needs immediately

[6] The PCR follows the proposition from the June 2016 annual review that the indicator is based on health facilities operating, be it in permanent or temporary accommodation and takes monthly HMIS reporting as the indicator.

[7] Based on contribution of DFID Nepal's earmarked health sector support to the IDHP recurrent expenditure budget line as a proportion of the total expenditure under that budget line (42.82%)

[8] Of the total 957 public facilities in the 14 earthquake affected districts, (only) 873 facilities reported to HMIS by March 2017. The reason for this is that the Community Health Units and Urban Health Clinics, which are under the Health Posts (HP) and Primary Health Care Centres (PHCC), are also listed as separate facilities. There are 137 such facilities in the 14 districts. Not all of these facilities, as in other parts of the country, report regularly as the higher facilities (HP, PHCC and hospitals) do. Many of them report by the end of the fiscal year.

after the earthquake. The Visiting Provider approach to family planning was evaluated as a cost-effective modality for increasing the coverage of family planning services including remote areas[9] and should be scaled up.

- The Contraceptive Prevalence Rate in Ramechhap district, the focus district that the PCR team visited, was reported to have increased from 25% before the earthquake to 29% by the end of 2016. The HTRP TA provided targeted interventions into eight districts[10] with a focus on long-acting reversible contraceptive methods.
- Free referral for obstetric complications was implemented in Dolakha and Ramechhap districts, as a humanitarian activity and was well accepted by district stakeholders including district line agencies and ambulance providers.
- The Financial Aid component of the programme allowed MoH's Aama programme (maternity incentives) to continue uninterrupted and has been instrumental in helping sustain access to - and use of institutional delivery.
- As indicated by two representatives of two multilateral agencies (WHO and UNFPA), a good division of labour between the various External Development Partners resulted in a comprehensive response that supported all essential health services.

The use of public health facilities

The Financial Aid component and the provision of technical assistance, in particular, the employment of district coordinators in the three most affected districts, supported the districts in restoring the functionality of public health facilities. Achievements include:

- The programme used approaches for Quality Improvement at health facility levels (both hospitals and rural health facilities), using self-assessment action planning processes, infection prevention demonstration and on-site capacity enhancement of service providers. The approach has been reported by health workers and management committees as being very supportive and having led to an improved Quality of Care.
- The Health Facility Survey collected data in the earthquake affected districts between October and November 2015, showing the use of basic health services in the earthquake affected districts at levels broadly similar to the national average[11]. Only one indicator, normal deliveries in health facilities, showed a level lower than the national average but anecdotal evidence suggests that that the uptake of institutional delivery has since improved. Access to basic health services and health commodities (including contraceptives) was disrupted for about a month after the earthquake.

The repair and construction of health facilities

In the 14 districts most affected by the earthquake, around 400 health posts, 24 primary health care clinics and two hospitals were completely or partially destroyed. Of 851 health facilities, only 250 were not affected by the earthquake. The programme has made critical contributions to the planning and budgeting of required civil works through rapid and detailed engineering assessments of all health facilities in the 14 earthquake-affected districts, including structure, utilities and land ownership status. Achievements include:

- The programme facilitated the design and signing of MoUs on the reconstruction and/or repair of health facilities between the MoH and external agencies and reviewed technical proposals from implementing agencies.
- The detailed engineering assessments were later extended to include all health facilities in 17 earthquake medium affected districts.
- The programme supported progress reviews organised by MoH on reconstruction work being undertaken by all partners.
- The reconstruction/retro-fitting/construction of all eight targeted health facilities is underway - five health facilities were completed by the end of March 2017. Despite environmental factors and local delays, the remaining three health facilities will be completed soon.

Summary of response to programme issues raised in previous annual reviews

All recommendations of the June 2016 annual review have been addressed.

Recommendation: to continue monitoring the progress and quality of the unfinished infrastructure work initiated under the programme.

[9] According to an evaluation and cost effective analysis conducted by DFID's National Family Planning project

[10] Three DFID funded districts: Ramechhap, Dolakha, Sindhupalchowk; Five USAID funded districts: Sindhuli, Okhaldhunga, Lalitpur, Nuwakot, Gorkha

[11] HFS Final report, January 2017.

