NHSSP Nepal Health Sector Support Programme

Essential Health Care Services

Capacity Assessment for Health Systems Strengthening

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An assessment of capacity building for health systems strengthening for the delivery of the NHSP 2 results framework

This Essential Health Care Services (EHCS) Assessment integrates the core components of the Child Health, Newborn Health and Nutrition Capacity Assessments and reflects the breadth of EHCS proposed for support by NHSSP. For further detail please refer specifically to the individual assessments in Annex 1.

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Acronyms

AHW	Auxiliary Health Worker
AMDA hospital	Association of Medical Doctors Asia – Nepal
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual Reproductive Health
BEOC	Basic Emergency Obstetric Care
BPP	Birth Preparedness Package
CABA	Children Affected By AIDS
CAC	Comprehensive Abortion Care
CARE	Care International
CB-IMCI	Community-Based Integrated Management of Childhood Illness
CB-NCP	Community-Based Newborn Care Package
CCM	Country Coordinating Mechanism
CEDPA	Centre for Development and Population Activities
CEOC	Comprehensive Emergency Obstetric Care
CHD	Child Health Division
CPR	Contraceptive Prevalence Rate
CRS	Contraceptives Retail Sales
DFID	UK Department for International Development
DG	Director General
DACC	District AIDS Coordinating Committee
DHO	District Health Office(r)
DoHS	Department of Health Services
DPT	Diphtheria, Pertussis (whooping cough) and Tetanus
EDP	External Development Partners
EHCS	Essential Health Care Services
EPI	Expanded Programme of Immunisation
FCHV	Female Community Health Volunteers
FHD	Family Health Division
FHI	Family Health International
FP	Family Planning

FPAN	Family Planning Association of Nepal
GAVI	Global Alliance for Vaccines and Immunisation
GBV	Gender Based violence
GESI	Gender and Social Inclusion
GoN	Government of Nepal
GTZ	German Technical Co-operation
HA	Health Assistant
HF	Health Financing
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information System
HP	Health Post
HPP	Health Policy and Planning
HR	Human Resources
HR CA	Human Resource Capacity Assessment
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
INGO	International non-government organisation
IUCD	Intrauterine Contraceptive Device
KAP	Knowledge Attitudes and Practices
KMC	Kangaroo Mother Care
M&E	Monitoring and Evaluation
MBBS	Bachelor of Medicine Bachelor of Surgery
MD	Management Division
MDG	Millennium Development Goal
MMM	Maternal Mortality and Morbidity
MMR	Maternal Mortality Ratio
MNH / MNCH	Maternal Neonatal (Child) Health
MNCHW	Maternal Neonatal Child Health Worker
MoH	Ministry of Health
MoHP	Ministry of Health and Population
MSI	Marie Stopes International
NACC	National AIDS Coordinating Committee
NCASC	National Centre of HIV/AIDS and STD Control

NCH	Neonatal Child Health
NDHS/DHS	National Demographic and Health Survey
NEWAH	Nepal Water for Health
NFHP	National Family Health Programme
NGO	Non-Government Organisation
NHCB	National HIV/AIDS and STD Control Board
NHEICC	National Health Education Information and Communication Centre
NHSP	Nepal Health Sector Programme
NHSP2-IP	Nepal Health Sector Programme II – Implementation Plan
NHTC	National Health Training Centre
NMR	Neonatal Mortality Rate
NSMP	Nepal Safe Motherhood Programme
NSV	Non Scalpel Vasectomy
OPD	Out Patient Department
ORS / ORT	Oral Rehydration Salts / Therapy
PAC	Post Abortion Care
PHCC	Primary Health Care Centre
PLAN	Plan International
PMNH	Partnership for Maternal Neonatal Health
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
PSBI	Presumed Severe Bacterial Infection
PSI	Population Services International
QM	Quality Management
RAG	Remote Area Guideline
RFA	Request for Applications
RH	Reproductive Health
RHCC	Reproductive Health Coordinating Committee
RTC	Registered Training centre
RTI	Research Triangle Institute International
SAVE	Save the Children
SBA	Skilled Birth Attendant
SHP / PHC-ORC	Sub-Health Post / Primary Health Care Outreach Clinic
SMNH	Safe Motherhood and Neonatal Health

SRH	Sexual Reproductive Health
SSMP	Support to the Safe Motherhood Programme
STI	Sexually Transmitted Infection
STTA	Short Term Technical Assistance
SWAp	Sector Wide Approach
TA	Technical Assistance
TCIC	Technical Committee for the Implementation of Comprehensive Abortion Care
TFR	Total Fertility Rate
ToR	Terms of Reference
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VACC	Village AIDS Coordinating Committee
VCT	Voluntary Counselling and Testing
VHW	Village health worker
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation
WRA	Women of Reproductive Age

1. Executive Summary

This capacity assessment was undertaken in November 2010. The overarching EHCS assessment and maternal and newborn health assessment was undertaken by Dr Louise Hulton, Dr Ganga Shakya , Maureen Dariang and Wilda Campbell. This capacity assessment was also informed by a nutrition assessment led by Helen Keller International (HKI) and neonatal and child health assessments led by SAVE.

Background

Strengthening and expanding equitable delivery of the Essential Health Care Services (EHCS) package is central to Nepal Health Sector Programme 2 (NHSP2). The NHSP2 Implementation Plan (NHSP2-IP) places an emphasis on the need to bring services closer to remote and underserved communities and reducing demand side constraints to those services which are available. In order to support delivery of the NHSP2 Results Framework it will be essential that technical assistance (TA) supports the MOHP/Department of Health Services (DOHS) to build on the successes of Support to Safe Motherhood Programme and the Health Sector Support Programme to ensure gains made towards Millennium Development Goals (MDG) 4 and 5 are sustained and support greater integration and improved quality of services in the delivery of EHCS at facility and community level.

Strategic Focus of EHCS TA

EHCS has a broad definition within the NHSP2 Results Framework (RF). The TA to EHCS will not be able to cover all components of EHCS defined within the RF. In this capacity assessment, we suggest that strategic focus of our TA will be on supporting delivery of quality and integrated maternal, neonatal and child health services, especially to reach underserved populations. TA to EHCS will incorporate maternal and neonatal health (including safe abortion). It will also incorporate child health to age 5 and those components of EHCS which overlap as core contributory causes of death for women and their children (to include nutrition, malaria, water and sanitation, family planning, and HIV). Gender based violence and mental health will be partially included, as will adolescent sexual and reproductive health. Through this strategic focus the TA will support the MOHP/DOHS to deliver on most of the core indicators of the Results Framework.

EHCS: Capacity Building Focus

Maternal and newborn health: A major issue in MNH is training of skilled birth attendants. The National Health Training Centre supervises the Regional training centres. Capacity within the NHTC needs strengthening in order to maintain quality of training and have adequate training sites, both in-service and pre-service. Moreover, at present CEOC service is available only in 32 out of 75 districts. Efforts to ensure a synchronised inputs from all levels to make all current CEOC facilities (13 non-functioning) functioning and expand CEOC services in the remaining districts (target 60 districts for 2015) is essential. Expanding birthing centres in all current 700 Health Post (HP) and 1000 HP, newly upgraded from SHP, will also improve accessibility of SBA service to remote locations and for underserved population. As the community-based newborn care programme matures, focus needs to be increased on case management of newborn illness in facilities, something which is currently rarely done in health facilities. The Community Based New Born Care Package is currently being piloted by CHD. There is a need to strengthen both community and institutional

postnatal care arrangements and related referral. This will involve close coordination between the FHD and CHD and PHC Revitalisation Division.

Child Health: The Capacity Assessment suggests that efforts will need to focus on those areas prioritised by NHSP2, specifically: maintaining programme quality by training new entrants (health workers and FCHVs), conducting refresher training, intensive supervision, monitoring and periodical review of the programme; developing public private partnerships for implementing the community-based integrated management of childhood illness (CB-IMCI) programme; Incorporating CB-IMCI protocols into pre-service curricula; Integrating tested CB-NCP interventions with CB-IMCI and safe motherhood after evaluation of CB-NCP programmes in piloted districts; revitalising the programme in low performing districts. A key focus of capacity development to improve child health needs to be the reduction of pneumonia and diarrhoea mortality in 1 to 59 month olds. The core recommendation being that capacity development efforts would be most effectively targeted by focusing on quality implementation at scale of the: measles, DPT, and Hib immunisation (Hib was recently introduced in the pentavalent vaccine); pneumonia case management through FCHVs and facilities; oral rehydration therapy, zinc supplements and continued feeding for children with diarrhoea and exploring household water treatment.

Family planning and Adolescent Sexual and Reproductive Health: The lack of EDP focus on FP is identified as a real gap and new momentum in FP is needed. This capacity assessment has highlighted some specific gaps and issues which require immediate focus. These are: post-abortion contraception; integration of FP with comprehensive abortion care (CAC); IUCD training; and better integration of RH services. Very few adolescents are utilising adolescent sexual and reproductive health services (ARSH) including emergency contraception (knowledge of emergency contraception among MWRA is only 9% & 15% of currently married adolescents are using contraception in 2009 NFHP survey) and there is need to support the FHD in scaling-up appropriate youth friendly services and demonstrating that they work at scale. It is recommended that NHSP2 efforts with regards to HIV/AIDS are focused on coordination and, where logical, better integration of services to improve access and efficiency of resources as well as simplifying pathways for users of reproductive health services. Piloting and scaling up integration of PMTCT in ANC services starting from HIV high prevalent and high risk districts.

Nutrition: The CA suggests and discussion within MOHP supports that there is strong support for developing a nutrition strategy that is life cycle and continuum of care based. There is a need for a specific policy on maternal nutrition. A Maternal Nutrition Working Group led by the Family Health Division and other key stakeholders is an idea that is supported by this assessment. Considering the recent and continued growth of urban areas, the lack of an urban nutrition strategy, targets and programming is identified as a gap in NHSP2. By advocating a more community based approach for nutrition, NHSP2 allows for the opportunity for improving access to nutrition interventions by socially excluded women and families.

Proposed Technical Focus of TA

Quality and Integration: Improved quality and integration of services at the point of delivery are critical strategic areas for capacity development, and will bring together efforts to

improve outcomes within the broader EHCS service spectrum supported by NHSP2. Currently Management Division (MD) is responsible for Quality Management in general but respective divisions and centres are responsible for quality of care in their programme area and for developing standards and protocols. Some institutional and policy frameworks need to be reviewed and updated to align them better with the NHSP2 vision for EHCS. Standardisation of EHCS protocols and ensuring application of these standards at service delivery points through review monitoring workshops and supportive supervision from district and regional levels and participation of HFOMC need strengthening.

