NHSSP Nepal Health Sector Support Programme

Regional Support

Capacity Assessment for Health Systems Strengthening

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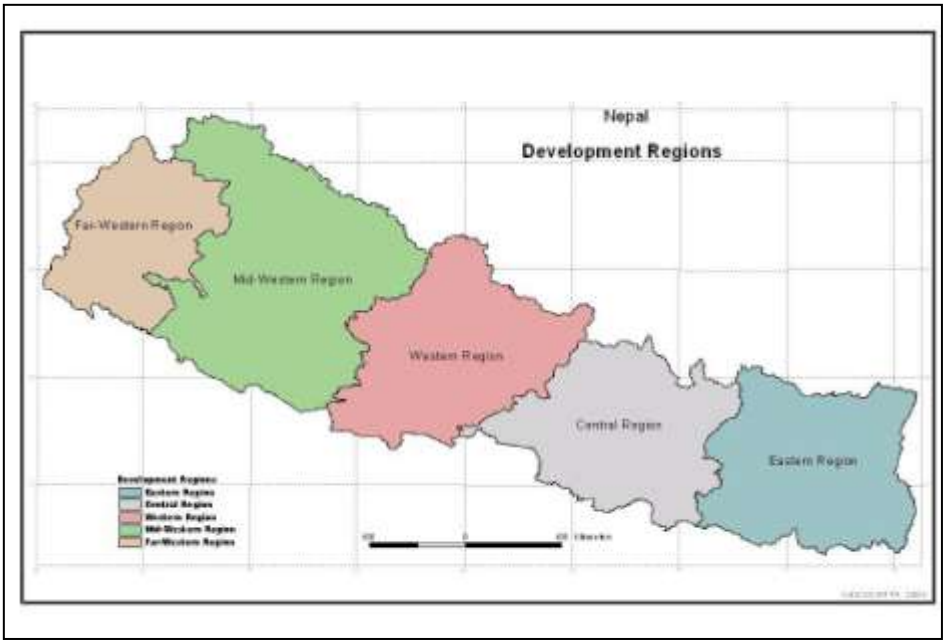

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LIST OF ACRONYMS

AWPB	Annual Work Plan and Budget
BCC	Behaviour Change Communications
DHO	District Health Office
DoHS	Department of Health Services
EDP	External Development Partner
EHCS	Essential Health Care Services
GESI	Gender Equality and Social Inclusion
GIZ	German International Cooperation
HMIS	Health Management Information System
HFMC	Health Facility Management Committee
HR	Human Resources
HSRP	Health Sector Reform Program
LTTA	Long Term Technical Assistance
MoHP	Ministry of Health and Population
MNCH	Maternal, Neonatal and Child Health
NFHP	Nepal Family Health Program
NHSP	Nepal Health Sector Programme
PHCC	Primary Health Care Centre
PHN	Public Health Nurse
PPICD	Policy Planning and International Cooperation Division
RD	Regional Director
RH	Reproductive Health
RHD	Regional Health Directorate
SSMP	Support to the Safe Motherhood Programme
STTA	Short Term Technical Assistance
TA	Technical Assistance

EXECUTIVE SUMMARY

Background:

In 2003, the MoHP transferred the management of nearly 1400 health facilities (PHCCs, Health Posts and Sub-health Posts) to VDCs. To date, there have been limited gains in building the capacity of the VDCs and the HFMCs to effectively manage these facilities. Capacity enhancement of VDCs and HFMCs remains as one of the major challenges for health systems decentralization in Nepal and a key concern of Regional Health Directorates.

Due to various constraints, including a decade long conflict, the Decentralization Act of 1999 has not led to the changes expected in most sectors including health. However in the run up to the pending transition to federalism or strengthened decentralization, MoHP has recently formed a steering group in the PPCID to pilot decentralization processes in selected districts. MOUs have recently been signed with several EDPs for single district pilots in four of Nepal's five development regions under MoHP's Local Health Governance Support Program.

Several UN agencies are directly involved in service provision at the grass-roots level. Implementation partners of EDPs and INGOs are also important players in decentralized health service delivery at district and VDC levels. Some are also very active in providing technical assistance to district health programmes. However there is, at present, a lack of coherence and coordination amongst these agencies and relatively few formal linkages with RHDs.