Output Title	Access to psychosocial and rehabilitation services by people in earthquake affected districts		
Output number per LF	2	**Output Score**	***A***
Risk:	Minor	Impact weighting (%):	20%
Risk revised since last AR?	N	Impact weighting % revised since last AR?	N

Indicator(s)	Milestones	Progress
2.1 Number of people receiving psychosocial support in earthquake affected districts	Target March 2017: 10,000	**Partially achieved :** a total of 7,378 people with mental health/psychosocial problems received psychosocial support: 3,991 received psychosocial support from community psychosocial workers; 2,124 received mental health care from a health worker; 688 received counselling; 371 received specialised care; 4 were admitted and 200 with mental health/psychosocial problems were referred. An additional 6,895 participated in community based awareness raising sessions on psycho-social issues and 194 (target 120) prescribers trained on the Mental Health Gap Action Programme (mhGAP) Humanitarian Intervention Guide (HIG) and 127 (target 120) non-prescribers trained on psychosocial support.
2.2 Number of people receiving physiotherapy and rehabilitation support from earthquake affected districts	Target March 2017: 3,500	**Achieved and exceeded:** a total of 6381 earthquake affected beneficiaries received support from HI Nepal and SIRC up to October 2016; of which 1351 were earthquake injured- 1,219 and 148 respectively (source: HI Nepal and SIRC).

Key Points

In addition to the services provided by the NGOs as described below, the programme supported the establishment of One-Stop Crisis Management Centres and Social Service Units in selected hospitals. These centres and units strengthened the support to victims of rape, physical and mental abuse and mental health problems

Psychosocial Support

The NGO Transcultural Psychosocial Organization (TPO) was subcontracted by Options to improve availability of services in focus districts. Achievements include:

- Development of contextually adapted standardised resources: TPO adapted WHO's Mental health mhGAP Humanitarian Intervention Guide (HIG), including training resources and standardised treatment protocols, to the local context.
- Development of capacity of community members to provide basic mental health and psychosocial support (MHPSS) services and establish referral mechanisms: community sensitisation sessions were delivered in the community to raise awareness (reaching 5431 community members); 52 community health workers (FVHCs) and non-prescribing health workers were trained to improve detection and referral; 116 prescribers were trained on mhGAP HIG to improve quality of care, and 127 non-prescribing health care workers were trained in psychosocial support. Training was supported with ongoing supervision and mentoring.
- Delivery of counselling services by newly trained Community Psychosocial Care Workers (CPSWs): CPSWs received 120 hours of training and delivered counselling services to 688 people.
- Coordination and advocacy with local and national governments: Using an approach based on experience and evidence generated from (DFID-funded) PRIME study, TPO worked closely with national MoH and local DHOs to advocate for the need for mental health service integration within the primary care system, which contributed to MoH formally assigning PHCRD as its focal unit for mental health, marking an important advance in identifying an institutional home to promote future work.

- The HTRP programme was instrumental in the revision of MoH's free drug list (to include newer, more effective psychotropic medications) in mid-2016, following sustained advocacy efforts from TPO.

The psychosocial support activities sought to address a significant and unmet need, in a difficult context in which it was estimated that 5-10% of people impacted by the emergency would suffer a mental health condition as a result.[12] Moreover, Nepal suffers from a severe shortage of mental health services, exacerbated by a lack of trained human resources and effective referral mechanisms, medication shortages, and social stigmatisation of mental illness. Given this context, HTRP targets were ambitious, particularly for a one-year programme. While undoubtedly the project made steps towards strengthening capacity of the Nepal health system to address mental health issues, there have been significant challenges which have compromised the sustainability of this progress. Some steps forward have been achieved, such as the funding for physiotherapy units at district hospitals and the funding for newly approved psychotropic drugs but ongoing advocacy is required. Nevertheless, the question can be raised whether the approach of a programme, which relied heavily on human resource training and upstream system strengthening, was most appropriate given the context and programme length. Instead, an approach mainly focused on service delivery might have led to a better achievement in terms of people supported. The additional focus on systems building may have been too ambitious, resulting in the target not met and an uncertain future for the mental health programme.

Lastly, the monitoring and evaluation framework for this element of the project does not assess impact. Indicators assess number of people trained, and numbers accessing services. However, it is unclear whether those trained continue to provide services, or what kind of support those accessing services received. Of note, the majority of people accessing counselling services received one session only (>80%). The lack of information in this domain precludes evaluation of the project's contribution to improving psychosocial outcomes for earthquake affected populations.

Rehabilitation

Handicap International Nepal (HI) and Spinal Injury Rehabilitation Centre (SIRC) were subcontracted to provide rehabilitation services to an estimated 2000 people (out of a total of 22,000 injured following the earthquake) requiring follow-up long-term rehabilitation.