Continuum of Integrated Care: The capacity assessment suggests that current institutional arrangements (resulting from years of multiple donors with differing priorities) of MNCH programmes could be integrated to ensure continuum of care and increase cost-effectiveness and coverage of core health themes of NHSP2. It is suggested that the continuum of integrated care for maternal, newborn and childcare is a recommended model for a health systems approach, which could be applied effectively in Nepal. The continuum of care conceptualises the healthcare system as a range of activities from families and communities, outpatient and outreach services to institutional clinical services, with attention to the life cycle. It advocates for high coverage and quality of integrated service delivery packages with functional linkages between the levels of care. Integration of nutrition interventions including breast feeding in MNCH programmes needs to be explored. Under the leadership of DG, a technical working group facilitated by SAVE for MNCH was formed for facilitating integration of MNCH programmes. A draft strategy will be available early 2011 which will guide the implementation of integrated MNCH programmes. TA will continue to support piloting and implementation of this strategy.

Geographic Coordination and emphasising underserved population: Underpinning the broader challenge of integration is the need for geographic coordination and focus. A coherent geographic strategy would provide a framework for prioritisation of interventions and increase synchronicity between inputs at district level.

As reflected in the GESI strategy, one model or expansion of MNCH/EHCS will not fit all areas of Nepal. The Remote Area Guidelines for Safe Delivery (2009) are the first step towards recognising this in practice. The piloting and scale up of these guidelines will help meet the needs of some of Nepal's most underserved populations. Going forward it would make sense to ensure that an integrated approach to remote area guidelines is taken to include, where logistically and practically efficient, a broader EHCS package, through development of an area plan. Coordination for integrated efforts to deliver EHCS to geographically disadvantaged areas is essential to reach NFHP 2 targets, reducing equity gaps. More context-specific planning and implementation would help focus efforts to reach other underserved or hard to reach populations (e.g. underserved urban populations). A more targeted and coordinated geographic approach will be particularly important to the achievement of substantial additional reductions in mortality in 1 – 59 month-olds, and greater equity in health outcomes. This will require a focus on quality and coverage of child health interventions among high-risk populations, including those in rural areas, the Mid-west and Far-west, among poorer families and those with less educated mothers of children under five, and include mountain areas. Such context specific planning would explore ways

to reach underserved and poorer communities (including urban poor) including integration/mainstreaming social inclusion training in CBNCP and FCHV review meeting.

Referral: Weak, non-existent and ineffective referral networks were identified as playing a contributory role in poor maternal health outcomes in the MMM Study (2009). Less has been documented about the state of broader MNCH referral networks. A logical subcomponent of the integration and quality of care would be a Referral Strategy to examine the blockages and barriers to good referral management across the relevant health areas. There is a clear opportunity to inform such a strategy through the mapping of points in a person's care journey and the development of strategies to improve referral into services and then between services. All components of the system need an active effective referral system linking them. Given that district health offices generally oversee hospitals and primary health care facilities (Primary Health Care Centres, Health Posts and sub Health Posts), Nepal's health system starts with a major advantage for developing and monitoring effective referral.

Public Private Partnership in delivering EHCS: Harnessing the potential of the private sector to help achieve MDG 4 and 5 poses a real opportunity under NHSP2. In some areas, the only CEOC site accessible to women is a private or NGO facility. The capacity assessment suggests the need for support to developing standards and guidelines to enable and strengthen involvement of the private sector within an appropriate regulatory framework in a way that most effectively supports national priorities.

Capacity building of NHTC to respond the training needs for delivery of quality EHCS services – maternal, new born and child health training. Expanding and improving the quality of SBA training is an urgent need to reach the NSHP 2 targets. The National Health Training Strategy (2004) needs a revision to respond the changing needs of health sector and NHSP 2 plan to upgrade this centre into a National Health Academy (which caters to both government and private sectors training needs), and secure the long term sustainability of this centre. As more and more nurses and ANM receive in-service SBA training, current in-service training sites could expand their focus to cater to the needs of private pre-services training institutions as clinical practicum sites.

Capacity building of regional and district level for quality and integrated EHCS delivery: The potential of supporting Regional Directorate (RHD) Office to operate in its full function can not be over emphasised as a means to reaching poor and underserved populations. Building the capacity of RHD for supporting EHCS delivery, supervision and monitoring would augment service delivery and quality of care.

Challenges and Opportunities

The Departments responsible for most of the components of EHCS covered in this capacity assessment are the Family Health Division and Child Health Division. The new Revitalisation Unit, under the DOHS will have an important part to play in improving access. Coordination of the various donor funded initiatives was identified as an important challenge in both FHD and CHD, constraining the delivery of integrated quality services. It is recommended that developing the institutional structures to improve coordination and integration be a major focus of capacity development within the NHSP2. The committee structure that supports

Reproductive Health/EHCS policy and planning is in need of a refresh to better reflect the priorities of the NHSP2. A revitalised RHCC could provide the coordination necessary between these sub-committees in order to strengthen integration and harmonise efforts.
Frequent movement of Senior Managers and other key clinical staff has an impact on the quality of MNCH services. Many of the staff in DOHS express willingness to learn more on management of programme implementation, budgeting, monitoring and assessment. In the case of the new Revitalisation Division, the lack of more than a few dedicated staff for the 22 posts has meant little progress in practice. The Nutrition Division is under Child Health but only has one nutritionist.

Proposed Capacity Development Strategy
The evidence reviewed through this capacity assessment indicates that the policy environment is conducive to improving EHCS health outcomes. The focus will need to be to build the capacity of the GoN: to pilot, evaluate, implement and embed additional service components of existing EHCS packages prioritised in NHSP2; scale up existing components of EHCS packages - notably SBA training and CB-NCP; to enable further reduction of pneumonia and diarrhoea mortality in 1 to 59 month olds focusing on underserved children; improve coordination within the public sector, with NGO and Private sector providers and EDPs to align efforts most efficiently against NHSP2 priorities; address existing gaps in the continuum of care; improve integration, reduce duplication and improve efficiency; develop and implement an area plan as a basis for coordinating health system and EDP inputs (to support the remote area strategy and focus efforts to meet the needs of other underserved populations); strengthen institutional arrangements to support the delivery of the above and institutional strengthening of NHTC to support staff capacity building.

Proposed Technical Assistance
Two embedded long-term positions are proposed within the DOHS (an MNCH Adviser within FHD and a EHCS Adviser within CHD / NHTC). The ECHS Adviser will be supported by on-going, non-embedded short-term TA from HKI and SAVE, which will ensure continuity of expertise and focus for nutrition, child and neonatal health and integration of maternal, new born and child health programmes.

The rationale for placing long-term embedded TA within the FHD and CHD /NHTC is to ensure capacity development across the continuum of care is sufficiently supported across priority areas of the NHSP2 and different levels including regions, districts and communities and training needs are adequately responded. These post holders will work very closely together to help develop and embed coherence and coordination between these two divisions and centre and their related areas of focus. Their positioning within FHD/CHD/NHTC will be agreed with the D-G. It is recommended that their Counterparts be directors of FHD and CHD/NHTC.

The MNCH Adviser and the EHCS Adviser will provide critical capacity development/ enhancement to those priority areas of the NHSP2 which need focused support outlined in the TA plan. The MNCH Adviser will further develop the capacity of the existing Safe Motherhood Coordinators (existing red book posts functioning at the regional level). Additional EHCS support to the 5 regional health directorates is envisaged. The Regional Assessment recommends that EHCS support be provided at Regional Level with a view to

developing regional capacity and ensuring the practical implementation of new, updated or revised ways of working. The division of responsibility between the proposed Advisers will reflect the priorities of the FHD and CHD / NHTC.

EHCS TA Matrix

Issues/ Gaps	Recommendations	TA response
Technical and Institutional		
Reaching remote and underserved population	Expansion of RAG to broader EHCS and implement Develop strategies and plan to improve coverage Adapt micro-planning for MCH and scale up for underserved areas Build regional and district capacity	• Support piloting of expanded RAG (number of districts to be defined) and scaling up among remote and underserved including urban areas • Explore strengthening community based programme (with GESI) • Support assessment of micro-planning process and revision for integration of MNCH • Regional focus to support implementation, supervision and monitoring • Training of regional and district level staff • Link with GESI
Referral system not adequate to reach underserved	Strengthen referral system with strengthening referral sites and linkage with rural facilities and communities encompassing maternal, new born and children (eg. Increased CEOC sites and BC, newborn care at referral centres, communication)	• Support to develop and pilot referral strategy/ guideline and scaling up
Interrupted services and quality issues due to un-synchronized inputs	Synchronicity of health systems strengthening effort. Eg. to follow infrastructure improvement with HR and supplies; HR management considering service provision (especially for CEOC sites)	• Support for enhancing inter-divisional/centres coordination in planning with all EDPs participation • Facilitate for robust information sharing

Issues/ Gaps	Recommendations	TA response
Inadequate coordination of TA inputs among EDPs	Development of implementation plan to stage inputs and provide framework for context specific plan which will provide GON a framework for selection of focus areas and issues for EDP support Revision of ToR and members of RHCC in line with NHSP 2 focused; Form Nutrition Committee lead by DG	• Pilot and facilitate to develop framework / guideline for context specific area planning • Coordination for synchronized efforts among EDP's TA at (DoHS level) focusing on continuum of care to improve access to integrated services • Secretariat support to RHCC and relevant sub-committees and facilitating linkage of sub-committees
Access to quality services and coverage of EOC, SBA, Family planning	Strengthening existing CEOC services and expansion according to national target Skill enhancement of SBA including improving enabling environment, supportive supervision, monitoring and training	• Study on current B/CEOC strengthening approach and piloting innovative approach for CEOC strengthening and scaling up • Support to develop and pilot follow up system following SBA training and scaling up • Support supportive supervision to ensure following guidelines/ protocols; • Support to strengthening management committees • Support for identifying and development of effective BCC tool and techniques to improve care seeking behavior (link with GESI) • Support to scale up SBA/ IUCD training sites
Opportunity to enhance private sectors involvement in providing quality EHCS and training	Ensure to follow guidelines/ protocols by public and private sectors Review the existing in-service and pre-service curricula to integrate current in-service curricula torelevant pre-service	• Coordinate with respective councils/ institutions to integrate relevant training curricula and regulate quality • Facilitate and support NHTC • Technical support to develop the strategy to implement the

Issues/ Gaps	Recommendations	TA response
	training curricula Institutional support to private sectors (PPP)	curriculum • Support institutional arrangement for PPP
Reported high suicide among reproductive aged women	Revise and implement GBV protocol in line with one-stop crisis centre approach as outlined in NHSP 2	• Support to revise and pilot GBV protocol in line with one-stop crisis centre approach • Support to improve counseling in post-partum care
Effective utilization of NHTC/ Staff College for delivery of EHCS	Revision of national health training strategy and explore for transition to national health academy in line with NHSP 2 focus Expansion of SBA and IUCD training sites and quality maintenance	• Support capacity assessment of NHTC, strategy revision and advise for feasibility of transition to national health academy • Support expansion of SBA and IUCD training sites; support to develop a system of quality improvement including follow up and support after training
Capacity of CHD staff to deliver child health/ new born health/ nutrition is not adequate	Develop and implement capacity development plan	• HR capacity assessment of CHD and support development and implementation of capacity development plan
Frequent turnover of staff	HRH strategy (MoHP) Encouraging team approach	• Support to inform DoHS and MoHP about functional sites and trained health workers – A link between various levels • Support whole site approach
Release and utilization of budget	Financial rules (MoHP) – criteria / guidelines development and implementation & monitoring	• Support to inform regional and district level on financial guideline; and monitoring

