TERMS OF REFERENCE

EVALUATION OF TASK-SHIFTING OF PHYSIOTHERAPY SERVICES

(INTEGRATION OF PHYSIOTHERAPY SKILLS INTO MID-LEVEL PROVIDER TRAINING FOR PARAMEDICS IN NEPAL)

I. ABOUT NEPAL HEALTH SECTOR SUPPORT PROGRAMME 3 (DFID-NHSSP)

The Nepal Health Sector Support Programme is the UK Department for International Development (DFID) funded technical assistance programme, which aims to support the Ministry of Health in its implementation of the current Nepal Health System Strategy (NHSS) 2015-2020. Between March 2017 and December 2020, DFID-NHSSP - a consortium led by Options, with HERD, OPM, and Miyamoto is providing General Health Technical Assistance to increase the capacity of the Ministry of Health to improve health policymaking and planning, procurement and financial management, health services and the use of evidence for planning and management. DFID-NHSSP 3 is also increasing the Ministry of Health's capacity to retrofit health infrastructure to withstand future earthquakes. Both components are provided by a team based in Kathmandu and "embedded" within the Government of Nepal. DFID-NHSSP comprises five streams of work delivered through an overarching, integrated, capacity enhancement approach, which include:

1. Health policy and planning
2. Procurement and Public Financial Management
3. Service delivery
4. Evidence and accountability
5. Health Infrastructure

DFID-NHSSP works closely with the three other DFID suppliers who deliver on the other components of the Nepal Health Sector Programme (NHSP) that includes monitoring, evaluation and operational research; social accountability; and public financial management. DFID-NHSSP actively collaborates with other External Development Partners (EDPs) who support the Nepal's health sector.

II. BACKGROUND FOR THIS TERMS OF REFERENCE

Nepal's census of 2011, which is the most recent source of national data on disability which reports that 1.94% of its population are disabled[1] but other studies have reported higher levels of disability[2]. Some suggest that low figures could be due to the way in which disability is defined and recorded. The census shows that while most number of people with disabilities live in the Terai regions,

[1] Disabiity atlas http://ku.edu.np/arts/drc/atlas.pdf

[2] Dhungana, B, 2006 The lives of disabled women in Nepal: vulnerability without support. Disability Society 2006; 21: 133–146

district-wise analysis shows that the highest percentage of people with disabilities are reported in western Hilly and Mountain districts[1].

A range of policy and legal instruments have existed in Nepal with regard to disability, and the most recent Nepal's Disability Rights Act of 2017, which replaced the Disabled Persons Welfare Act of 1982, is a significant departure from the welfare-based approach to the rights-based approach to disability. Despite this, the capacity of the health system to deliver quality services is limited due to lack of required skills and resources. Although systematic workforce data about physiotherapy practice in and status of rehabilitative health services in Nepal are unavailable, reports after the 2015 earthquake suggest that the public health system was strained to respond to the demand in services. Despite the high need for the health system in Nepal to have professionals who can cater to physiotherapy requirements of disabled people, only 25 physiotherapists are currently employed by the Ministry of Health at 10 tertiary hospitals across the country. A UN study pointed out that the challenges in post-earthquake Nepal were exacerbated for persons with pre-existing conditions as well as those who were newly disabled as a result of the earthquake. As healthcare and rehabilitation facilities are largely centralised at the national and district level, these were inaccessible for the earthquake affected communities, particularly as roads and infrastructure had been damaged[3].

Health of women with disabilities in Nepal is also of major concern as nearly 54% of these women report ongoing health problems and 45% face reproductive health issues[4]. A study of healthcare provider attitudes towards women with disabilities in public health facilities of Rupandehi district in Nepal, found negative attitudes with poor knowledge and skills on providing services[5]. Similar findings were also reported by another study which found that married disabled women considered pregnancy and childbirth to be normal but preferred to deliver at home, and health workers felt unprepared to meet the needs of disabled women[6]. Moreover, reproductive morbidities (e.g. pelvic organ prolapse, pelvic floor dysfunction, fistula) and birth related impairments (e.g. cleft-palate, club foot) are often not recognised by health workers or by communities as ones that need physiotherapy even amongst women without disabilities.