SIRC focused on spiral injuries. Achievements included:

- The provision of inpatient services (145 patients admitted), and provision of follow-up home visits to 217 patients following discharge.
- The conduct of home-based carer training programmes (107 home carers trained).
- Neuro-rehabilitation training for 50 nurses.
- Vocational training for 30 patients, including IT and sewing training packages.

HI had a broader remit to address rehabilitation needs identified in the early EQ response period, as well as to address gaps in rehabilitation services within Nepal's health system: Achievements included:

- Setup and equipment of functional physiotherapy units within seven health facilities, resulting in 4,617 people provided services (including 1,127 with EQ-related injuries) in hospital or via community outreach.
- National and district level training of health and rehabilitation professionals and social workers.
- Establishing a referral system, including standardised forms and guidelines, for hospital and community based services.

Activities were underpinned by a monitoring and evaluation framework which clearly linked them to improved outcomes, including strengthened clinical procedures and professional development, improved functional independence and fewer long-term adverse outcomes for service users.

Both NGOs capitalised on the recent establishment of the Disability and Rehabilitation Unit within Department of Health Services (under the Leprosy Control Division), as a central government focal point for disability. This policy window meant that the health system strengthening approach of these projects worked well and TRP support allowed activities to be based on strategic and systematic analysis of the health sector context, with activities designed to bolster existing support and respond to identified gaps, in addition to allowing the linking of disaster response with long-term health development plans.

[12] WHO/UNHCR Mental Health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG)

Summary of responses to issues raised in previous annual reviews (where relevant)

The recommended equity analysis of key service indicators was undertaken in the final provider reports and a report on programme sustainability was completed in early 2017.

Efforts were also undertaken to prioritise which interventions should be advocated for integrating into future MoH AWPBs. This met with some success, as outlined earlier, but uncertainty remains, particularly in the context of decentralisation.

Recommendations for future programmes

Subcontracting NGO-delivered psychosocial and rehabilitation services through a well-established key supplier in Nepal has been an effective mechanism for DFID to provide rapid support in an emergency context where there are gaps in existing public health services. However, substantial support to the NGOs and quality assurance of the deliverables has been required from NHSSP.

In the context of post-earthquake recovery, where specific needs emerge during implementation, a flexible approach to output-based contracts is needed, allowing modification of deliverables to reflect ground realities.

Output Title	Restoration of health system's capacity to plan, manage and monitor post-earthquake health and wellbeing needs		
Output number per LF	3	**Output Score**	***A***
Risk:	Minor	Impact weighting (%):	20%
Risk revised since last AR?	N	Impact weighting % revised since last AR?	N

Indicator(s)	Milestones	Progress
3.1 District level post-disaster response and recovery plan prepared	Target March 2017: None listed. The baseline was: District level post disaster response and recovery plans were completed by July 2015	**Achieved:** District coordinated plans for transition and recovery developed by three DHOs
3.2 Health sector recovery and transition plans implemented	Target March 2017: Health sector recovery and transition plans implemented	**Achieved:** Health sector transition and recovery plan implemented in all programme focus districts
3.3 Health sector recovery and transition plans regularly monitored using HMIS and other information sources	Target March 2017: Health sector transition and recovery plans and their progress reviewed	**Achieved:** Health sector recovery and transition plans in all programme focus districts have been regularly monitored using HMIS and other sources and reported in quarterly reports

Key Points

HTRP provided district coordinators in the three focus districts to work in the District Health Office reporting to the DHO. The district coordinators helped the District Health Office respond to the impact of the crisis. The coordinator presence helped the DHOs coordinate EDPs and other actors including the rational allocation of external resources*.* Other partners provided valuable support as well, for information and documentation needs (WHO) and peripheral planning (USAID-funded Health for Life).

HTRP support for integrated district planning

The achievements under the planning, implementation and monitoring of the health sector recovery and transition plans include:

- In the three districts supported by DFID-NHSSP, a district integrated plan for recovery and transition was developed by all partners involved. The HTRP district coordinator played a significant role in assisting the DHO to develop the integrated district plan with partners.
- The district coordinated plans focused on access to and provision of quality maternal new-born and child health, family planning, psychosocial support, injury rehabilitation and other RH services including gender based violence from district hospital level to community level.
- The plans included infrastructure repair and reconstruction including WASH facility, equipment and furniture. Also included were health system issues such as human resources, improving the referral system, monitoring and evaluation including e-reporting by health facilities and equity monitoring. Community level awareness and demand creation activities mainly focused on strengthening the services provided by the Female Community Health Volunteers.
- Activities from more than 15 partners in Dolakha and Sindhupalchowk and 10 partners in Ramechhap were included in the coordinated district plans. This has facilitated the channelling of scarce resources to needed areas and has avoided duplication.
- A number of processes were used to monitor progress in EQ affected districts including supporting the MoH to re-establish HMIS and to strengthen the Early Warning and Reporting System (EWARS), and, by the end of the programme, most public health facilities reported their activities regularly through HMIS (see also under Output 1.1).