TA plan for Child and New born Health (through SAVE)

Gaps/Issues	Actions needed	TA need
Child Health		
Sustaining the coverage of Measles, pertussis (in DPT), and Hib immunization and preferably seeking to increase coverage in populations with low coverage, and continuing to ensure program quality.	Develop strategies and plans to improve the coverage particularly in unreached population (Integrated under Area Plan) RAG for child health expansion	Integrated under Area Plan
	Develop strategies to improve the quality of immunization program	Develop capacity to analyze the data to identify low coverage population. Provide technical support to develop strategies and plans to improve the coverage and quality of service
Access to appropriate providers for pneumonia and diarrhea case management not adequate.	Develop the strategy to assess and improve the low coverage pneumonia and diarrhea case management (Integrated under Area Plan)	Integrated under Area Plan
Lack of awareness for prompt care seeking for pneumonia and diarrhea case management	Develop effective behavioral change communication and community mobilization activity to improve the prompt care seeking for case management. (SAVE Yr 1-3)	Technical support for a formative for identifying and development of effective BCC tool and techniques to improve care seeking (SAVE Yr 1-3)
No standard pneumonia and diarrhea case management particularly at referral site and private sectors	Develop and implement protocol and guide for standard case management of pneumonia and diarrhea at referral site and private sectors (SAVE Yr 1-3)	Provide Technical support to develop protocol and guide for standard case management of pneumonia and diarrhea at referral site.
Referral system for case management of diarrhea pneumonia	Develop and implement functional referral system for case management of diarrhea	Under referral system for MNCH

Gaps/Issues	Actions needed	TA need
poorly functional	and pneumonia (will be part of referral system/network for MNCH development)	
National Child Health program not incorporated in the in-service and pre-service curricula (including physicians, Staff Nurses, Health Assistants, AHWs, and ANMs).	Review the existing in-service curricula to integrate the national IMCI protocols Yr 2 & 3	Facilitate the process to review the existing in service curricula and strategy to integrate IMCI protocols in the curriculum bringing in National Health Training Center (NHTC)
	Review the existing pre-service curricula (physicians, staff nurses, Health assistants, AHWs and ANM) to integrate the national IMCI protocols in the pre-service curricula Yr 2 & 3 Develop a strategy to implement the curricula Yr 2 & 3	Facilitate the process to review the existing in service and pre-service curricula and strategy to integrate IMCI protocols in the curriculum bringing in National Health Training Center (NHTC) and Ministry of Education also. Technical support to develop the strategy to implement the curriculum
Newborn Health		
Funding for Scaling up of Community-Based Newborn Care Program not secured	Evaluation of Community Based Newborn Care pilot implementation and secure funding for scale up. Yr 1 (Funded under SNL)	Technical support to evaluate CB-NCP pilot implementation and lobby for securing funds for scale up.
Scale up strategy for effective implementation of the program not done.	Develop strategy and plan for the modification and scale up of program Yr 2 & 3	Build the technical capacity to develop strategy and plan for modification and scale up of CB-NCP
Strategy for newborn referral system not developed	Development of strategy and plan for effective system of referral for newborn. Yr 2 & 3	TA to develop strategy and plan for effective referral of newborn building on the report of "Assessment of Health Facility for Newborn" (PESON-2010)
Weak linkage between CB-NCP and CB-IMCI package	Develop strategy for integrating newborn health into IMCI Yr 2 & 3	Technical support for identifying area of integration of newborn health intervention in CB-IMCI

Gaps/Issues	Actions needed	TA need
		in line with recommendation from CB-NCP pilot final evaluation Technical support to develop strategy for implementation
Newborn interventions and CB-NCP not addressed in SBA package	Develop strategy and plan to integrate newborn health in SBA Yr 2 & 3	Technical support for assessment for areas of integration of newborn health in SBA in line with recommendation from CB-NCP pilot final evaluation. Identifying area of integration of newborn health intervention and CB-NCP in SBA Technical support to develop strategy for implementation

Program Implementation matrix grid for key recommendations for Nutrition (through HKI)

Proposed area	**Program Strategies/Activities**	**6 month plan**
Integrated life-cycle approach to address malnutrition	Maternal nutrition • Explore strategies to improve caloric intake during pregnancy such as food supplementation, BC activities • Implement program to improve maternal dietary diversification • Improve maternal nutrition counseling in current government programs such BPP, CB MNC esp. during ANC visits Adolescent nutrition • Explore piloting adolescent iron supplementation programs in schools • Integrate key adolescent	Central level discussion workshops series with key nutrition stakeholders to identify and refine program strategies. Identify topics for operations research with CHD/Nutrition section and finalize research plan Revise and Refine the school health and nutrition strategies to include nutrition issues relating to adolescents Assist the NPC/NNCC to

	nutrition messages in Adolescent Friendly Reproductive Services program districts Child nutrition • Scale up IYCF/MNP activities in Nepal • Utilize existing multi-sectoral community groups to disseminate IYCF messages • Integrate IYCF counseling messages national programs such as CBIMCI, iron intensification	finalize the multi-sectoral nutrition action plan Ensure NHSP-2 Results Framework includes more nutrition indicators and is aligned with the text of the document.
Enhance the capacity of current and future staff on national, regional and local levels	Provide STTA based on technical gaps raised by the nutrition section at CHD Support nutrition section to train district level nutrition focal persons on issues such as IYCF, maternal nutrition etc Hold biannual technical update meetings at the central level	Together with the nutrition section/CHD Identify key technical gaps and human resource needs Facilitate discussions with IOM/academic institutions and DOHS for short-term in-service programs implemented for government staff
Assist the government to increase the number of technical as well as managerial staff allocated to nutrition functions	Discuss institutional strengthening including restructuring of nutrition section with key stakeholders at the ministry esp on establishing central level nutrition center under Department of Health Services Facilitate discussion with the Institute of Medicine(IoM)/ academic institutions for short term placement at nutrition section/CHD	Facilitate discussion with the MoHP to explore ways to restructure nutrition section Facilitate discussion with IoM for short term programs at CHD

Area of HCS Focus	TA Support
- Safe Motherhood - Newborn Health - Child Health - Nutrition - Family Planning - GBV - ASRH - Safe abortion	- 2 LTTA and STTA from SAVE, HKI, IPAS and Options - Support to assess/evaluate, planning, workshops, training, piloting, monitoring and scaling up/ implementation support

2. Background

Strengthening and expanding equitable delivery of the Essential Health Care Services (EHCS) package is central to the Nepal Health Sector Programme II (NHSP-2). The NHSP-2 Implementation Plan (NHSP2-IP) emphasises the need to bring services closer to remote/underserved communities and reduce demand side constraints to services which are available. The Ministry of Health and Population (MoHP) has committed to adding more services to the existing EHCS package to further address poor health outcomes, particularly among the poor and excluded. The NHSP2–IP also recognises that, with limited availability of financial and human resources, additions to the EHCS package come at a significant opportunity cost.

In order to support delivery of the NHSP2 Results Framework, Technical Assistance (TA) must support the MoHP/Department of Health Services (DoHS) to build on the successes of previous and current TA programmes, ensuring progress towards Millennium Development Goals (MDG) 4 and 5 is sustained, reduce inequity in health outcomes and supports greater integration and improved quality of services in the delivery of EHCS in facilities and communities. As EHCS has a broad definition within the NHSP-2 Results Framework, it will be necessary to identify the specific elements for our TA inputs. In this capacity assessment we suggest that our NHSSP-2 TA could most strategically focus on supporting delivery of quality and integrated maternal, neonatal and child health services, especially to reach underserved populations.

In this capacity assessment, the term EHCS will primarily incorporate maternal and neonatal health (including safe abortion) and child health to age five. It also includes ECHS components that overlap as core contributory causes of death for women and their children (including nutrition, malaria, water and sanitation, family planning and HIV); gender based violence and mental health (partially included); and adolescent sexual health (partially).

The focus on MNCH reflects the TOR requirements for this programme which indicated a focus on the EHCS system related issues alongside a sub-sector focus on MNH. In addition MH is commonly considered as a tracer sub-sector for health systems strengthening. It is also the case that the majority of indicators in result framework aim to improve MNCH services, utilisation and outcome. The burden of disease study of 2007 also shows majority of disease burden is related to communicable, maternal,perinatal and nutritional which constituted 45.5 % of years of life lost due to mortality (the largest burden of disease in Nepal).

Limited assessment was conducted in areas of EHCS which have substantial support from external development partners (EDP), such as adolescent sexual health and HIV. Our support to aid effectiveness will promote coordination of TA planning across EDPs and leverage TA support from non-pooled EDPs.

3. Technical / Institutional Assessment

3.1 Technical Assessment

a) Status of Health Outcomes

The NHSP-2 vision is to "improve the health and nutritional status of the Nepali Population, especially the poor and excluded". The NHSP2-IP (2010-15) provides a good overview of the status of health outcomes for all core components of EHCS[1].

In order to meet MDGs 4 and 5 in the next five years:

- The maternal mortality ratio must be reduced from the currently estimated 229 (281 DHS 2006) to 134
- The under 5 mortality rate must be reduced from the currently estimated 50 to 38 per 1,000 live births (NHSP 2 target for under five mortality is less than MDG target).
- The infant mortality rate must be reduced from the currently estimated 41 to 32 per 1,000 live births
- The neonatal mortality rate from estimated 20 to 16 per 1,000 live births.

Over the past 10 years, there have been improvements in equity and access to health services. Recent studies indicate progress among most groups and evidence of reductions in inequalities (KAP Study 2009; DHS 2006; NFHP mini DHS 2010). Despite this, significant inequalities in health outcomes still exist; the National Demographic and Health Survey 2006 (NDHS) provides the strongest evidence of disparities based on sex, caste/ethnicity, poverty/wealth and geographical area. Inequities in maternal survival are large, with women aged under 20 or over 35 years, or from Muslim, Terai/Madhesi and Dalit groups more at risk (Suvedi *et al.* 2009).

Women and children living in remote areas and from excluded and underserved populations continue to have consistently poorer outcomes across all key health areas, suggesting the need for renewed efforts to redress this. Lessons learned and successes from previous interventions (such as the Equity and Access Programme of Support to Safe Motherhood) need to be utilised to further improve access (cross reference GESI Capacity Assessment).

b) EHCS Core Policies, Strategies and Guidelines

The Government of Nepal (GoN)/MoHP has demonstrated commitment to addressing the high rates of maternal and child mortality using evidence based strategies supported by increased investment. Evidence based policy making requires a strong foundation of research, monitoring and evaluation, and Nepal is exceptional in this respect, particularly in maternal and child health, where a number of key evidence based policies, strategies and guidelines have been introduced[2]. These are key to achievement of MDGs 4 and 5.