Institutional Challenges and Opportunities:

Regional Health Directorates (RHDs) have been established in Far-West; Mid-West; West; Central and Eastern Regions. Each is headed by a Regional Director (RD) who reports directly to the Secretary of Health. The RHDs are theoretically responsible for managing public health sector human resources, supervising and monitoring district health offices and coordinating with other regional health agencies and programmes of the EDPs and NGOs.

The sanctioned role of the RHDs in managing and strengthening health systems in Nepal is recognized at all levels but chronic under-resourcing since their establishment means that this potential has not been realised. RHD responsibilities far outweigh their levels of authority and available resources leading to their effective marginalisation and a significant disconnect in national health systems management.

While the RHD staffing structure is appropriately designed, there are a number of internal weaknesses that impact on performance. Offices are not equipped properly and, as a result, essential functions suffer. Mobility is also limited due to a shortage of vehicles and very limited budgets for operating and maintaining vehicles.

An additional major concern is that many senior staffing positions in RGDs remain vacant so requiring the RD adopt short term ad-hoc arrangements to manage the work. Rules and regulations governing the use of funds for monitoring and supervision are insufficiently flexible to allow travel to the large number of districts in each region. Some of these districts are remote mountainous districts with no road access and are consequently rarely visited.

Despite being the main arm of the government for monitoring and supporting district health offices, RHDs have not been adequately empowered and resourced by MoHP for this role. Further, RHDs lack oversight of important regional health institutions including regional stores, regional and zonal hospitals and regional health training centers despite being mandated to monitor them. Other MoHP entities such as the Departments of Drug Administration and Ayurveda also tend to bypass the RHDs in communication flows as do most DHO led technical assistance programmes at district level.

The authority of Regional Directors has also been eroded in recent years by the increasing politicization of human resource management reported at all levels. RDs and other staff are frequently posted and transferred with little notice, in an ad-hoc manner and without consultation.

Some important EDP assisted initiatives have supported health systems strengthening in MoHP over the years but there is dearth of documentation on these inputs. As a result, it is difficult to draw historical lessons able to inform health systems strengthening at regional, district and VDC levels. The provision of TA to address system bottlenecks remains a major sectoral challenge.

There is a need to increase the capacities and authorities of RHDs. Strengthened RHDs will potentially serve as working prototypes for the Provincial Health Secretariats anticipated under Nepal's new federal structure. In this context it is expected that a slimmed down MoHP and DoHS will be responsible for formulating policies and providing oversight functions but that major financial resources, decision making authority and technical assistance will be controlled at provincial level.

Proposed Strategic Focus of TA:

Fill vacant posts in RHDs

- As a matter of urgency, we recommend reviewing the RHD staffing status across all regions and actively supporting processes to fill vacant positions with priority given to section heads and technical officers (e.g. statistical officer, planning officer, PHN officer, health education officer). We further recommend making policy provision for the local recruitment and multi-year contracting of regional staff in order to fill remaining posts or short term gaps. It is expected that LTTA may need to provide stop-gap support to RDs until regular vacancies are filled.

Strengthen the internal organization of RHDs

- In addition to providing LTTA inputs in key technical areas (see below), NHSSP is advised to support the organizational development of RHDs through, in particular, (i) team building (ii) management skills training and (iii) upgrading office facilities and improving mobility.

Strengthen the technical capacity of DHOs and programme functionaries

- We recommend a staggered approach to deployment of three embedded LTTA advisers to each RHD to enhance technical capacity and support key work streams in the following NHSP 2 core areas:

    1) Planning, Monitoring and Health Systems Strengthening

    2) Essential Health Care Services (MNCH/RH/Nutrition) and

    3) Gender Equality and Social Inclusion / BCC

- It is recommended that the first LTTA teams be deployed in mid-west and far-west regions reflecting the low overall health status and service access levels in these regions. Capacity enhancement processes can then be tested prior to scaling up in the three remaining three regions approximately six months later.

- An early LTTA activity will be to compile and disseminate to RD staff lessons learned from various TA and INGO programs e.g. HSRP, SSMP, NFHP-1 and 2 (USAID), especially those focused on program strengthening at regional and district levels.

Strengthen the control and management functions of RHDs

- It is recommended that NHSSP LTTA help to facilitate dialogue between MoHP and RHDs to reassert the mandated functions and authorities of RHDs and support processes likely to result in the adequate resourcing of RHDs.