Health information

In addition, to efforts to re-establish HMIS in EQ affected districts, DFID's TA and health advisers contributed to the development, implementation and analysis of the National Health Facility Survey (UNICEF-led), completed in 2016, and the National Demographic and Health Survey (USAID-led) in 2017. These provide a useful source of progress and comparison data that can help identify and target where further effort is needed in the restoration of health services. As noted earlier, most indicators show that an improvement above pre-EQ levels and indeed better performance than many other non-EQ affected districts. DFID and other EDPs should take this into account in their policy dialogue with the MoH, when developing their new strategies and in the identification of any focus districts, while ensuring that efforts are continued to sustain these gains.

Summary of responses to issues raised in previous annual reviews (where relevant)

The level to which the HTRP TA has been able to strengthen processes, systems and capacity of the MoH/DHoS/DHO to enable strong sector coordination to future earthquakes is uncertain given the likely changes in institutional arrangements and changing functions and responsibilities during and after the devolution. However, future administrative and programme staff should be able to tap into the extensive resources produced in the form of templates, guidelines, lessons learned and examples provided.

Recommendations for future programmes

It will be important for DFID to engage with other External Development Partners (EDPs) on changing disaster preparedness modalities as the devolution in Nepal evolves and changes in decision making, operational structures and procedures, and communications channels materialize.

D: VALUE FOR MONEY & FINANCIAL PERFORMANCE

Key cost drivers and performance

The key cost drivers for earmarked financial aid (FA) were the expenditures in the GoN Integrated Health District Programme (IHDP) budget line for which DFID spending is earmarked, namely: (i) recurrent expenditure, including Aama-related maternity and transport incentives; (ii) supervision and training costs; (iii) drugs and medical supplies; and (iv) maintenance. 98.7% of the HTRP budget (£10.69 million out of £10.83 million) was spent at project completion, including the disbursement of all £6 million of HTRP FA support.

The key cost drivers for technical assistance (TA) are the cost of the 65 deliverables under the contract submitted to DFID. TA fee rates and international and national TA shares were monitored in accordance with contract provisions.

VfM performance compared to the original VfM proposition in the business case

The Business Case noted historically high levels of allocative efficiency, and the opportunities to improve technical and administrative efficiencies. It prescribed the monitoring of a number of indicators. Performance against these indicators is set out in Annex 2.

Financial Aid, backed by TA, has facilitated the Ministry of Health (MoH) to understand the importance of specific programmes and treatments and to include them in the annual work plan and budget[13].

FA has also been instrumental in assisting MoH to develop better systems for managing spending, notably through encouraging the adoption of a FM Improvement Plan (FMIP), with follow-up taking place through a joint donor-government finance committee. The expansion of TABUCS[14], facilitated by support from HTRP TA, has enabled the more efficient use of MoH funds by expanding its use into a tool used in budgeting and planning. In particular, development of a TABUCS spending authorisation module has significantly reduced paperwork, saved a good deal of administrative time in obtaining spending authorisations and improved budget execution allowing MoH to spend 91% of their budget in FY 2016/17, compared to 80% in 2015/16 and 73% 2014/15.

Budget execution rates have risen significantly over the life of HTRP, although the share of spending in the last trimester has also risen. The latter is mainly due to: delays in budget authorisation and spending especially regarding procurement; slow cash advance clearance; and delayed reporting of grants provided to the autonomous hospitals. HRTP TA has supported MoH to address this issue by adding a separate authorisation module in TABUCS (see below), which is expected to reduce delays.

Economy
92% of TA usage (days) in HTRP was on significantly less expensive national consultants (see Annex2) – a greater share than in other comparable DFID programmes[15].

Efficiency
A DFID-supported Health Infrastructure Information System enabled a refinement of reconstruction needs, with 24% fewer facilities being reconstructed and better prioritisation and matching of need to appropriate supporting agencies. HTRP TA was used concurrently in NHSSP and HTRP, enabling running costs to be shared, leading to more efficient TA and management inputs. Administrative and management costs and per unit training costs are low (see Annex 2). Furthermore, the budget allocation for EHCS has increased from 72% to 75% of the IDHP budget (in line with the general agreement between EDPs and government of Nepal), which will allow an increased population to receive primary health care services over time.