[1] Please refer to this document in conjunction with this Capacity Assessment. Further information is included in Annex 1.
[2] See Annex 3 for a list of the major policies, strategies and guidelines which currently form inform implementation efforts in EHCS.

However, although appropriate policies, strategies and guidelines have been developed, implementation may require support and there are examples of overlap and duplication. A review of policies is recommended, to establish how effectively they support the aspirations of NHSP2-IP, to identify and address gaps, and improve integration and coordination where possible. A selection of policies, strategies, guidelines and packages that frame much of the work within EHCS currently are identified below. These include the Free Health Care Policy; Skilled Birth Attendance Policy; Neo-natal Health Strategy; Birth Preparedness Package; the Community Based Newborn Care Programme; Remote Area Guidelines and Referral Guidelines.

See Annex 3 for expanded list of relevant policies

Free Health Care

The Free Health Care Policy for EHCS[3] is a key component of Nepal's efforts to improve access to basic essential services. Assessment of the implementation of Free Health Care Policy Report indicates increased service utilisation by the poor and marginalised. The extension of free services in 2007-8 resulted in a 35% increase in Out Patient Department (OPD) contacts (although there are suggestions that OPD figures are now growing beyond what would be expected, suggesting manipulation of the figures, distorted by the new payment system per OPD (NHSP-2

The Aama programme focuses on delivering free services to women delivering at health institutions and providing incentive payments to address financial barriers to access (such as transport costs). An early evaluation of free delivery care indicates encouraging results in beginning to influence access of the poor and disadvantaged to services. *(cross reference Health Financing Capacity Assessment).*

Continued strong monitoring of the effectiveness and impact of free health care and free delivery care with incentive payments is key. This, and monitoring of financial management is addressed further in the *Health Financing Capacity Assessment*. A particular area of focus from the perspective of EHCS outcomes is quality of care. With a young and growing population, combined with increasing utilisation and existing bottlenecks (staff and essential supplies), the potential impact on quality of care and, in effect, health outcomes, is an important risk that will need to be monitored. Efforts will need to be focused on strengthening the health system to ensure the capacity to deliver quality services to growing numbers with limited resources.

Skilled Birth Attendance

The 2006 SBA Policy and 2007 In-Service SBA Training Strategy were milestones in the drive to address quality and availability of maternal and neonatal health care. An SBA is defined as a physician, midwife (including auxiliary nurse midwifes (ANM)) or nurse with specialised training in the internationally defined core SBA skills. The need for sufficient numbers of SBAs to be trained and deployed to primary health care levels with the necessary support is

[3] Free Health Programme Guideline 2004

emphasised, and strengthening of pre-service and in-service training institutions to ensure SBA competencies. Adjustment of pre-service curricula to include SBA skills is stipulated, including those for MBBS, certificate nurses, and ultimately ANMs. In the longer term initiation of a professional midwife cadre is envisaged. For Nepal to meet its MDG target of skilled assistance at 60% of births, an estimated 5,000 SBAs need to be in place by 2012.

A review of the SBA policy and training strategy is currently under way. The Human Resource (HR) policy also needs to be reviewed as currently only about 3,000 staff employed by the Government (doctor, staff nurse and ANM) are eligible for SBA training[4]. However, GoN as well as local Health management committees are contracting out nurses and ANMs to deliver care within health facilities in order to provide 24 hrs delivery service. These contracted out staff are currently not trained as SBAs as this is not possible under current regulations. In addition there is a need for an increase in staffing posts by GON in line with expanding birthing centers and CEOC sites and increased beds in hospitals. Other ongoing changes that influence staffing levels and needs include: the upgrading of 1,000 Sub-Health Posts (SHP) into Health Posts (HP); addition of birthing units to HPs; development of additional Basic Emergency Obstetric Care (BEOC) services (aiming for at least one in all 75 districts) and Comprehensive Emergency Obstetric Care (CEOC) (target 60 districts). A policy is needed urgently to enable the training in SBA of locally contracted doctors and nurses. This is true also of the private sector where a mechanism is needed to ensure nurses and ANMs working within this sector are trained as SBAs. It is currently not clear how many nurses/ANMs currently work in the private sector. Clarity on this is needed together with a plan to train them and incorporate them in the national strategy. UNFPA are hosting a workshop in early 2011 to examine SBA policy and strategy. This will be a good opportunity to reach some consensus about priority actions to address the current situation and examine the national strategy and review targets.

Neonatal Health Strategy

The 2004 National Neonatal Health Strategy complements the SBA effort by focusing on interventions at family/community levels that are proven to impact maternal and newborn complications. The strategy was incorporated into the National Safe Motherhood and Neonatal Health Long Term Plan (2006-2017) and is in line with the Second Long Term Health Plan (1997-2017), the Nepal Health Sector Programme Implementation Plan and the MDGs (reduction of NMR to 15 by 2017).

Birth Preparedness Package

The BPP, implemented by the family Health Division (FHD), is a major behaviour change effort addressing safe motherhood issues at community/ family level, encouraging healthy behaviours (including postnatal care) and preventing harmful practices. It targets antenatal, intra-partum, and postnatal periods to promote: birth preparedness, demand for quality delivery care, evidence based neonatal care practices (breast feeding, thermal care, clean cord care), and for home births, clean delivery care and referral of complications. It is delivered to women in their communities through the Female Community Health

[4] The DoHS annual report reveals 1,062 sanctioned posts for doctors and 5,935 for nurses, including ANMs, of which 77% of doctors' posts and 90% of nurse/ANM posts are filled

Volunteers (FCHV)[5], but also calls for institutionalised neonatal care as a sub-specialty of in-service and pre-service curricula for providers at secondary and tertiary facilities. It has become a basis to integrate a number of community based maternal and new born care including misoprostol, Chlorhexidine and Calcium.

Community Based Newborn Care Programme

In 2009 the CB-NCP was implemented by the Child Health Division (CHD) with different partners in 10 districts. It is delivered by FCHVs in the community and comprises neonatal survival interventions (both preventive and case management) including promotion of institutional delivery and clean delivery practices for home deliveries, postnatal care, community case management of pneumonia (PSBI), care of low birth weight newborns, prevention of hypothermia and recognition of asphyxia, initial stimulation and resuscitation of newborns (bag and mask). As part of the package, FCHVs are paid incentives to attend delivery (or immediately postpartum).

Development of the CB-NCP was a collaborative effort between CHD, FHD and partner organisations (CARE, PLAN, Save the Children-SNL, and UNICEF). It was implemented in collaboration with the National Health Training Centre (NHTC), Regional Health Training Centres and National Health Education Information and Communication Centre (NHEICC). A secretariat office for overseeing implementation was established in the CHD. The initial phase of CB-NCP was planned for a five-year period (2007–2011), with the intention of then using programme evaluation data to decide whether it is feasible to implement the programme more widely. Refer to *Newborn Health Capacity Assessment* (provided on request) for evaluation findings to date.

Remote Area Guidelines

Nepal is a leader in recognising the effects of its extreme geographical variation on health outcomes, through the Remote Area Guidelines (RAG) for Safe Delivery, endorsed in 2009. This facilitates differing approaches adapted to conditions in remote and difficult parts of the country, especially in the mountains. Expanding RAG from safe motherhood to other EHCS would enhance programme reaching the underserved population.

Referral Guidelines

Referral Guidelines were developed in 2009-10, although they are still in draft form and further work is needed to ensure a sufficiently broad scope that provides a platform for the improvement of referral networks (including telemedicine, local transport strategies and strengthening knowledge and relationships between sites within a referral network). Consensus building and coordination between divisions and partners will be key.

[5] FCHVs are selected by the mothers' groups in each village and typically work about six hours per week with connection to the SHP.

Table 1. Health Provider Training Coverage Implemented Nationally

	Birth Preparedness Package	Skilled Birth Attendance	Community Based Newborn Care Package
Primary health care provider	Female Community Health Volunteer	Doctors, Midwives, Nurses ANM	Community Health Workers, Female Community Health Volunteers
Current target	All targeted health care providers of 75 districts	2,000 health care providers in 75 districts	All targeted health care providers of 10 districts
Future target	75 districts	5,000 staff	75 districts

c) Technical Capacity Issues in Expanding EHCS

Continuum of Integrated Care

The NHSP2-IP reflects a broad range of health care needs and services within EHCS, providing a foundation for focusing different strands of effort into a coherent whole. A disjoint exists currently between many of the core health themes of NHSP-2, in part as a result of institutional arrangements and many years of inputs from multiple donors with differing priorities (demographic, health and geographical). The majority of output indicators relate to maternal, neonatal and child health, and the continuum of integrated maternal, neonatal and child care is a recommended model within a health systems approach, advocated by the Partnership for Maternal Neonatal Health (PMNH)[1,2]. NHSP-2 provides an opportunity to achieve this in Nepal.

The continuum of care conceptualises the healthcare system as a range of activities, from families and communities, outpatient and outreach services to institutional clinical services, with attention to the life cycle. It advocates for high coverage and quality of integrated service delivery packages, with functional linkages between the levels of care. Cost effectiveness analysis has demonstrated that packages for maternal and neonatal interventions are more cost effective than individual interventions, largely due to synergies on costs[3,4]. The continuum of integrated care refers also to Sexual and Reproductive Health (SRH) and HIV. Sound evidence exists to support building DoHS/GoN capacity to improve integration of, and linkages between, SRH and HIV/ AIDS funding, policies and programmes, to reap positive synergies and increase efficiency[5,6].

During NHSP-1 the integrated district development programme was introduced, a step towards integration at this level of service. Implementation of NHSP-2 requires a coherent agenda for broader integration, to overcome barriers such as institutional arrangements, funding/donor priorities and poor management capacity at district level, which have not enabled integration and sometimes prevented it.