III. DFID-NHSSP SUPPORTED INNOVATION ON TASK-SHIFTING FOR PHYSIOTHERAPY SERVICES

Identification, treatment and management of disabilities is part of the Nepal Health Sector Strategy (NHSS 2015-2020), included in MoH/DoHS/LCD policy, strategy and ten-year action plan (2017) and the Implementation Plan. The National Health Training Centre (NHTC) has endorsed training for health workers (including paramedics) to manage injury and trauma, but to date, has not included any training on physiotherapy skills needed for disability management and rehabilitation. DFID-NHSSP aims to support the government to fill this gap, and test an innovative approach to the delivery of physiotherapy services, particularly building on the learning from the HTRP experience.

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[3] Lord A, et al, Disaster, Disability, & Difference, A Study of the Challenges Faced by Persons with Disabilities in Post-Earthquake Nepal, May 2016

[4] Khanal, N.A. 2013. Status of Reproductive Health and Experience of Mother-hood of Disabled Women in Nepal.

[5] HR Devkota, E Murray, M Kett and N Groce, Healthcare provider's attitude towards disability and experience of women with disabilities in the use of maternal healthcare service in rural Nepal, Reproductive Health2017, 14:79 https://doi.org/10.1186/s12978-017-0330-5

[6] Morrisson J et al. Disabled women's maternal and newborn health care in rural Nepal: A qualitative study, Midwifery, Volume 30, Issue 11, Pages 1132–1139, November 2014m https://doi.org/10.1016/j.midw.2014.03.012

Nepal has a long and successful history of 'task-shifting' where certain specialist tasks are given to health workers from a lower cadre. Adopting this approach, DFID-NHSSP aims to support NHTC to train male and female mid-level cadres (paramedics and auxiliary health workers) on physiotherapy skills, at the primary level facilities (PHCC and HP; and where possible primary hospitals less than 15 beds), to enable them to provide basic physiotherapy services and make them more accessible to people with disabilities. The basic physiotherapy services that can be provided at such primary level facilities and the range of disabilities that can be addressed has been identified by NHTC[7].

Purpose of the innovation

- **Test the task-shifting approach**: The key purpose of the innovative approach is to test whether it is possible to task-shift basic physiotherapy services to para-medics (such as health assistants and auxiliary health workers). The focus will be on building physiotherapy skills for selected paramedics, through a sub-contracted organisation that specialises in physiotherapy training and service delivery. The skills to be trained on will be reviewed and approved by NHTC and the Technical Working Group (TWG). The information from this could be used post-pilot (at a later date), to further develop health workers' curriculum, for example, to address physiotherapy skills that are needed to address reproductive morbidities as part of the Skilled Birth Attendant curriculum, or include physiotherapy skills required for other health providers (i.e. nurses, CHWs & FCHVs) as appropriate.

- **Explore the potential to include in mid-level practicum training curricula**: In terms of institutionalising the approach and ensuring that physiotherapy services are provided in a sustained manner, the long-term vision is to include physiotherapy skills as a part of the regular schedule for mid-level practicum training and any follow-up refresher trainings as required. The mid-level practicum is a three-month clinical and management refresher training which focuses on building skills of mid-level health care providers to diagnose illnesses better, perform medical procedures, and manage their workplace. The training approach and content that DFID-NHSSP will help develop through the current ToR, therefore needs to be appropriate to the mid-level practicum levels and length of curriculum.

Note: The development of the curriculum and implementation of the training will be the responsibility of a contracted agency (not a part of this current TOR)