[13] Examples include: inclusion of psychotropic drugs in the list of free drugs, psychosocial counselling at district level, expansion of one stop crisis centres, a budget for TABUCS training, establishing of a separate entity oversee rebuilding/infrastructure related work.
[14] Transaction and Budget Control System (TABUCS) infrastructure was restored in 31 districts; a specific module was developed for EQ affected districts to enable better data capture of EQ expenditures, and data entry clerks were supported in the three focal districts.
[15] Comparison was made with the Kenya MANI, Bangladesh UHSP and India Odisha WASH programmes.

Effectiveness
HTRP has ensured that essential health services were quickly restored in the worst affected districts: restoring functionality of health services enabled over 9.17 million people (target 6 million) to access essential health care services from public health facilities by February 2017. This increase in access is despite the tendency for Government spending on basic health services to be reduced over time as hospital and other spending has increased. The expansion and full government ownership of the Aama programme increased institutional delivery, and thereby reduced maternal deaths[16] - demonstrating programme effectiveness.

Equity
The focus of HTRP has been support to primary care services. This has clear equity benefits compared to support for secondary and tertiary health care services, given the increased difficulty for the population to access the latter services. The programme has focused on the most affected districts and on the most vulnerable members in the community - pregnant women and newborns, those with serious injury and those requiring psycho-social support.

Assessment of Programme Value for Money
The programme represented good value for money. The combined investment of earmarked financial aid, embedded technical assistance and focussed support through implementing partners has enabled the value for money of funds to be maximised. The programme has primarily supported primary health care services which are the most cost effective and pro-poor type of health spending. The development of a District Engineering Assessment tool for assessing infrastructure damage developed by Programme TA enabled a timely and effective infrastructure response and more accurate estimates of reconstruction needs, enhancing the value for money impact of reconstruction.

Quality of financial management during the programme

Financial Aid:

TA support to TABUCS, a government accounting system, has directly contributed to improving the quality of financial management and the optimisation of available finance, while reducing the risk of fraud and corruption. The system enables the capture of accounting transactions at source while enforcing budgetary control procedures so that no expenditure can take place without an approved budget. Outstanding audit data for the last nine years has also been uploaded to TABUCS to aid audit clearance. Results from a Crown Agents rapid assessment prior to the final financial aid disbursement in July 2016 indicated that, although there are ways to improve TABUCS further, for example by enhancing uptake by hospitals, it is providing a sound financial control and monitoring mechanism.

Date of last narrative financial report	Third Trimester Financial Monitoring Report, 2015/16 (Vault No 6685187)	19 April 2016
Date of last audited annual statement	Audit Report 2014/2015 (Vault No 13156305)	07 July 2017

Technical Assistance:
As an output-based contract, HTRP followed well defined and pre-agreed financial monitoring and disbursement procedures.

Date of last narrative financial report	N/A	
Date of last audited annual statement	Annual Audit Report 2015 (Quest No 5424460)	26 April 2016

[16] Service delivery data shows that more than 140 women benefited, at least 10 women were saved from maternal death or lifelong disability, and at least 20 new born lives were saved because of this provision.

E: RISK

Quality of risk management over the life of the programme

Overall, the risk matrix as outlined in the Business Case was adequate and the mitigation measures appropriate. The implementation risk, rated as low was well managed by the TA provided, except for the risk related to human resources, which materialized. Except for the monitoring of vacancies and transfers, little else could be done to prevent disruption of programmes due to insufficient (trained) staff through frequent transfers.

The operating environment risk also materialized. The unrest at the border with India and the resulting fuel shortage was managed as well as possible through the coordination of transport arrangements with other EDPs. The unrest however did cause delays with regards to the civil works due to interrupted supplies.

The governance and fiduciary risks, rated as high, were managed well through the adherence to the risk mitigation measures mentioned in the Business Case. This involved active engagement in the Financial Management Improvement Plan, the Procurement Improvement Plan, the roll-out of TABUCS, annual fiduciary reviews and the follow-up of audit queries.

The lessons learned include the continuing high risk to programme implementation during the on-going political fragility in Nepal and the continued need for coordinated fiduciary oversight with improvement noted in MoH's financial management but less so in procurement. Despite considerable TA over many years from health donors, including DFID, it seems that only a restructuring of the Logistics Management Division might improve MoH's procurement performance.