- LTTA should also support efforts to develop joint action plans with RHDs and MoHP/DoHS to address some of the key human resources management issues at regional and district levels and below and facilitate the role of RDs in managing those human resources assigned to them.

- The introduction of a performance-based appraisal system for all staff is recommended to be used as the basis for meritocratic staff transfers, promotions, incentives and punitive actions. Liaison with NHSSP's Human Resources TA is anticipated in this area.

- TA should also support RDs for the adoption of new management tools (e.g. resource mapping, planning, performance evaluations and quality control) for the management of district level programs with feedback used to further develop these tools

Build coalitions with all players working for health system strengthening to build the capacity of RHDs:

- It is recommended that NHSSP embedded TA support RDs to work with regionally based EDPs and INGOs to develop a joint compact and programme of coalition building and joined up working to strengthen health systems at regional, district and VDC levels. This should include mapping various TA inputs drawing on the regional mapping exercise appearing in section 5 of this report.

- It is further advised to follow this up through the preparation of a regional programming and TA plan led by each RD drawing on lessons learned from the GIZ supported health systems strengthening initiative in Mid and Far West Regions.

Health Facility Management Committees (HFMCs) to be strengthened as the first level of decentralization

- NHSSP TA should support each RD to work with DHOs and technical support agencies/INGOs in their respective areas to identify HFMC management successes and current constraints and prepare a regional strategy for improving management of HFMCs by VDCs and HFMCs.

Develop focused remote area/disadvantaged population strategies

- Advisers should support RDs to take a lead in coordinating agencies specializing in remote area working and targeting disadvantaged populations in order to develop comprehensive sub-regional strategies and plans linked to DoHS' context specific initiative for underserved populations.

- The resulting list of recommended changes in policy frameworks, program designs, priorities and administrative rules and regulations should be sent from the RHDs to MoHP with a view to overcoming access barriers in underserved areas.

Support the piloting of MoHP's Local Health Governance Decentralisation Program in Western Region

- We recommend that NHSSP have membership on the PPICD Steering Committee which was set up to implement MoHP's Local Health Governance Support Program (LHGSP) and support a single district pilot in Western Region. We further recommend that one of the RDs be represented on the Steering Committee.

Proposed Capacity Enhancement Approach:

NHSSP's overall approach to capacity enhancement draws on the work of Potter and Brough[1] and is described in the capacity enhancement section of NHSSP's inception report.

With regard to regional TA support arrangements, it is recommended that the proposed embedded LTTA position for Health Policy and Planning in the PPICD be the focal point in MoHP for providing support for health systems strengthening at regional, district and VDC levels. This will particularly include efforts to translate policy pronouncements at the centre into effective actions in regions and districts.

Each LTTA will be jointly managed by his/her RHD counterpart (see section 4) and appropriate Options LTTA based in DoHS. These counterparts will be involved in helping to set TA work priorities and in TA performance appraisals. The successful placement of LTTA clearly depends on the availability of appropriate counterparts. Staffing shortages in some regions may mean that temporary counterpart arrangements, including partnering directly with the RHD Director, are needed until additional staff are recruited. An important early task for the TA will be to support the RD in recruiting these additional staff.

The availability of office space in RHDs to accommodate embedded TA varies across regions. Central and Far Western Regions are currently unable to offer a work space and so local offices will need to be rented.

[1] Potter C and Brough R, Systemic Capacity Building: A Hierarchy of Needs, Health Policy and Planning 19(5), 2004

REGIONAL ASSESSMENTS

1.0 Introduction

Regional Health Directorates (RHDs) were established in each of Nepal's five development regions (Eastern, Central, Western, Mid West and Far-West) in 1972. During this rapid assessment, staff and managers of all five Directorates took part in participatory reviews of RHD strengths, challenges and TA requirements.

Each Regional Directorate is headed by a first class officer, the Regional Health Director who is responsible for planning, supervising and monitoring public health programmes and human resources in the region.

The overall objective of the RHD is to strengthen district public health systems and provide technical, supervisory and monitoring support to districts. RHDs are also mandated to support district health offices and coordinate the activities of external stakeholders including EDPs and I/NGOs. They are further responsible for monitoring Regional Medical Stores, Zonal and Regional Hospitals, Regional Health Training Centres, Regional Drug Administration Offices and Ayurvedic Health Facilities.