IV. The Theory of Change and the Logic Model

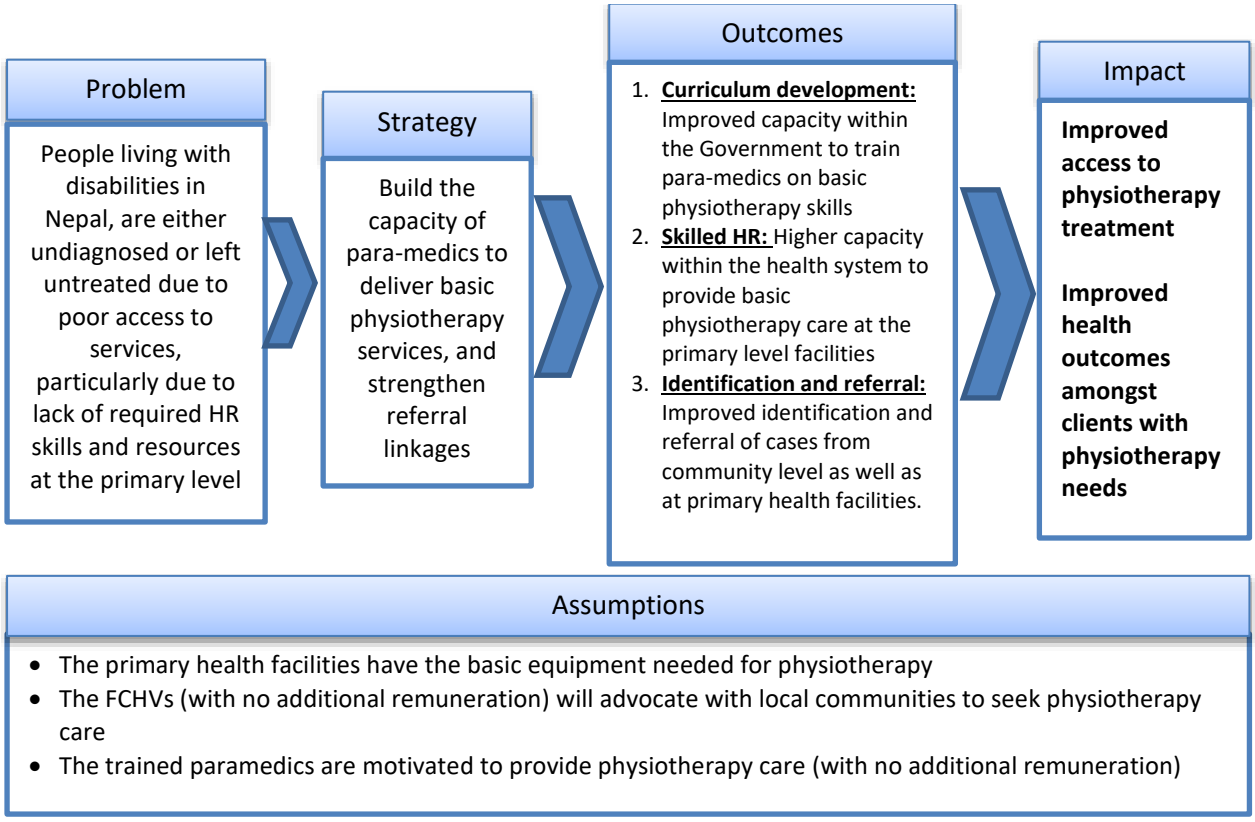
The Theory of Change for this intervention is provided in Figure 1. The underlying problem that was identified in an earlier phase of the DFID-funded technical assistance programme, is that Nepal has number of people with living with disabilities who are either undiagnosed or left untreated due to poor access to services. One major challenge is the capacity of the health system to deliver quality services due to lack of required skills and resources. Despite the high need for professionals who can cater to physiotherapy requirements of disabled people, only 25 physiotherapists are currently employed by the Ministry of Health at 10 tertiary hospitals across the country. A UN study pointed out that the challenges in post-earthquake Nepal were exacerbated for persons with pre-existing conditions as well as those who were newly disabled as a result of the earthquake. As healthcare and rehabilitation facilities are largely centralised at the national and district level, these were

[7] This can be shared with the evaluation agency after the signing of the contract.

inaccessible for the earthquake affected communities, particularly as roads and infrastructure had been damaged[8].

The strategy adopted by the current intervention is to address this need by building the capacity of lower-cadre health professionals to deliver basic physiotherapy services, and strengthen referral linkages, so that access to the right care at the right time and right place is ensured. Through this intervention, DFID-NHSSP aims to have a tested curriculum and training modules appropriate for task-shifting physiotherapy services; created a pool of skilled para-medics who can provide the services; and established clear guidelines and mechanisms for a referral system from the community level. This will have contributed to improving access[9] to physiotherapy treatment as result of provision of care at facilities closer to people's communities, as well as to improved outcomes health outcomes through the appropriate diagnosis and treatment.