Figure 1. Coverage of Key Maternal Newborn and Child Survival Interventions

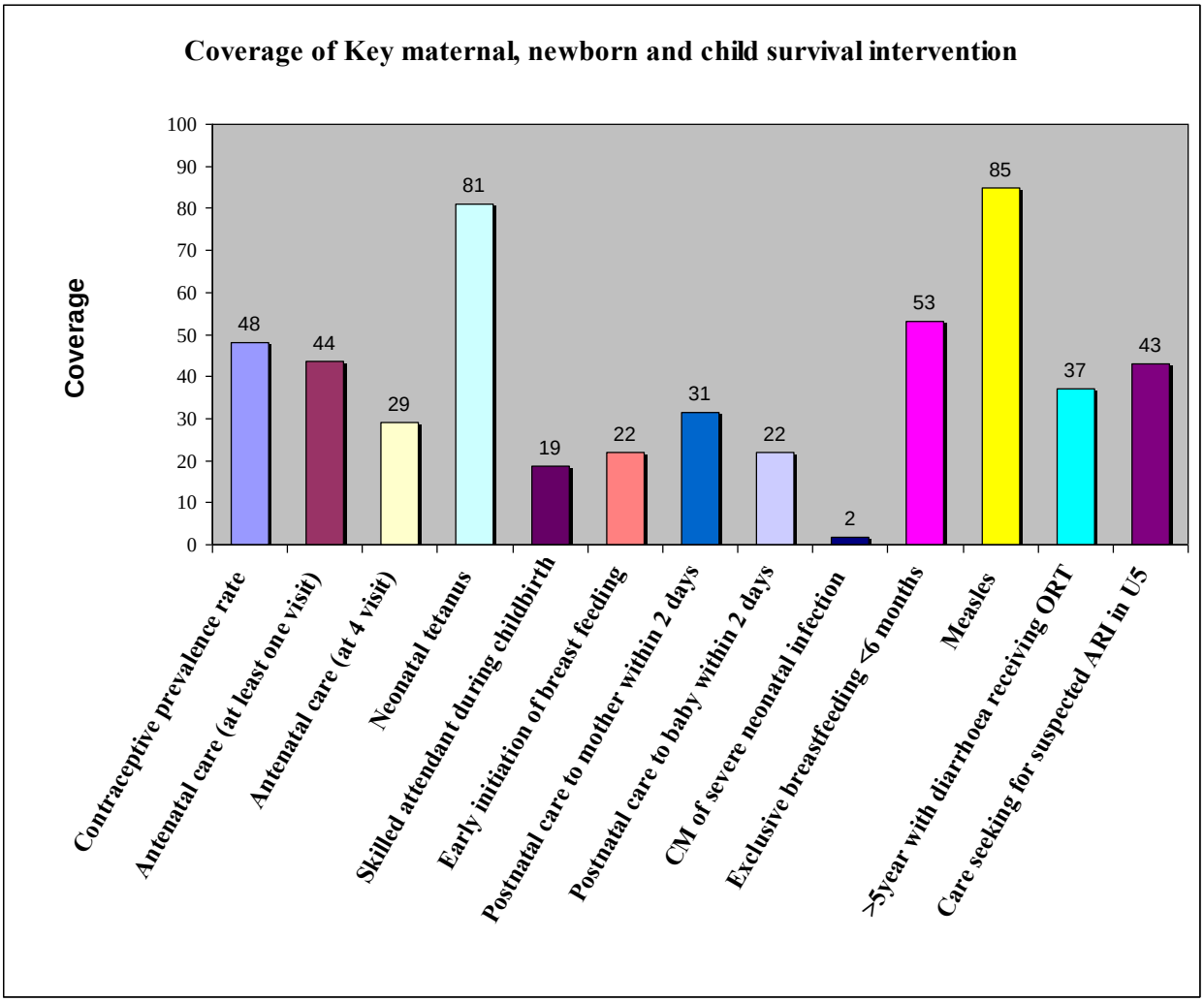


Figure 1, from NDHS 2006, shows estimated coverage for interventions along the continuum of care from pre-pregnancy to early childhood, which shows wide variation. Median coverage is high for interventions such as vaccinations, which can be delivered vertically and at prescheduled times. However, it is low for interventions that have to be delivered on demand, such as treatment for childhood illness and caesarean sections. The weakest links are demonstrated by gaps between the proportions of women in contact with health services for postnatal or delivery care, and the receipt of interventions that can and should be delivered in association with those contacts, which are key to increasing survival of newborns and mothers.

Geographic Coordination

Underpinning the broader challenge of integration is the need for geographic coordination and focus. From an external perspective, national level efforts appear to lack a coherent geographic strategy providing a framework for prioritisation and synergy of interventions at district level. One of the issues affecting quality of care, highlighted in the Maternal Mortality Morbidity (MMM) Study 2009, was the lack of coordination between critical

service inputs, such as HR, infrastructure, essential drugs, supplies and equipment, GESI and M&E. Life saving drugs were not available at all relevant sites continuously and infrastructure renovation was not coordinated effectively with other inputs to ensure sites were ready to function. Better coordination is needed to synchronise inputs to the same area at the same time.

An Area Plan would be one way of addressing this, and could also provide a framework to support coordination of EDP investment in line with national priorities. Currently the district focus of EDPs lacks coordination, and when they set their long term plans and priorities there is little flexibility over the period of the EDP investment for adjustment according to need or national strategy.

As reflected in the GESI strategy, one model of MNCH/EHCS will not fit all areas of Nepal. The Remote Area Guidelines for Safe Delivery (2009) are the first practical step towards recognising. Piloting and scale up of these guidelines will help meet the needs of some of Nepal's most underserved populations. It is also reported that remote area guidelines for family planning have been drafted by NFHP, although not yet shared widely. An integrated approach to remote area guidelines across the broader EHCS package would seem to make sense, where feasible. More context specific planning and implementation would help focus efforts to reach other underserved or hard to reach populations (including urban). Mapping is required to identify who is doing what and where, and to identify where it is most pressing to improve integration or coordination.

The capacity assessment suggests that a more targeted and coordinated geographic approach will be particularly important to the achievement of substantial additional reductions in mortality among the age group 1-59 months, and to greater equity in health outcomes. It is suggested that this will require a focus on quality and coverage of child health interventions among high risk populations, including those in rural areas, particularly the mid and far west and mountain areas, among poorer families and those with less educated mothers of children under five.[6] To date, the health sector has focused mainly on the "universal coverage" approach to achieving its objectives. The GESI component of NHSP provides an opportunity for the Government to explore the extent to which TA could be beneficial at central, regional, and/or district levels, to map and target high risk populations, and/or implement approaches to community mobilisation to increase use of key health services and practices among high risk groups.

Quality of Care

Improving quality and integration of services at the point of delivery are critical strategic areas for capacity development, and will bring together efforts to improve outcomes within the broader EHCS spectrum supported by NHSP-2. This requires review and updating of institutional and policy frameworks for better alignment with the NHSP-2 vision, as discussed below. The recently developed guidelines for Health Facility Quality Management (QM), Performance Based Management System and Integrated Supervision are quality standards approved by the MoHP and can be seen as a general District QM system.

[6] Even though, according to the 2001 census of Nepal, this part of the country accounted for only 7% of the total population at that time.

GTZ recently undertook a review and assessment of the impact of the introduction of specific QM tools at facility and district level, in order to better understand the process involved. There are plans to revise and simplify the tools in the near future. GTZ also support the introduction and implementation of the tools in their partner districts in the mid and far western regions. There is a clear role for NHSSP-2 to develop the capacity of DoHS to introduce and institutionalise these three modules for national implementation (based on evaluation of their effectiveness). As GTZ and Nepal Family Health Programme (NFHP) both supported the development of the quality of care guideline, NHSP-2 will need to work closely with these partners to develop government capacity and embed a strong quality management culture throughout EHCS, with a particular focus on quality of care in facilities at district level and below.

Currently Management Division (MD) is responsible for Quality Management in general, but other divisions and centres are responsible for quality of care in their programme areas. The focal person within MD has reportedly oriented 40 districts on the quality of care guideline and been responsible for the formation of new quality management committees at district and facility level, although their effectiveness is yet to be evaluated and the guideline has not been widely circulated. While orientation on these guidelines will be important, this alone is not sufficient, as improved responsiveness within the wider health system is fundamental. Coordination of supply side inputs is an important aspect of quality, and while the guidelines can help inform, they cannot alone improve responsiveness to identified needs. Health system strengthening through NHSP-2 can be considered successful when supplies are available as needed. The role of MD will be critical in driving efforts to synchronise inputs.

Appreciative inquiry approaches were piloted and partially scaled up during Support for Safe Motherhood Programme (SSMP) as a method of improving quality through facility management committees. Evaluations of the effectiveness of this were positive and it would be sensible to consider expanding and embedding this as a whole service method.

Capacity development will be needed to help improve and embed quality monitoring across all EHCS, which is currently covered through a patchwork of different methods and models. Evidence on quality is not systematically collected or used.

Essential Health Care Services

Reproductive Health and Family Planning

Family planning (FP) services are, in theory, provided at all levels of the health service, through the government health system, non-government/private sectors and social marketing. Twenty-five government hospitals have separate institutionalised units providing FP and MNCH clinics. The NHSP-2 Results Framework targets 70% of PHCC and HP to provide five FP methods by 2015. According to the 2006 DHS, 25% of women have an unmet need, which if met would give a CPR of 73%. Although increasing, utilisation of modern FP methods is still very low in some pockets of geographical areas and population groups (see

GESI CA)[7]. The biggest differences in use are by religion (only 16% of Muslim women use a modern method) and by ecological region (only 33% of hill and mountain women use one).

The current main FHD partners for FP are NFHP, UNFPA, FPAN, MSI, PSI, GTZ and CEDPA, although there has been a recent shift in the partner focus away from FP and towards newly emerging issues. For example, UNFPA has moved into human rights and Gender Based Violence (GBV), reproductive health in conflict and uterine prolapse; FPAN to adolescent health and HIV; GTZ to adolescents; and MSI to abortion. USAID is initiating a five-year **Integrated Nutrition Programme** (March 2011), with a much reduced focus on FP compared with the current NFHP, and the geographic focus will be in 25 selected USAID priority districts. The FP component will focus mainly at community level with limited focus on the health system[8].

Nepal will not be able to reach the current target of CPR 67% by 2015 unless commitment is renewed. In view of the benefits of FP for safe motherhood, child health and development, education and the macro-economy, Nepal needs to reinforce the momentum for uptake of family planning.

The **lack of EDP focus on FP** is identified as a gap. This capacity assessment has highlighted some specific issues which require immediate attention:

- It is not yet clear whether the MoHP focus will be on delivery of FP services through the public or private sector, or a combination of both. Clear definition of the role of the MoHP is needed, in terms of whether it will be the provider or the contractor of services, and therefore, whether commodities will be provided by the public sector or whether social marketing will be a key tool.
- Post abortion contraception is not integrated with family planning. This may be partly because Post Abortion Care (PAC) is considered an emergency procedure and lacks supervision to support improved FP counselling and services. This is an important gap.
- Comprehensive Abortion Care (CAC) is also not fully integrated with FP. This is particularly acute in USAID funded districts where there is a lack of functional coordination with FP and CAC. The referral pathways for women post CAC are unclear.
- An important supply issue (also impacting post partum and post abortion FP counselling and services) is the inadequate number of IUCD training sites nationally (there are currently only 4). The low national target reflects the limited training capacity. The target is to train 45 providers per year in IUCD insertion. Forty five providers per year is not adequate to meet the national target of having 5 services (condom, pills, depo, IUD and implants) in all HP and above level. There are currently 700 HP and 200 PHCC.
- The focus of FP efforts has been largely through community based interventions in MNCH, with minimal attention to services in health facilities. This has resulted in a real service gap for those wishing to access services at facilities, with even those that do provide FP services often not offering the full range of methods.