Nepal's Regional health status is described in Appendix 1 which shows significant disparities across regions. NHSP 2 highlights the vital role to be played by Regional Health Directorates in delivering national health objectives and identifies a need to strengthen their capacities to achieve this. The enhancement of RHD capacity depends crucially on building on current strengths and addressing various internal and external constraints that impair performance. The most prominent of these factors are outlined below.

2.0 Strengths of RHDs

The RHD organisational structure is well thought through and widely seen to be fit for purpose so allowing, at least in theory, RHDs to meet their monitoring, supervisory and coordinating mandates. For this reason, RHDs are acknowledged to be the "best fit" precursors to the state based health bodies expected under Nepal's proposed federal structure. Additional strengths include:

1. The number of sanctioned posts in all regional health offices appears appropriate even if a high proportion of these posts currently lie vacant.

2. Regional officials are generally committed to their technical roles.

3. The availability of EDPs and INGOs willing to collaborate with RHDs to improve planning, monitoring and coordination efforts appears high in all regions.

4. The potential for regional cross-sectoral working and coordination with other Ministries is good given the proximity of RHDs to other line Ministry offices and the Regional Administration Office.

3.0 Constraints of RHDs

All RHDs share a number of common constraints as described below.

Offices: RHD offices in general lack adequate physical facilities, furniture, equipment and basic office supplies. This is attributed to under-budgeting and a budget system that prevents the virement of funds for immediate priority purposes**.**

Mobility: The mobility of RHD officials is limited by transportation shortages. Each RHD runs a single vehicle for use primarily by the Director, and only occasionally for monitoring and support visits. The budgets for running costs and maintenance are reported to be inadequate for a full year's operation. Officer level staff must normally use public transportation during field visits.

Inaccessible terrain in the hills and mountains makes some monitoring trips extremely difficult. Transport availability in the MW, FW and Eastern regions is generally poor while the high number of districts in central region (19) imposes a high workload on RHD staff. In addition, current GoN travel rules limit field visits to seven days thereby effectively ruling out the monitoring or remote districts.

Human Resources: Staffing Structure: RHD's staffing structures, job titles and numbers of approved posts vary between the regions. The roles and responsibilities of senior level staff appear unclear since job descriptions are outdated and not formally issued upon appointment.

Understaffing: While all Regional Health Director posts are currently filled and each Directorate has 1 or 2 senior level officers in place, almost 50% of all office level posts are currently vacant. Of particular concern it that many of these posts have remained unfilled since their creation. The most commonly vacant posts are: **statistical officer**, **planning officer**, **public health nursing officer** and **health education officer**.

Responsibility for officer level recruitment does not rest with the RHD but with the MoHP and the Public Service Commission (PSC) which recruits once in a year. Recruitment procedures are reported to be complex and subject to delays and occasional cancellations.

Staff Grading: While all regional supervisor posts are currently filled, the lack of staff grading differentials between regional staff and their district level counterparts can limit their authority and effectiveness. District supervisors can be more knowledgeable and experienced than their regional equivalents leading to credibility concerns.

Staff Transfers: The practice of frequent staff transfers is common across all Regions. Party political, trade union and administrative interference in transfers is widely reported and results in some predictable consequences for the effectiveness of RHD teams. Excessive numbers of short duration postings and the mismatching of skill sets to roles are widely reported.

Staff Management: Despite being professionally committed to their roles, motivation levels among many RHD staff appear to need boosting. Staff management guidelines have yet to be developed, job

descriptions are outdated and rarely issued, and no budgetary provisions are made for staff development.

Approaches to staff appraisals are not carried out in such a way as to support an individual's work performance while the lack of RHD authority to reward or penalise staff is reported to impact negatively on overall performance management.

Postings to RHDs are also perceived to lack status and be disadvantageous for rapid career development. Staff report receiving little recognition and encouragement from the centre for inputs made and being passed over for training scholarships and attendance at international conferences.

Further management concerns have arisen in some Terai districts where monitoring staff have received physical threats from local health staff after reporting poor or irregular local practices. Even though these events are generally reported to Regional Directors, there is no clear mechanism for disciplining such staff and the RD appears powerless to act.

Communications: Information flows from the centre are frequently seen to bypass regional offices and link direct to district health offices. Similarly, districts tend to report to MoHP/DoHS rather than RHDs. Both effectively serve to undermine RHD authority.