Figure 1 Theory of Change



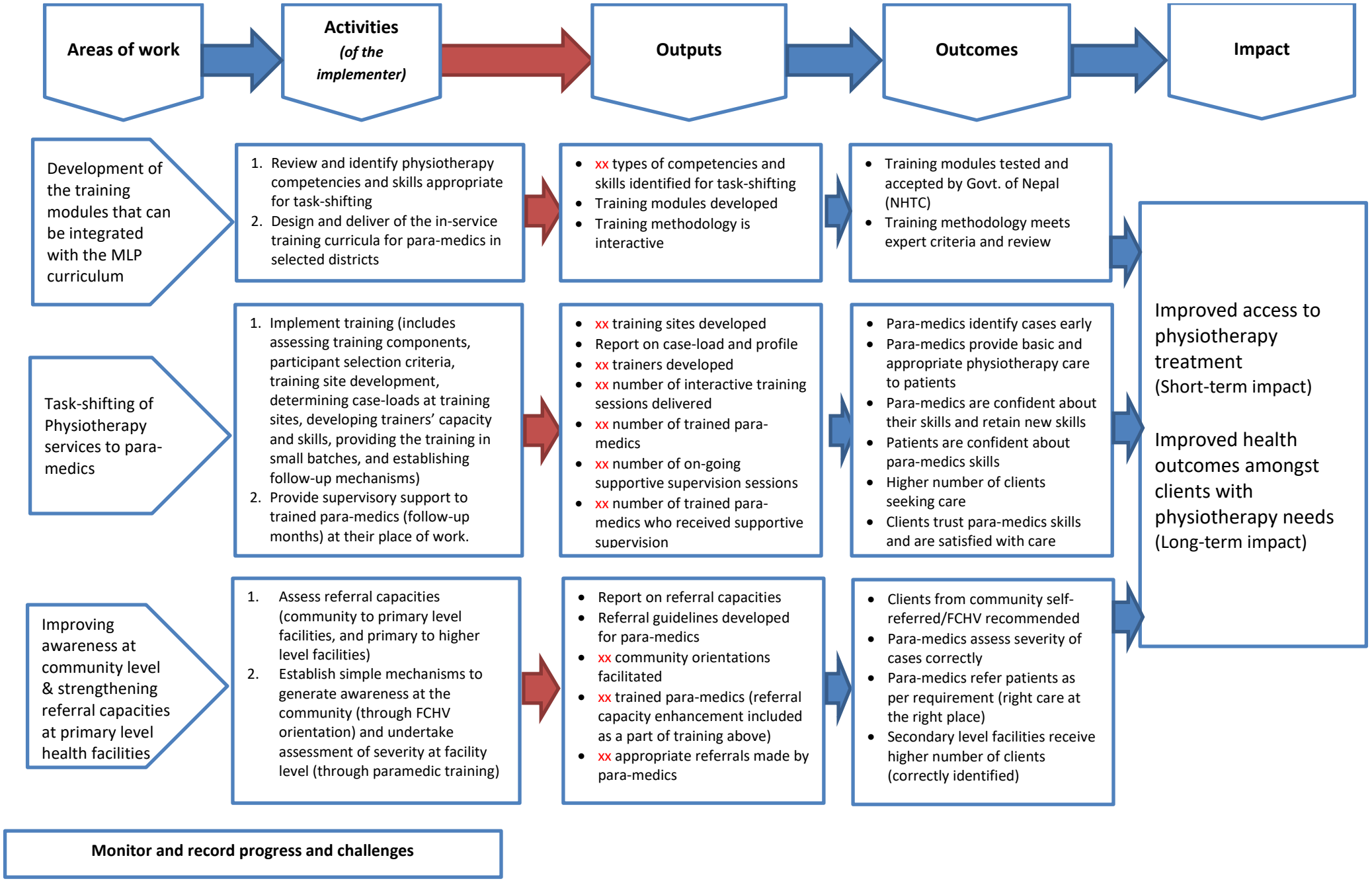
Based on this broad Theory of Change, a draft logic model for the intervention is presented in Figure 2, which adopts an outcomes approach model. This focuses on the early aspects of programme planning and attempts to connect the resources and activities with the results desired. As the physiotherapy task-shifting intervention is expected to be implemented and tested over a year, substantial changes at the outcome levels are expected within a year, while impact level changes are