F: COMMERCIAL CONSIDERATIONS

Delivery against planned timeframe

Financial Aid	
Forecast was £6,000,000 by end of March 2017	Disbursement to date is £6,000,000.
Technical assistance	
Forecast was £4,833,831 by end of March 2017	Disbursement to date is £4,691,924

Performance of partnership(s)

The perspectives of EDPs interviewed provide a very positive impression of the partnership between the government, the EDPs and the NHSSP TA team. This partnership has matured over many years and is in fact one of the reasons that the programme could respond quickly and effectively. Fundamental was the social capital built between the NHSSP TA team, the MoH and the EDPs that allowed for well-coordinated and well-designed support structures and processes. This is in contrast to the well-meant but often less effective support efforts from agents outside of this partnership. The fact that the DFID Health Adviser at the time of the earthquake was the Chair of the External Development Partner Group certainly helped coordination with the partners in the health sector.

Asset disposal and value obtained by DFID

The DFID Nepal HTRP asset register was managed and maintained by Options Consultancy Services Ltd. and they updated the inventory list on a regular basis and shared it with DFID for recording and spot check purposes. There were adequate control mechanisms in place for monitoring and ensuring they were used for the intended purpose. An asset spot check was done in conjunction with the spot check for NHSP 2 in September 2015. After the update in June 2016, as mentioned in Annual Review, two more verifications were done, in September 2016 and March 2017. The HTRP asset disposal proposal was approved by DFID in July 1017 with the transfer of assets to NHSSP-3, the Ministry of Health and DFID as appropriate and with the transfer of the proceeds of the sale of old equipment and furniture to DFID.

G: CONDITIONALITY (½ page)

Partnership principles assessment

The partnership principles have not changed from those outlined in the Business Case and the June 2016 annual review. The Partnership Principles are outlined in the Development Partnership Arrangement that has been signed between the Nepal and UK Government and were re-assessed before any tranche of sector budget support/financial aid was provided. No partnership principles have been breached to date. The main conditions relating to disbursement of financial aid are outlined in the Joint Financing Agreement (JFA) which was signed at the start of NHSP-2 in 2010, between the Ministry of Finance and donors and the newer JFA for 2015-2020. The conditions include:

- Funding by financial aid donors is made into the foreign currency account (FCA) in advance of expenditure by MoH, at Government's request. Subsequently, funds are disbursed from the FCA into the Government budget to reimburse expenditure already occurred.
- If the FCA balance is already enough to fund donors' share of expenditure for the next two trimesters, donors are entitled to not disburse.
- Financial aid donors use the Financial Management Report and Implementation Progress Report as the basis for disbursement to the FCA each trimester. It allows donors to stop disbursing if financial reporting slows or if expenditure deviates from the agreed annual work plan and budget.
- Financial aid donors have the option to use any breach of the Government's JFA obligations as a reason not to disburse. That could include late audits, evidence of expenditure deviating from the agreed annual work plan and budget, or late financial reporting.

H: MONITORING & EVALUATION (½ page)

Evidence and evaluation

The Theory of Change outlined in the Business Case has remained relevant. Although a formal impact evaluation of this programme was not planned, there has been a concerted effort to draw conclusions and lessons learned from various aspects of programme design and implementation, including the external review of the programme through this PCR, a number of in-country lessons learned initiatives organized by the Ministry of Health and NHSSP, and the planned independent compilation of documentation of the experiences and lessons learned - forthcoming. External verification and evaluation of some of the more innovative approaches, such as the family planning visiting providers and the employment of NGO implementing partners were planned. These are either completed (the visiting providers initiative) or in progress (the employment of NGO implementing partners) and will form part of the lessons learned documentation.

About this review

This PCR was carried out by two external consultants, a public health specialist and an economist, and a DFID London Health Advisor. Key partners from the Government of Nepal, EDPs and HTRP implementing partners were consulted (see annex 3) and field visits were undertaken to Ramechap District (PHCC Primary Health Care Centre and Health post, District Public Health Office, and to the SIRC facility in Sanga to understand how their services were being delivered and managed at various levels. This review makes use of Health Facility Survey data (2016) and Health Management Information Systems (HMIS), and reports by implementing partners, from MoH and development partners who reviewed the health sector response on the anniversary of the earthquake (May 2016).