Monitoring: District level monitoring is reported to be sub-optimal and unlikely to yield consistent quality data. Staffing shortages mean that district data collected by RHDs are frequently not cleaned and analysed prior to being forwarded to the HMIS section in DoHS. Further, while monitoring checklists exist they tend not to be adapted to track local health concerns.

In addition, analysed data from HMIS are not routinely fed back to regions and districts and thus are not available for review and planning purposes. The mapping of service availability and disaggregated service utilisation appears weak, related to low levels of appreciation of the need for social inclusion monitoring.

The monitoring of RHD performance by the centre also appears to require strengthening. Regional staff called for more regular and systematic interactions between MoHP/DoHS and RHDs. At present engagement is limited to occasional regional visits and annual regional review meetings

Planning: Planning remains the exclusive preserve of DoHS and MoHP such that regional and district health plans are simple aggregations of centrally sanctioned budgets. Regional and district health offices are not directly involved in priority setting nor are adequate budgets made available to respond to local public health emergencies and natural disasters.

C**oordination:** There is limited capacity within RHDs to coordinate regional EDP/INGO inputs. The majority of EDP/INGOs implement vertical district level programmes with only occasional links to RHDs.

Basic profiles of each regional directorate including HR. transportation and logistical status and perceived TA needs are laid out in the table below.

4.0 Regional Profiles

Region/Indicator	Eastern	Central	Western	Mid-western	Far-western	Remarks
1. Number of districts	16	19	16	15	9	
2. HR posts: sanctioned filled	44 27	48 31	44 34	47 34	44 27	33% vacant
a. Officer post (sanctioned)	12	16	12	14	12	
b. Officer post (filled)	5 filled; 4 present	8 filled; 6 present	6 filled; 5 present.	7 filled; 6 present	6 filled; 4 present.	63% unfilled or absent
c. Officer post (vacant)	7	8	5	7	6	50% of posts filled
3. TA Needs	a. Planning, monitoring and systems strengthening b. EHCS (SMNH /RH/ Nutrition) c. GESI / BCC	a. Planning, monitoring and systems strengthening b. EHCS (SMNH /RH/ Nutrition) c. GESI / BCC	a. Planning, monitoring and systems strengthening b. EHCS (SMNH /RH/ Nutrition) c. GESI / BCC	a. Planning, monitoring and systems strengthening b. EHCS (SMNH /RH/ Nutrition c. GESI / BCC d. STTA for remote area pilots	a. Planning, monitoring and systems strengthening b. EHCS (SMNH / RH/ Nutrition c. GESI / BCC d. STTA for focus needs	
4. Availability of counterpart	a. Yes (stat. Off) b. No c. No	a. Yes (Public H. Administrator. b. Yes (SrPHO) c. No	a. Yes (Stat. Off) b. No c. No	a. Yes (PHAdm.) b. Yes (SrPHO) c. Yes (SrPHO) d. No	a. No b. No c. Yes (HE officer) d. Not required	

5. Logistics (transport) support needs	4 wheel drive vehicle for the field	4 wheel drive vehicle for the field	4 wheel drive vehicle for the field	4 wheel drive vehicle for the field.	4 wheel drive vehicle for the field,	
6. Availability of space for TA	Yes, shared room available	No, need own arrangement	Yes, shared room available	Yes, shared room will be available (after July 2011)	No, need own arrangement	

5.0 Existing TA and External Partners' Support

Most EDPs and INGOs working in the regions provide direct implementation support to districts. Only a very small number have formal links with RHDs and support systems strengthening although most agencies are reported to be responsive to RHD requests to support individual events including thematic workshops.

A notable exception here is the GIZ funded Health Sector Support Programme (HSSP) which provides TA to RHDs in Mid-West and Far-West regions primarily in support of systems development and adolescent health programming. Outputs have included the creation of a regional health coordination team and a 3 year strategic plan for the Region and its 15 districts. Progress in the Far West has been less marked primarily due to RHD under-staffing.