[8] Lord A, et al, Disaster, Disability, & Difference, A Study of the Challenges Faced by Persons with Disabilities in Post-Earthquake Nepal, May 2016

[9] Access is interpreted through three dimensions – physical access, financial affordability and acceptability. This intervention addresses only specific aspects of these dimensions, which the evaluators needs to be cognizant of. https://www.who.int/bulletin/volumes/91/8/13-125450/en/

expected to take longer. The outcomes are expected to indicate the beginnings of any changes, in terms of improved uptake of physiotherapy services, and thereby contribute to impacting better access to care in the short-term, and improved health in the longer-term. The logic model also shows the causal linkages from each set of activities leading to expected outcomes. It is important to note here that this logic model will need to be discussed and refined further through a consultative process that includes the implementing agency, the evaluation agency and DFID-NHSSP.

Figure 2 The Logic Model (TBC)



V. OTHER PROGRAMME DETAILS

Sections II and III of this ToR layout the broad framework for the intervention. Further details that could be helpful are given below:

- The implementing agency is expected to develop curriculum and training materials that are appropriate for service levels and follow NHTC training, evaluation and certification standards
- The pilot will be undertaken in three areas (previously districts – Dhading, Dolakha and Dhanusha).
- Implementing agency will train mid-level provider/para-medics (health assistants and senior auxiliary health workers) in an interactive way, in small batches of 10-15. At least 200 para-medics from the three districts are expected to be trained.
- Para-medics are expected to treat patients with physiotherapy needs at their respective health facilities as appropriate and refer any serious cases to higher facilities.
- Para-medics will also be trained to orient FCHVs at their regular meetings to interact with communities to generate awareness on the physiotherapy intervention and create an enabling environment.
- The para-medics training is expected to start in April/May 2019 and the implementation support for the pilot will be provided approximately till end of Jan 2020.

VI. SCOPE OF THE PROPOSALS

DFID-NHSSP invites research and evaluation organisations that specialise in evaluations (impact and outcome evaluations) to submit proposals to undertake an independent evaluation of the physiotherapy task-shifting pilot. Given below are the set of requirements laying out the scope for the proposal:

1. The objectives of the evaluation are
    a. to investigate the outcomes and the short-term impact of the pilot, which will need to be guided by the ToC and the Logic Framework described in the sections above to include
        i. health systems level outcomes
        ii. individual health provider level outcomes
        iii. client level outcomes
    b. to estimate costs and assess the task-shifting approach for its value-for-money
    c. to document and understand process issues from an implementation perspective
2. Applicants will need to propose robust evaluation questions that are aligned with the ToC and Logic Model – which include questions that are relevant for assessing outcomes/short-term impact as well as understanding process.
3. Methodological considerations
    d. Applicants will need to propose a rigorous evaluation design (e.g. experimental, quasi-experimental or a similar suitable design) and methods that are fit-for-purpose to answer the key research questions – aligned with the ToC, Logic Model and the objectives
    e. Mixed methods (with a strong quantitative component) are recommended. Applicants are encouraged to suggest new approaches to test the ToC, assess outcomes/impact, document process and gain any other contextual understanding.
    f. Applicants are encouraged to suggest innovative and reliable methods of data collection where possible. We also encourage use of any suitable secondary data in addition to the primary data.

g. Regular programme monitoring data will be collected which could be also considered as an additional source of information if needed.

4. Proposed deliverables: Applicants will need to propose payment-linked deliverables for each stage of the evaluation. Suggested deliverables could include finalised evaluation design and methods, detailed pre-analysis plan, baseline report, progress reports, evaluation tools, evaluation reports, etc.