[7] (CPR 1996 – 26%, 2001 – 35%, 2006 - 44%)

[8] The most relevant output is 2.5. Facility-based and outreach family planning services provide effective counselling on healthy timing and spacing of pregnancy (HTSP) as important for good health and nutrition – under this, they are to improve the capacity of health system at local health facilities, outreach clinics and FCHV level to improve counselling and service delivery.

- Overall, RH services need to be better coordinated to facilitate integration of FP, CAC and PAC. USAID has created strong FP infrastructure in 24 districts, but not a broader RH package. Following withdrawal of USAID support two yeas ago, health staff no longer receive supervision/support for quality of care. USAID are requesting district health offices to take over buildings and staff, although not all have done so. This offers an opportunity to support and build on investments.

HIV/AIDS: National Centre of HIV/AIDS and STD Control (NCASC)

The National AIDS Control Programme is mainly focusing on Voluntary Counselling and Testing (VCT), Antiretroviral Therapy (ART), STIs, prevention and treatment of opportunistic infections and Prevention of Mother to Child Transmission (PMTCT), including community based PMTCT. Technical support is provided by UN agencies and Family Health International (FHI), with I/NGO programmes targeting high risk groups for prevention. The Government has established 76 VCT sites (in addition to 120 I/NGO sites) 25 treatment and 10 sub-treatment centres, 22 PMTCT sites with 30 Community based PMTCT, and 35 opportunistic infection treatment centres. The seventh Global Fund round ($ 12.3 Mil for 2 years) goes to UNDP, SAVE and FPAN. USAID funding is implemented by FHI, acting as the main technical resource group in HIV and Nepal Contraceptives Retail Sales (Nepal CRS) company (CRS) for social marketing.

It is recommended that NHSP-2 efforts in HIV/AIDS are focused on coordination and better integration of services to improve access and efficiency of resources and simplify pathways for users of RH services. For example, integration of PMTCT within antenatal care (ANC) was discussed during the annual review. Current PMTCT coverage is 4.5% and the target for 2015 is 80%.

Maternal and Newborn Health

Nepal's Maternal Mortality Ratio declined by half between 1996 and 2006, to 281 deaths per 100,000 live births, a 26% drop per annum (NDHS 2006). This decline was corroborated by the 2009 MMM Study, which calculated the MMR for eight study districts as 229 per 100,000. Even so, to reach the MDG 5 target of 134 by 2015, a continuing decline of 13% per year is needed. Despite the impressive progress to date meeting this target will remain a considerable challenge as the more intractable barriers to improved access to quality care are those yet to be addressed.

Neonatal deaths are about ten times the level of maternal deaths but have also declined over the same period – from a Neonatal Mortality Rate (NMR) of 39 per 1,000 live births to 33, of which two thirds die in their first week of life. Achievement of the MDG 4 target of 16 per 1,000 by 2015 is considered likely. Despite this progress, neonatal deaths contribute about 54% to the under five mortality rate compared to 41% in 2001, and 69% of infants who die are neonates.

The neonatal period covers the first 28 days of life, a period of transition when newborns are particularly vulnerable to any lack of consistency and coherence within the service setting. In this capacity assessment, newborn health is covered in the sections on maternal

health (MNH) and child health (NCH), reflecting the immediate relationship between maternal health, safe delivery and the postnatal days, when a different, but related set of risks and behaviours influence health outcome.

The major challenges for the SBA training programme relate to numbers (maintaining the momentum of training achieved to date and identifying sufficient staff eligible for training) and provision of sufficient support to enable newly trained SBAs to function effectively[9].

There are currently 16 SBA training sites in Nepal, with a commitment in the SBA strategy to establish at least a further four. All are hospital based, some at private institutions, for which further quality assurance mechanisms are needed to ensure consistent quality of training. The NHTC directly supervises the training sites, with only a minor role played by the regional training centres. Support for capacity development within the NHTC will be a priority for NHSP-2, to improve coordination and quality assurance and to regain the initial momentum of training, which has suffered as a result of budget and logistical constraints.

A particular challenge is the low availability of trained SBAs remote/ rural areas, for example five districts in the Karnali region have no ANM sanctioned posts at HP level, despite FHD having filed a request for this essential cadre – the "backbone" of rural services. Public Health Nurses (PHN) at district and regional health offices are the major drivers for increasing SBA services, but not all districts have PHN sanctioned posts and those that do exist are not all filled. Addressing such bottlenecks is critical to improving access to the underserved. These issues are magnified for specialists, such as obstetricians and anaesthetists, needed for Comprehensive Emergency Obstetric Care (CEOC) who are fewer in number and even more geographically limited. The 2009 HR strategy recommendations for increasing the availability of surgical and anaesthetic skills should be revisited.

As an important mechanism for increasing healthy behaviours and demand for delivery care, and strengthening the continuum of care, utilisation of ANC rose from 24% for any check-up with an SBA in 1996, to 44% nationally (39% in the rural areas) in 2006 (NDHS 2006). Amongst those who had ANC, 57% reported being informed about pregnancy complications and where to go for help (NDHS 2006), but these percentages were far lower for women in the lower wealth quintiles, with less education or residing in rural areas, again reinforcing the need for specific focus on these groups.

Developing capacity to improve quality of care will be an important focus for NHSP-2, in line with findings from the 2009 MMM study, which identified a number of areas requiring increased support. Key issues include ensuring adequate staffing and skills mix; reliable stocks of essential drugs; universal use of evidence based practice (such as magnesium sulphate); and availability of 24-hour laboratory facilities for timely detection of high risk conditions, such as eclampsia or low haemoglobin.

There are currently 45 districts with 94 CEOC facilities (of which only 81 are functioning CEOC facilities). In practice only 32 districts have functioning CEOC service and 12 districts have non functioning CEOC due to HR and various other reasons. Among the 81 functioning

[9] Skilled Birth Attendants and Related Staff – Issues, Bottlenecks and Opportunities (please refer to the Human Resources Capacity Assessment)

services 25 are GON, 16 medical colleges and 40 private ,NGO and mission hospitals. This indicates the importance of the private and NGO sectors to service delivery in MNH. The burgeoning of the private sector presents a real opportunity to help achieve MDGs 4 and 5. In some areas the only accessible CEOC site is a private or NGO facility, and thus this sector offers a way of reaching some of the most underserved populations. However, it is recommended that NHSP-2 build capacity to develop and apply appropriate regulation standards to ensure quality and strengthen involvement of the private sector in a way that most effectively supports national priorities.

There is scope for further improving newborn care within facilities, an area which has not received as much attention as community based efforts. Scaling up some of the work initiated by UNICEF, especially in C/BEOC sites is a priority.

An unintended consequence of the Aama free delivery care and incentive programme is the tendency of women to by-pass peripheral birthing centres (PHCC and HP) in favour of larger and referral hospitals, overloading these facilities with uncomplicated deliveries to the detriment of care for complicated cases. Also of concern is the incentive paid to health workers for attending home deliveries, which has been associated with financial mismanagement.

Postnatal and Newborn care

With the increased demand for community based maternal and neonatal interventions and greater utilisation of services at static (HP/SHP) and dynamic outreach clinics, appropriate referral of sick newborns and quality of newborn care at referral sites, needs to be assured. In particular, secondary referral care of complicated newborn cases urgently needs to be addressed, through improving the availability of health facility interventions for newborns, such as neonatal resuscitation and Kangaroo Mother Care (KMC). Many referral sites are not equipped to manage complicated neonatal cases and require support to introduce case management of newborn illness, both for first referrals from the community and further referrals.

The low estimates for early initiation of breast feeding (35%) and exclusive breast feeding (53%, decreased from 68%) are concerns in relation to healthy newborn practices, requiring support for improved counselling and behavioural change communication to mothers and families at service outlets and through the mass media.

Immediate postpartum visits are key to the wellbeing of both mother and baby and provide a contact where messages for improved practices/behaviours can be given and potential health complications identified. The visits also offer an opportunity to deliver other interventions, such as postpartum vitamin A, curative care for the sick newborn, and initiation of growth monitoring (improving the coverage of weighing at birth). There has been a marked increase in the proportion of women receiving postpartum care, from only one in ten women 1996 to almost three in ten in 2006 (NDHS 2006). As might be expected, women with facility deliveries were four times as likely to have the two-day postpartum visit than those delivering at home. Other inequities include higher rates for mothers aged less than 20, having first births, urban, and those from wealthier and most educated groups, all

more likely to have PNC within 24 hours and from an SBA. Despite the encouraging increase in uptake of PNC, there is a need for focused efforts to further improve this service, which is identified as the weakest part of MNCH service provision (Subedi et al 2010; DHS 2006).

The Community Based New Born Care Package (CB-NCP) is currently being piloted by CHD. Although the focus is the newborn, there are opportunities to further integrate health messaging and care for the postpartum mother. There is a need to strengthen both community and institutional PNC arrangements and related referral, which will require close coordination between the FHD and CHD to support thinking to help improve integration and access and ensure IEC and BCC efforts are aligned and supportive. The role of the FCHV is critical. The evaluation of the CB-NCP will be carried out in June 2011.

Child Health

Nepal is on track to achieve its MDG 4 target of 47 under-five deaths per 1,000 live births, with a 2008 figure of 51. Among the 37,000 annual under-five deaths in 2008, 61% were neonates, and among the 14,000 post-neonatal under-five deaths, an estimated 36% were due to diarrhoea and 27% due to pneumonia (total 9,000). No other single cause contributes substantially to post-neonatal under-five mortality in Nepal. As maternal causes now account for only 11% of all deaths of women of reproductive age, there are substantially more deaths among 1 to 59 month old children from these two causes alone, than there are deaths among women from all maternal causes combined[10].

Case management in communities and facilities, including prompt care seeking, quality standard case management and referral, are core areas to be strengthened to support improvements in child health outcomes. It is suggested that capacity development efforts need to focus on areas prioritised by NHSP-2, specifically:

- Maintaining programme quality by training for new entrants (health workers and FCHVs), refresher training for existing staff, intensive supervision, monitoring and periodical review of the programme
- Developing public private partnerships for implementing the community-based integrated management of childhood illness (CB-IMCI) programme
- Incorporating CB-IMCI protocols into the pre-service curriculum of health workers
- Integrating tested CB-NCP interventions with CB-IMCI and safe motherhood after evaluation of CB-NCP programmes in piloted districts
- Revitalising the programme in low performing districts.[11]

The child health assessment concludes that a key focus of capacity development to improve child health should be the reduction of mortalities due to pneumonia and diarrhoea among 1 to 59 month olds, with the core recommendation that capacity development efforts would be most effectively targeted by focusing on quality implementation at scale of the following interventions:

[10] Please refer to the Child Health Assessment for full technical discussion.
[11] Ibid, page 29.