A summary of key stakeholders providing technical or financial support to RHDs is given below. None of the listed TA reports directly to regional directors but to their own agencies:

SN	Partner	Number and types of TA support	Region
1.	WHO	Two non-embedded technical officers (MBBS Dr.) supporting polio monitoring	All
2.	H1-N1	Two technical officers (IT and epidemiologist) embedded in RHD	All
3.	GIZ	One non-embedded officer supporting adolescent health	Far-west and Mid-west
5.	Netherland Leprosy Relief (NLR)	Short term non-embedded technical support in TB programme	Far-west and East
6.	International Nepal Fellowship (INF)	Short term non embedded technical support in TB, RH and leprosy	Mid-west and West
4.	BNMT	Short term non-embedded technical support for TB programming	East
7.	UNICEF	Periodic support for meeting and workshops	All
9.	NFHP	Periodic support for meetings and workshops	All
11.	HIV/AIDS (Centre)	Proposed – one technical officer for each regional offices	all
8..	SAVE	Periodic support for meetings and workshops	Far-west and Mid-west
10.	FHI	Periodic support for meetings and workshops	Far-west

6.0 Conclusions and Recommendations

RHDs' responsibilities far exceed their levels of authority and resource provisions. As such, they are unable to meet their mandated roles. Additional factors include major human resource shortages, frequent staff transfers, inadequate physical facilities, transportation shortages, and the by-passing of RHDs in communications flows.

The staff and TA skill set at regional level is also highly uneven and unlikely to be able to meet NHSP 2 objectives. Three core thematic areas appear to require additional TA support across all regions. These are: 1) Planning, Monitoring and Health Systems Strengthening, 2) Essential Health Care Services (SMNH/RH/Nutrition) and 3) Gender Equality and Social Inclusion/BCC (including rights, gender based violence and women's health issues).

In order to enhance the capacity of RHDs, the following additional support is recommended:

a. Develop policy to re-assert the mandate of RHDs and ensure that they are sufficiently empowered and resourced to discharge their duties effectively.

b. Improve the working environment in regional directorates including physical facilities, office space, equipment, transportation and other appropriate facilities.

c. As a matter of urgency, review the staffing status across all regions and fill all vacant positions with priority given to section heads and technical officers (e.g. statistical officer, planning officer, PHN officer, health education officer).

d. Make policy provision for the local recruitment and multi-year contracting of staff in order to fill any remaining posts or short term gaps.

e. Introduce a performance-based appraisal system for all staff to be used as the basis for transfers, promotions, incentives and punitive actions. Liaison with NHSSP's Human Resources TA is recommended here.

f. Deploy TA teams to enhance RHD capacity to support key work streams and strengthen Regional Health Systems. There is an immediate need for full time embedded TA for a minimum period of approximately 30 months in 1) Planning, Monitoring and Health Systems Strengthening; 2) Essential Health Care Services (MNCH/RH/Nutrition) and 3) Gender Equality and Social Inclusion / BCC. These TA will initially need to work with RHDs to help fill vacant positions. Additional STTA is anticipated to be needed in MW and FW regions.

g. Identify counterparts within each RHD for all TA posts. Staffing shortages may mean that temporary partnering arrangements, including with the RHD Director, will be needed until additional staff are recruited. An important early task for the TA will be to support the Director in recruiting additional staff.

6.1 Proposed TA and Management Arrangements

Proposed outline job descriptions for the 3 proposed TA posts per region are presented below. Additional short term TA requirements are also described in this section.

With regard to management arrangements, each full time TA will be co-managed. He/she will report directly to his/her counterpart but will be functionally accountable to the RHD Director. Technical line management will be provided by the appropriate NHSSP TA based in DoHS and MOHP. Any difficulties arising from these arrangements will by taken up by the Team Leader, Health Policy and Planning (National Lead) or Senior Quality Assurance Adviser as appropriate. Seniority within TA teams will be agreed during recruitment which will involve Regional Directors. Each Director's view on priority gaps and the qualifications and experience of candidates will be important factors here.

6.2 LTTA Job Descriptions

Proposed post	**Regional Planning, Monitoring and Systems Strengthening Specialist**
Key responsibilities	a. Support the RHD in health systems management especially strategic planning, systems development, including IT (supported by the Head of Finance and Admin) and personnel management (supported by the HR adviser). b. Maintain oversight of regional health development including analysis and understanding of the region, underperforming areas and populations, private and NGO providers and RHTC performance in order to build the evidence for targeting resources to needy areas. c. Provide technical back stopping and skills transfer to the RHD for the receipt, compilation, analysis and interpretation of district level data and provide appropriate feedback to districts. d. Provide technical support to the RHD for the development of annual regional and district plans using appropriate data and information. e. Support context specific planning and programming. f. Provide support to the RHD for the coordination of various EDP and INGO inputs in the region and strengthening linkages with regional administration and line agencies (e.g. DWSS for watsan) g. Support RHD staff to provide appropriate monitoring and evaluation support to district health offices and hospitals and support the development of HFMCs.