VII. ENGAGEMENT PROCESSES REQUIRED

a. The selected evaluation agency will be expected to work closely with DFID-NHSSP and the implementing agency in finalising the logic model, key measurable indicators and on the timing of the data collection (e.g. baseline/endline and any other data gathering exercises). It will be important to ensure to complementarity between the programme monitoring (which is the responsibility of the implementing agency) and the evaluation and avoid any duplication.

b. Periodic meetings will be required with DFID-NHSSP and/or the implementing agency, and relevant government stakeholders throughout the contracted period. These will be agreed at the contracting stage

c. All deliverables will be reviewed by DFID-NHSSP and/or any other evaluation expert as deemed fit by DFID-NHSSP. Written feedback will be provided, which the contracted agency will be expected to respond to.

d. The applicant may need to sign and data privacy and protection agreement with DFID-NHSSP/Options

VIII. PROPOSAL SUBMISSION GUIDELINES

The proposals must include the following:

- Contextual discussion (not more than 1 A4 size page; Calibri – font size 11): This section should clearly lay out the applying organisation's understanding of the issue being addressed from a health systems strengthening perspective. This will be assessed for the level of independent analytical thought applied to understanding the context and not a mere duplication of background material provided in this ToR.
- Evaluation Design (including evaluation questions), Methodology and Timeline (not more than 5 - 6 A4 pages; Calibri – font size 11): This should be aligned with the details provided in the previous sections on ToC, Logic Model and the scope defined for the proposal. This will have to be bulk of the proposal and we encourage you to include any graphics for clarity where relevant. This section will be assessed for technical robustness and relevance of the design and methods; clarity of evaluation questions; justification of methods used, and appropriateness of timing of evaluation activities.
- Quality assurance mechanism (not more than 1 A4 page: Calibri – font size 11): This should include details on the quality assurance mechanisms that will be in place at each stage of the work, in terms of design, data gathering and producing high quality deliverables.
- *Optional:* Any other relevant details (not more than 1 A4 page: Calibri – font size 11): This could any other details which can help strengthen your proposal and include for example, recruitment and training plan for staff, data management plan, reporting plan, dissemination plan, etc.
- Team composition (not more than 1 A4 page: Calibri – font size 11): This should include details of the structure of the proposed evaluation team - with named individuals for the senior and

mid-level positions, and a brief paragraph on the expertise of the individuals. For all other junior positions, details of the type of job role and the number of people planned should be included. The CVs of all the named individuals should be included as an annex. Each CV should be no longer than 2 A4 pages. The entire team as a whole (and not individuals) will be assessed for demonstrated experience of high-quality evaluation and research of the senior and mid-level team, members with suitable sector and methods experience, adequacy of the entire team. The team will also be assessed (in conjunction with the budget proposed) on the how substantial and adequate the level of effort has been planned for the senior and mid-level positions.

- Organisational capacity statement (not more than 2 A4 pages; Calibri – font size 11): This should include why the applicant organisation is suitable for the evaluation, providing details on evaluation methodological expertise, experience of conducting independent health related research and evaluations, experience of working with government, any research or evaluation products of the applicant organisation, and other relevant information to support the application.
- Budget: A fully itemized budget in a separate Envelope.

IX. Bid Submission

The Technical Bid and Financial Bid must be sealed and submitted in separate envelopes and reach the Nepal Health Sector Support Programme (DFID-NHSSP, Oasis Complex, Patan Dhokha by 17.00 hours on 22 February, 2019.

DFID-NHSSP reserves all rights to reject any or all quotations/proposals without assigning any reason whatsoever.

X. Bid Evaluation Criteria

Bids are evaluated on the basis of both technical and financial proposal; 70% weightage is allocated for technical component and 30% for the financial component. Within the technical component, the proposal will be evaluated first using the following criteria for assessing suitability of the bid:

- Registration certificate; tax clearance certificate (10)
- Understanding of context/scope (15)
- Evaluation Design (including evaluation questions), methodology and timeline (30)
- Quality assurance mechanism (10)
- Team composition (25)
- Organisational capacity statement (10)

The financial proposal will be evaluated on the basis of price bid.