Monitoring progress throughout the programme

The monitoring system to track progress has been extensive and intensive through regular meetings with the TA team to review progress against deliverables, procurement transactions, risks and mitigation measures and through regular field visits to EQ affected districts to gather information both from health providers, district authorities and beneficiaries. The Department of Health Services Annual Review, Joint Annual Review and Health Sector EQ Response review provided forums for review of progress and

DFID's/HTRP's contribution to the wider response. The social audit and GESI work were the major vehicles for gaining beneficiary feedback. Ongoing evaluation of performance was conducted through review and analysis of information systems (including TABUCS, HMIS, Financial Reporting System reports) and through detailed reports on the output-based deliverables, providing a solid monitoring system with adequate opportunities to triangulate information and provide a satisfactory level of confidence in the monitoring of the programme. Outputs were subdivided into assessment, implementation and monitoring components, which helped promote flexibility for NHSSP and decrease risk for NGOs. Thus, payment deliverables were carefully designed to reflect the uncertainty involved in post-disaster planning, while ensuring accountability and enhancing local engagement (e.g. through specifying both completion and local endorsement of district plans). Issues concerning choice of indicators and log frame components, particularly those relating to NGO performance, have been highlighted above.

Annex 1: Summary Sheet Annual Review June 2016

Annual Review - Summary Sheet

This Summary Sheet captures the headlines on programme performance, agreed actions and learning over the course of the review period. It should be attached to all subsequent reviews to build a complete picture of actions and learning throughout the life of the programme.

Title: Re-establishing Health Services in Earthquake Affected Districts of Nepal. **(DFID Nepal Health Transition and Recovery Programme (HTRP))**		
Programme Value: £10,353,807		**Review Date:** 18 June 2016
Programme Code: 203413	**Start Date:** 30 June, 2015	**End Date:** currently 15 July 2016 but approval of a costed extension to 31 March 2016 is anticipated[17]

Summary of Programme Performance

Year	**2016**							
Programme Score	**A**							
Risk Rating	**Moderate**							

Summary of progress and lessons learnt since last review

This is the first Annual Review. Overall, this programme is delivering effective and much needed interventions. DFID's approach of combining earmarked financial aid with Technical Assistance (TA) has contributed to the restoration of health services across many key indicators in the 14 most earthquake (EQ) affected districts. Data shows that utilisation of key services is higher than the average for the 31 EQ affected districts and the national average. Unusually for a post disaster programme, the programme is achieving systems as well as service delivery level outcomes. The programme presents good value for money, particularly as it focuses on access to essential health care services and on areas of unmet need-spinal injury, rehabilitation and psychosocial care in a post-disaster context. There have, however, been delays in the programme partly as a result of a 2-month Government of Nepal (GoN) approval process, and political unrest at the border with India limiting access to fuel and wider supplies.

Key lessons include:

- DFID Nepal's existing programme and relations with GoN, Ministry of Health and external partners significantly enabled the rapid development and implementation of this programme. It is unusual for a post-disaster programme to have outcomes at the systems level. This has resulted in more rapid implementation and greater programme efficiency and effectiveness with reduced financial risks. In a rapid-onset post disaster context this programme represents good value for money.
- Strong coordination and governance of the programme and its partners, and a flexible and adaptable approach has helped effective implementation, enhanced partnership and mitigated risks, most notably as a result of border restrictions with India and fuel crisis.
- In the context of post-earthquake recovery where specific needs emerge during implementation, a flexible approach to output-based contracts is needed, allowing modification of deliverables to reflect on-the-ground realities.
- The indicators don't fully reflect the breadth and depth of the activities undertaken and outcomes achieved. The business case and logframe were developed during a period of high stress and intensity of workload. A review of the context and logframe after three months would helped refine and improve the logframe to better capture key aspects of the business case and performance,
- Availability and retention of health workers remains a problem. WHO are planning to increase their engagement on Human Resources for Health but in the short-term this will continue to be a challenge to programmes.

[17] *This annual review has been conducted on the basis that a costed extension until the end March 2017 will be approved by DFID and the Government of Nepal.*

- Sustainability of a number of proven approaches and areas where demand has been created is a challenge. Buy-in is required at central level and planning to include in the annual work plan and budget should have commenced earlier. The economic case for Ministry of Health (MoH) support must be clear if the MoH is to make informed choices on priorities.
- Transaction Accounting and Budget Control System (TABUCS) contributes substantially to improving expenditure planning and reporting processes at district level. Further capacity development is required to speed up planned and efficient expenditure of funds at district level and for planning and reporting.