1. Measles, pertussis (in DPT), and Hib immunisation (recently introduced in the pentavalent vaccine, combined with DPT and Hep B)
2. Pneumonia case management through FCHVs and facilities
3. Oral rehydration therapy (ORT) and continued feeding for children with diarrhoea
4. Zinc supplements for children with diarrhoea

See *Child Health Capacity Assessment* for further detail.

Four areas of child health stand out as requiring strong coordination and partnership work:

1. Hand washing with soap: Exploring options (with DoHS, UNICEF, and other key WASH/WatSan sector partners) for increased health sector support for education of families to increase this practice (where there is adequate access to water)
2. Household (point-of-use) water treatment and storage: Exploring options (with DoHS, UNICEF, and other key WASH/WatSan sector partners) for increased health sector support for implementing this intervention at scale; for example integration with IMCI
3. Community-wide sanitation/increased use of improved sanitation facilities: Community mobilisation to increase demand to stop open defecation, exploring options (with DoHS, UNICEF, the NGO NEWAH, and other key WASH/WatSan sector partners) for increased health sector support for implementing this intervention at scale
4. Introduction of rotavirus and pneumococcal conjugate vaccines through routine immunisation: Dialogue with DoHS and WHO/Nepal on the introduction of these vaccines, with GAVI support, in the near future.

The Child Health Capacity Assessment concludes that the following interventions do *not* appear among those currently most important for implementation at scale (through the health sector) to reduce pneumonia or diarrhoea mortality in 1 to 59 month olds in Nepal:

- Reducing indoor air pollution (extent of impact of feasible interventions remains uncertain, not considered a health sector intervention in Nepal)
- Prevention of HIV in children and cotrimoxazole prophylaxis for HIV-infected and exposed children (low HIV prevalence in the general population)
- Improved drinking water supply (not considered a health sector intervention in Nepal).

Key bottlenecks and gaps identified in the Child Health Capacity Assessment are:

a) *Logistics, procurement and release of budget*
   - There have been examples in recent years of system-wide periodic shortages of key supplies for child health and family planning commodities at health facilities, including ORS and zinc. Centralised bidding with local purchase is a new approach to addressing some of these procurement issues.
   - Substantial delays have occurred at times in release of budget and have hampered programme implementation.

b) *Quality of case management in the private sector*
   - There is very little control over the private sector, where case management practices are often inconsistent with IMCI and other standard protocols. Respondents noted that this issue cannot be addressed by training alone, as the profit motive will drive

over-treatment, even among well-trained providers. The requirement for standardisation of SBA service in private institutions that are included in the Aama programme could be a new start. Licensure of all private providers was noted as an important step to help address these constraints, but a difficult area to regulate given the number of small pharmacies practising medicine in Nepal.

- There is concern about the ability of referral level hospitals in providing quality child and new born health care services. A rapid situation assessment is recommended.

c) *Policy and planning (including aid effectiveness, efficiency, and/or consistency with national planning)*

- Many donors prefer to fund new interventions or strategies, rather than supporting ongoing implementation of standard proven interventions and programmes. As a result, health staff at all levels struggle to introduce new interventions, while also continuing to implement important routine services with less donor support.
- The need for developing CHD staff's skills based on programme need and planning capacity was expressed.
- Capacity development on national capacity to review and advise at national level on child health programming needs including introduction of new vaccination.

Adolescent Health

In Nepal, very few adolescents are utilising Adolescent Sexual Reproductive Health (ASRH) services, as these are generally not easy to access and not sufficiently youth-friendly. Building on the lessons learned from past and existing ASRH programme experiences, the national ASRH programme, consisting of behaviour change interventions and youth-friendly health services, will be scaled up in both public and private health sectors. To address this, under the FHD programme, orientations will be provided for district health managers and other key actors at district level, with a training package for mid-level health care workers and operational guidelines on how to operate an adolescent and adolescent-friendly service at each level of government health facility. At present 94 health facilities in 10 districts are providing adolescent friendly health services. There are youth information centres in 35 districts. At least 1,000 health facilities in the 75 districts will provide adolescent friendly health services by 2015.[12] In particular, the NHSP2-IP includes a target to reduce fertility among 15 to 19 year old girls. GTZ has implemented youth friendly services in 26 facilities in five districts.

The national adolescent health strategy (2000) and implementation guidelines (2007) were followed in 2008-09 by GTZ support for health services and counselling in the public sector. Other sectors have worked to reduce the practice of early marriage, but little has been done to reduce pregnancy among married adolescents. A senior DoHS respondent noted that lack of funding is an issue and there is a need to design, assess and scale up appropriate interventions. The FHD-led Adolescent Reproductive Health Sub-Committee now holds quarterly meetings, has contributed to the NHSP2-IP draft document and engaged with

[12] Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015, Final Draft, Ministry of Health and Population, Government of Nepal, 1 June 2010, pages 22 – 23.

other sectors, supported by GTZ, UNFPA and Save the Children. This body will be an important point for capacity support.

Nutrition

A recent assessment by the Government[13] to identify gaps in addressing childhood malnutrition found sub-optimal infant and young child feeding practices contribute significantly to the poor nutritional status of young children, particularly in rural areas. Stunting, underweight and wasting affects 49%, 39% and 13% of preschool children respectively and nearly one in every two children (48%) is anaemic[14]. Whereas breastfeeding is close to universal in Nepal (98%), only one in three women (35%) initiates breastfeeding within one hour of delivery, and only one in every two children (53%) is exclusively breastfed until six months of age. The median duration of exclusive breastfeeding is only three months. Introduction of appropriate complementary food when a child is six months old was only 63%. Furthermore, a widening of the gap in nutritional status across wealth quintiles is also observed, with children from lowest wealth quintile carrying the highest burden of malnutrition.

Although Nepal has made good progress in achieving the health related MDGs and is on track for MDGs 4, 5 and 6, substantial improvements in the overall growth of young children will be needed to meet MDG1 (reduction in hunger). The lack of sufficient progress in improving the nutritional status of women and young children is also highlighted in the NHSP-2, and has led the MoHP to identify nutrition as a high priority area for investment, with activities outlined in NHSP-2 to improve nutrition in the country. These activities include a range of food utilisation and nutrition related services, including child growth monitoring and promotion, micronutrient supplementation, food supplementation and interventions to improve child survival. However, it is essential that the health sector work closely with other sectors to reduce the prevalence of stunting. This also highlighted as one of the key lessons learned in the recent sector-wide approach (SWAp) document[15].

The Nutrition Capacity Assessment highlights the following gaps:

a) *Life cycle approach:*
   - There is strong support within MoHP for developing a nutrition strategy that is life cycle and continuum of care based. Under NHSP-2 there is a need to support the linking of infant, child, adolescent and maternal nutrition under one paradigm.

b) *Maternal nutrition:*
   - A specific policy on maternal nutrition is needed. The concept of a Maternal Nutrition Working Group, led by the FHD and other key stakeholders, is supported by this assessment. Discussions are taking place within the FHD, with a view to forming the group.

c) *Urban nutrition:*

[13] Department of Health Services, Ministry of Health and Population, Government of Nepal. Nepal Nutrition Assessment and Gap Analysis. 2010

[14] DHS (2006). Nepal Demographic and Health Survey. Ministry of Health and Population, Government of Nepal, Kathmandu, Nepal.

[15] RTI International (May 2010): *The Sector-Wide Approach in the Health Sector, Achievements and Lessons learned*. Research Triangle Park, NC, USA.

- The NHSP-2 document and current government programming do not currently focus on nutrition issues among urban populations. In the light of recent and continuing growth of urban areas, this is a major gap that should be addressed.

d) *Gender and Social Inclusion:*
   - By advocating for a more community based approach to nutrition, NHSP-2 opens the opportunity for improved access of socially excluded women and families to nutrition interventions. GESI training modules must be strengthened for FCHVs and other community health workers that are delivering nutrition and other community based health interventions.

See the Nutrition CA (to be provided on request)

Safe Abortion Care

Abortion was legalised in 2002, following which a total of 1,000 service providers have been trained in Manual Vacuum Aspiration (MVA) techniques at five training sites, and at least one approved Comprehensive Abortion Care (CAC) service site established in each of the 75 districts (total 301, including both public and private). Between 2004 and 2010, over 400,000 women received safe services, with at least 50% of acceptance of a modern contraceptive method. This successful programme has been driven by the FHD Technical Committee for the Implementation of Comprehensive Abortion Care (TCIC) a multi-partner forum to which Ipas has provided support.

To build on the success of this important contributor to improved maternal health, support is needed for the following:

- Integration with other reproductive health services, particularly FP, partly because FP clinics provide a more appropriate environment for CAC than the currently used maternity units, and partly to ensure availability of a full range of contraceptives.
- Increased access to services closer to communities, rather than only at the district headquarters, and keeping fees to a minimum with exemptions for poor women. FCHVs have successfully provided early pregnancy testing in Bhaktapur, followed by counselling to support women's decision making, and referral for services as appropriate. This initiative should be considered for scaling up.
- Increased choice, in particular through the recently introduced medical abortion option, for which regular supplies of Medabon need to be assured.
- Targeting youth, in recognition of the changing RH needs of adolescents accompanying other social changes, such as increased education of girls and later marriage. The 2008-09 MMM study highlights this issue.

Inclusion of abortion in EHCS is the logical next step for improving access, as the human resource skills and types of facility, equipment and environment required for provision of services are very similar to those required for MNH and FP services, and safe abortion messages can be effectively combined with other RH messages. This will also support programme learning from innovative approaches used in the safe abortion programme (such as PPP) which can potentially be scaled up in other areas.

Mental Health

The shocking finding of the 2008-08 MMM study that suicide was the main cause of death among women of reproductive age has focused attention on mental health. Underlying mental health problems were found in 8% of these suicides (Pradhan *et al.* 2010). NHSP2-IP recognises the challenge of addressing mental health when it remains poorly understood and where resources are so limited. A current Suicide Study, jointly funded by DFID and UNICEF, is investigating this in more detail to identify contributory factors to poor mental health. Preliminary findings indicate major gaps in government provision for mental health services: there is no official office representing mental health (Jordans *et al.* 2010); no regulatory body to assure the quality of care provided (Jha and Adhikari, 2009); and of the 3% of gross domestic product spent on the health system, only 0.02% is allocated to mental health (Jha and Adhikari, 2009). WHO reports show there was no increase in mental health spending between 2001 and 2005 (WHO, 2001; WHO, 2005a), and only minor improvements to infrastructure and health personnel.

The Government is currently devolving powers within the health field to the 75 districts, integrating mental health into primary health care (WHO, 2005a). This approach offers the opportunity for stricter control of resources appropriate to local need (Solberg, 2010), and a shift in focus to community and individual care and treatment, entailing "a wider range of services, coordinated treatment programmes, services closer to home, ambulatory care, and partnership with caregivers (Trivedi *et al.* 2007, p.58)".