	h. Support the RHD to ensure regular, accurate and timely progress and financial reporting from facilities and districts and onward reporting to DoHS and MoHP. i. Provide support for regional level monitoring and evaluation training j. Provide technical support for the preparation of the quarterly and annual reports. k. Provide technical support for the preparation of evidence based quarterly and annual reviews of district and regional health programmes. l. Provide technical support for the implementation of periodic studies and research. m. Facilitate the establishment and functioning of a District Health Information Committee (DHIC) to act as a governing body for the District Health Information Bank (DHIB). (see M&E capacity assessment).
Person specification	**Essential:** a. A MPH degree from a recognised university with appropriate experience. b. Training in health system strengthening and data analysis and monitoring. c. Experience in working with government counterparts, donors and I/NGO partners. d. Experience in providing technical supervision and support to field level programmes including health programmes. e. Experience with personnel management and working in a multidisciplinary team. f. Strong communication and networking skills. **Desirable:** a. HMIS training. b. Experience of providing technical support to government and building capacity of counterparts. c. Working in the health sector. d. Good planning, data management and analytical skills.

Proposed post	Essential Health Care Services (MNCH / RH / Nutrition) Regional Specialist
Key responsibilities	a. Enhance the capacity of RHDs to plan, programme, supervise, quality assure and monitor EHCS in the areas of MNCH, RH and Nutrition and pass these skills on to districts. Work closely with the Regional Safe Motherhood Coordinator in these areas. b. Provide technical back stopping and skills transfer support to the RHD, including focal persons, and districts, for the establishment, staffing and management of B/CEOC and Birthing Centres including strengthening referral systems and supporting community based MNCH programming including BCC. c. Provide technical support to the RHD to prepare and implement the monitoring of MNCH/RH/Nutrition district and urban health plans. d. Support context specific planning and implementation. e. Provide technical support to the RHD to conduct evidence based quarterly/annual reviews of district level MNCH / RH / Nutrition. programmes. f. Support RHD networking on RH/EHCS linkages to watsan. g. Support RHD linkages with programme division and various centers to ensure budget allocations reflect priority district needs.
Person specification	**Essential:** a. A graduate/master's degree in nursing with MPH or BPH. b. Specific training in SBA/newborn care. c. Experience in working with government counterparts, donor and I/NGO partners. d. Experience of technical supervision and support to field level programmes including community based health initiatives. e. Experience of working in multidisciplinary teams. f. Strong communication and networking skills. g. Ability to mobilise diverse stakeholders and build consensus. h. Experience of health service delivery strengthening. **Desirable:** a. Specific training on Nutrition, /FP/Abortion/Adolescent health b. Experience of providing technical support to government and building the capacity of counterparts. c. Good planning, programming, monitoring and analytical skills. d. Strong communication, networking, facilitation and report writing skills.

Proposed post	Regional Gender and Social Inclusion / BCC Specialist
Key responsibilities	a. Enhance the RHD Director's and team's capacity to mainstream GESI in health programming including: ○ Support coordination of RHD and regional line agency GESI inputs including those of the Prime Minister's Office's Gender based violence initiative and the Ministries of 1) Local Development; 2) Women, Children and Social Welfare, and 3) Education and others as appropriate. ○ Support RHD and DHO coordination with district level GESI inputs including those of DDCs, VDCs and EDPs/INGOs. ○ Support local implementation of MoHP's GESI strategy including the establishment and functioning of Social Service Units in health facilities, One Stop Service Centres for victims of GBV and the multi-year contracting of local NGOs for equity and access programming. ○ Develop a GESI evidence base for the region to inform RHD and District planning and monitoring. ○ Provide technical support to DHOs for the local planning, implementation and monitoring of GESI programmes. ○ Support the RHD, Health Education Officer and Districts to programme IEC/BCC including awareness-raising on free essential health care services, Aama and other entitlements. ○ District health management planning for GESI. ○ Strengthening social accountability mechanisms and civil society engagement in monitoring services and entitlements including through strengthening HFMCs. ○ Build the capacity of the RHD to understand and integrate GESI into the systems and functioning of the RHD and, in turn, support the capacity building of the Districts in GESI. ○ Work with RHTCs to build GESI capacity including support for orientation and training. ○ Support DHOs to participate in GESI elements of DDC planning. ○ Application of the Remote Area Guidelines including VDC targeting and the development of micro-planning tools across various subsectors. b. Undertake equity and access, and rights based advocacy, and networking with government stakeholders and CSOs.