Summary of recommendations for the next year

1. **For DFID**: the PCR should be undertaken externally i.e. non-DFID Nepal staff and includes a humanitarian adviser
2. **For DFID and TA team:** summarise and disseminate the key lessons learned, for DFID internally and for the wider external audience, to help inform future programme responses to similar disasters.
3. **For the TA team:** The TA team's focus should continue to support the MoH on prioritising and monitoring health infrastructure work in the 14 EQ affected districts, and where appropriate facilitating discussions with implementing agencies and other donor partners. It is important, however, that they do not, by default, become TA for implementing partners or other donor agencies as well. Timeline- ongoing.
4. **For DFID and TA team:** to better prioritise which interventions they would like to be eventually integrated onto the red book and strategize how best to do that, in a timely manner. Timeline- by end March 2016
5. **For DFID and TA team:** for the Project Completion Review (PCR) to more closely consider whether just supporting birthing centres rather than a health post as a whole was the best approach and make recommendations for future EQ response programmes on this strategy- by end July 2017 (PCR date).
6. **For TA team:** to follow-up on the indicators where the delivery of services and utilisation is still low, e.g. access to safe abortion statistics family planning uptake. Discuss remedial action with district health authorities and DFID if required- by end September 2016.
7. **For DFID**: review and revise logframe- by end July 2016.
8. **For TA team:** DFID's support to coordination in the three focus districts and on infrastructure has been commended by key informants. The Aama programme (maternity incentives), supported through HTRP FA, has been instrumental in helping sustain access to and use of institutional delivery. These three areas should be documented as case studies and used inform future EQ planning- by end February 2017.
9. **For TA team:** in relation to key risks, undertake equity analysis of key service indicators and outcomes as far as is possible with the data available to assess whether inequitable distribution is an issue- by October 2016.
10. **For DFID and TA Team:** Continue to engage with other External Donor Partners (EDPs) on the implementation of the Consolidated Annual Procurement Plan (CAPP), Procurement Improvement Plan (PIP) and Financial Management Improvement Plan (FMIP). TA team to step up level and quality of TA engagement on these issues. Ongoing
11. **For DFID and the TA team: to provide** benchmarks/comparators for the value for money TA indicators. By end October 2016.

ANNEX 2 (DATA RELATED TO SECTION D)

HTRP: VFM Data and comparison with Business Case Benchmarks		
Program Element	**Assessment Criteria**	**HTRP performance to date**
Financial Aid		
Allocative efficiency	Share of budget spent on essential health care services (EHCS). Benchmark 72.7% 2014/15	2015/16 - EHCS Budget share: 80.6% 2016/17 (Up to April 2017) - EHCS share: 88.9%
Administrative and financial efficiency	Budget execution. Benchmark: Share of spending carried out during the third trimester compared to previous years.	2014/15 – Budget execution: 73% (38% spent in 3rd Trimester (3T)) 2015/16 – Budget execution: 80% (47% in 3T) 2016/17 – Budget execution: 91% (51% in 3T)
Technical assistance		
Economy	• Average national, regional, international expertise rates • % of days/expenditure by national, compared to international, consultants	• Average daily international consultant rate = £547; National daily consultant rate = £76. • 8% days international; 92% days national
Efficiency	• Administration and management as % of total expenditure • Unit cost per training participant	• 8.7% up to June 2016. Overhead costs reduced further in the extension phase (to March 2017) • £25 per unit
Effectiveness	• Government approval rate of technical assistance products • Technical assistance products that are supply led versus demand driven • Technical assistance products that are strategic versus short-term	• 100% • TA is demand driven as activities are planned and implemented through government entities. • A significant share of the TA has been directed to improving the supply of services for the longer-term as well as the shorter-term e.g. the detailed engineering assessment; the production of standardized infrastructure designs, strengthening of TABUCS / HMIS
Cost Effectiveness	• Case studies of technical assistance products to quantify impacts	• A qualitative value for money assessment of DFID support to a district engineering assessment (DEA) of earthquake damage has been carried out and shows that the DEA provided more realistic estimates of damage, allowing expenditure and works to be better targeted

Annex 3: Key Informants interviewed

Current and former Government officials:

The Secretary of Health and a former Secretary of Health
A former Director of Health Services and a former Chief of the Policy, Planning and International Cooperation Division
The district Director of Health and his team, Ramechhap district
A Senior Infrastructure Engineer
The Chief of the Primary Health Care Revitalization Division

Representatives from the following bilateral and multilateral partners:

DFID
An ex-DFID Health Adviser
KfW
WHO
UNFPA
World Bank

Representatives of the following Non-Governmental Organization:

The Advisers of the Nepal Health Sector Support Programme (NHSSP – Options/Oxford Policy Management)
The Transcultural Psychosocial Organisation
Handicap International

The Spinal Injury Rehabilitation Centre