Person specification	**Essential:** a. A Masters degree in social science or anthropology. b. Training and experience in gender and social inclusion programming. c. Experience of working with government counterparts, donors and I/NGOs. d. Experience of technical supervision and support to field level programmes including community mobilisation. e. A proven ability to mobilise diverse stakeholders and build consensus. f. Experience of working in multidisciplinary teams. g. Strong communication and networking skills. **Desirable:** a. Experience of working in the health sector. b. Social mobilisation and IEC/BCC training. c. Experience of implementing IEC/BCC programmes. d. Experience of providing technical support to government and building the capacity of counterparts. e. Good analytical and reporting skills.

6.3 Key TA Tasks

The following tasks have been identified as requiring priority attention in each RHD from long term embedded TA or short term technical assistance:

1. Orientation on NHSP 2 including the importance and limitations of NHSSP TA.
2. Further assessment of individual capacity enhancement needs in relation to individual health programmes.
3. Addressing attitude barriers to improving work performance in Regional and District health facilities using Appreciative Inquiry (AI).
4. Enhancing knowledge and technical skills on gender and social inclusion and conducting regional GESI planning.
5. Specific capacity enhancement inputs on:
    - Programme management including planning, monitoring and supervision.
    - Regional and district resource mapping and regional co-ordination with internal and external stakeholders.
    - Major public health initiatives (e.g. Free Essential Health Care Services) to enable RHD teams to carry out effective supervision, mentoring and on-site monitoring.
    - Enabling RHD/DHOs to support health facility upgrading for BC/BEOC/CEOC.

- Internal management systems including office management, IT communications and networking, upgrading computer skills, telephone intercoms, effective staff communications including meetings and time management (supported by NHSSP's Head of Admin and Finance).

6. Capacity building on data management including data verification, data storage, analysis, data use in planning and decision making.
7. Context specific planning at local level.

6.4 TA Logistical Support Requirements

The following equipment and transport is recommended for supply to each TA team.

- 3 laptop computers
- 1 network printer
- 1 multi-media projector
- 1 photocopy machine
- 3 telephone sets
- 1 fax machine
- 1 4-wheel drive vehicle (to be used primarily for monitoring support visits)

Appendix 1: Regional Health Status

Regional health performance against key indicators is presented below. Most Regions are seen to be off-track for meeting 2015 targets but with wide variations seen across regions.

TABLE REQUIRES VERIFICATION (include nutritional status)

SN	Key indicators	Achievements: Regional and National Average						Target for 2015
		East	Central	West	Mid-west	Far-west	National	
1.	CPR	46	42	31	41	35	43	67
2.	ANC 1st visit (% of expected pregnancy)	86	89	81	97	90	88	
3.	ANC 4th visit (% of ANC 1st visit)	48	57	61	47	44	51	80 (SLTHP)
4.	Delivery by SBA (among expected pregnancy)	29	31	27	29	25	29	60 (2017)
5.	Institutional delivery (DHS 2006)	16.6	24.2	17.4	13.6	8.5	17.7	40 (2017)
6.	PNC 1st visit	50	51	51	49	45	50	
7.	Number of functioning birthing centre and B/CEOC sites			0 38 19		112 9 5		
8.	EPI coverage: BCG DPT\/Polio Measles TT		97 82 81 45	0 76 80 78	103 88 97 79	99 86 91 67		
9.	HIV prevalence rate					1.5		
10.	IMCI coverage (% of severe pneumonia among new ARI)	0.43	0.36	0.37	0.68	0.71	0.48	
11.	% of severe dehydration (district wise trend in percentage)	0.26	0.39	0.22	0.52	0.5	0.38	

It is noted that Mid and Far-west regions generally lag behind other regions in most health staus indicators suggesting the need for additional inputs including differentiated staffing and intensified programme inputs (e.g. nutrition support in MW region).