In the light of the size and complexity of the problem, NHSP-2 can only begin the process of addressing it. The focus will need to be on building capacity to develop a stronger policy framework; using evidence to raise awareness of the extent of the issue and shedding light on the contributory factors identified in current future research; bringing together evidence to inform the design of interventions and improving coordination within the public sector, between EDPs and between local and international NGOs to ensure mental health remains on the agenda. It is critical that dialogue continues and resources are identified to address this major health concern. Poverty and social exclusion can be a cause and a consequence of poor mental health (Prince *et al.* 2007, p.11).

Strengthening Systems and Approaches to Improve Access and Outcomes

Remote Areas

The goal of the RAG is to provide access to care for women in remote areas where CEOC is not available within six hours and obstetric first aid within four hours of travel. Strategies include task shifting to available health workers and volunteers and innovative transport options, based on local plans. Making these guidelines a reality will require focused attention and resources.

Piloting of the rural ultrasound programme, part of the FHD annual plan and area strategies, will require support for development of guidelines, implementation, including training of nurses, and monitoring. Operations research will be critical for capturing evidence to inform scale up and to advocate for changes in training restrictions.

The government has implemented telemedicine programmes in 25 districts, an innovation that has great potential. Currently it operates mainly at district hospital level using VSAT and internet, but health workers in peripheral areas without these facilities would benefit from telephone consultations providing support from supervisors and doctors, especially for complicated deliveries and serious childhood illnesses. This would improve quality of care, increase confidence of health workers and facilitate/ speed up referral. Again, operations research will be important in the further piloting and scale up of telemedicine across EHCS.

There is great potential to expand the remote area package to include appropriate evidence-based interventions such as calcium, chlorhexidine and other integrated management of childhood illness (IMCI) interventions. These opportunities will need to be explored piloted.

Referral

A referral strategy would be a logical sub-component of the integration and quality of careF strategy, as this area requires serious attention in order to improve maternal and neonatal outcomes in emergency situations. The existing barriers to good referral management need to be examined across the relevant health areas to inform strategy development, for example mapping of points in the "care journey" to improve referral into services and then between services. The importance of coordinated district level health networks for reduction of maternal mortality is particularly apparent because of the critical role of EOC[7,8]. Lack of effective referral systems in remote and mountainous regions has created a wider equity gap.

A key challenge to address is to ensure effective linkages between the various components of the health system. Since district health offices in Nepal generally oversee hospitals and primary health care facilities (PHCC, HP and SHP), this provides a natural starting point for developing and monitoring effective referral. NHSP-2 is an excellent opportunity for the GoN/DoHS to take a lead in piloting and assessing the implementation and monitoring of referrals, an area that is little understood.

Human Resources

Human resource constraints relate to both training capacity and placement and retention of personnel in appropriate posts. There are shortages of sanctioned posts related to MNCH at several levels of the health system, and the staffing structure has seen few changes over the last 30 years, during which time the population of the country has doubled and many new MNCH interventions have been introduced, leaving staff struggling to manage the substantial variety of health interventions and programmes. Restructuring of sanctioned posts is planned, but awaiting government decisions on the form of the expected new federal structure of government. The majority of regions have vacant VHW post who are major provider of vaccination to children in community. Adding to this, there is a backlog for training FCHVs, key community level workers, the effects of which are exacerbated by the gradual replacement of village based VHWs with better qualified but often non local and more facility based AHWs, as the front line supervisors of FCHVs.

In-service training programmes are constantly trying to keep up with the introduction of new interventions and strategies, such as IMCI and SBA skills, which have not yet been incorporated or standardised as a part of pre-service training. Thus a large proportion of staff lack important knowledge and skills. In addition, the number of training centres and skilled trainers is insufficient to keep up with demand. Furthermore, as a high proportion of health workers are now educated at private training institutes, which must pay to have their instructors trained in new interventions, such as in IMCI and SBA skills, there is a risk that not all will do this and they may therefore not provide up-to-date pre-service training. NHSSP could usefully explore feasible approaches to standardisation/introduction of pre-service health worker training in IMCI and SBA skills in training institutions, including in the private sector.

High rates of transfer of health staff are an important constraint to implementation of effective health programming, particularly when this involves not only transfers between posts, but also across roles, as is the case, for example, among Health Assistants (HA) transferred between roles at health facilities and IMCI focal point positions at district health offices. As a result, many IMCI focal points at DHOs have not been trained for this role.

National Training Capacity

Improved capacity of the NHTC is core to improvement of quality across the results framework[16]. As there has been no detailed assessment of NHTC it is not yet possible to develop a strategy for strengthening the national training capacity. However, it is clear that many senior professional positions in NHTC are vacant, and there is a lack of necessary skill mix. At regional level there are similar issues, with the key posts of Chief Training Officer and PHN often vacant. New positions of an appropriate skill mix were proposed many years ago but have not been filled[17]. The MoHP has also committed to taking actions to develop NHTC as an autonomous centre that is better able to design, develop, implement, monitor and evaluate national training programmes[18]. Other key issues noted are:

- An apparent lack of confidence in NHTC, as evidenced by CHD often preferring to use private and NGO training and HIV also delivering their own training.
- The need for responsiveness to new technologies (such as medical abortion), child health and new born health training
- Revision of national health training strategy (2004) to respond the changing needs of health sector and support NHTC to assess its internal capacity and explore for future institutional setting whether to remain as current function or to re-structure for a national health academy is needed.
- The need for scale up of SBA training, which is at the heart of the results framework.
- As more and more nurses and ANM receive in-service SBA training, current in-service training sites could expand their focus to cater to the needs of private pre-services training institutions as clinical practicum sites.

[16] Assessment of national and regional training capacity is covered in more detail in the HR capacity assessment.
[17] Ibid, page 70.
[18] Ibid, page 71.

- In addition quality of training needs an on-going focus to ensure that it meets high standards.

Public Private Gaps and Opportunities

Private providers, including retail shops, account for a large proportion of the treatment provided for childhood diarrhoea and pneumonia in Nepal, particularly in urban areas and in the Terai. Efforts to train retailers and increase sales of life saving products (such as "Jeevan Jal" ORS packets) through the private sector, go back to at least the late 1970's and early 1980's, but there is currently little effective accountability of the private sector to government, and a strong economic incentive for private providers to over-prescribe. NHSP-2 should explore the feasibility of approaches to increasing the accountability of private sector providers to government and standardising their case management practices.

With respect to maternal and newborn health the private and NGO sector already play a significant role being the major providers of functioning CEOC nationally. As noted above nearly half of the 81 functioning CEOC services are delivered by private ,NGO and mission hospitals. This indicates the importance of the private and NGO sectors to service delivery in MNH. The burgeoning of the private sector presents a real opportunity to help achieve MDGs 4 and 5. In some areas the only accessible CEOC site is a private or NGO facility, and thus this sector offers a way of reaching some of the most underserved populations. There is great potential to strengthen monitoring, regulation and coordination with the private sector. It is recommended that NHSP-2 build capacity to develop and apply appropriate regulation standards to ensure quality and strengthen involvement of the private sector in a way that most effectively supports national priorities.

3.2 Institutional Assessment

a) Specific Institutional Environment, Organisational Structure Management and Working Environment

Two departments within the Department of Health Services are responsible most components of EHCS covered in this capacity assessment: Family Health Division (FHD) and Child Health Division (CHD). The new Revitalisation Unit, also under the DoHS will have an important part to play in improving access, with a focus on urban/environmental health, social health insurance and free health care. All divisions report to the Director General.

Coordination of the various donor funded initiatives was identified as an important challenge in both FHD and CHD. Without such coordination, delivery of integrated quality EHCS is hindered and inefficiencies are created, often resulting in duplication or gaps. Development of the institutional structures to improve coordination and integration is recommended as a major focus of capacity development within the NHSP-2.

The DOHS facilitates the Divisions, centres, regions and districts to ensure timely approval of plans and strategies, release of budgets, and mobilisation of human resources. A number of

institutional and capacity challenges and issues identified within the DoHS are worth noting here.

The FHD has responsibility for reproductive health programmes including Family Planning, Safe motherhood, Safe Abortion, Adolescent Health, RH of elderly women, GBV, prolapsed Uterus etc. In FHD the number of staff posted is not adequate for monitoring and supervision of RH programmes. Currently, a temporary post of Safe Motherhood coordinator post was created in each Region funded through FA. This post needed to be made a permanent post. Programme focal person's ability in both technical and managerial area is not balanced.

Child health Division (CHD) has three sections – Nutrition, Expanded Programme of Immunization and IMCI section – covering child health, new born health, nutrition and immunizations programmes. The number of staff currently assigned to nutrition programming in Nepal cannot meet the planning, implementation and monitoring needs of the nation's nutrition targets as they relate to the MDGs and the NHSP2. Current Nutrition section has two staff out of 5 sanctioned post. The the technical capacity of MOHP-DOHS staff in the areas of nutrition is not sufficient to meet the nation's needs nor the goals set out in the NHSP 2. Within CHD there is no personnel with an advanced degree focusing on nutrition. The need for key staff members who have the capacity to assist the CHD in developing, planning and implementing programmes based on evidence is essential. Additionally, these staffs are needed to provide assistance to regional and district level staff for program implementation, coordination and monitoring of nutrition interventions that address local realities. There is a shortage of staff at several levels who are dedicated to IMCI: three staff in CHD, one at regional level working on IMCI on a part-time basis, and one at district level. The PHC Revitalisation Division, established recently, has the responsibility for Urban and environment health, Free health programme, social Health protection etc. The Division has already formulated 'Urban Health Policy' which is being reviewed. This division also has only a limited number of staff out of 22 sanctioned posts.

The different Divisions with the DOHS have clear roles and responsibilities. Shortage of sanctioned posts related to MNCH at several levels of the health system was noted. New MNCH activities have been incorporated into the health system in recent decades, but the staffing structure has seen few changes over the last 30 years (during which time the population of the country has doubled). As a result, staff at central, regional, district, and health facility levels are left struggling to manage the substantial variety of health interventions and programmes. Sanctioned posts are generally by jurisdiction, rather than related to population numbers or terrain (access). Regional offices lack an adequate number of technical staff to support and supervise the districts in their jurisdictions. A respondent noted that a restructuring of sanctioned posts is planned, but awaiting government decisions on the form of the expected new federal structure of government. The number of staff managing financial issues in each division and centres vary with only one person available at FHD seconded from DoHS, transferred every two years. Frequent transfer of higher level staff within DoHS hampers quality, continuity and commitment of staff.

Frequent movement of senior managers impacts the quality of services, and there is a shortage of staff at these levels with the required management training – most are clinically trained and have express willingness to learn management of programme implementation, budgeting, monitoring and assessment. The new Revitalisation Division has only a few dedicated staff for its 22 posts, which has limited its effectiveness.

None of the divisions/centres expressed any difficulty in getting initiatives approved and managing their division, but all felt it was difficult to ensure programmes were implemented as envisioned at field level. Inadequate supervisory staffing at each level was a repeated issue, with all acknowledging that bottlenecks could be overcome by particularly strong and dedicated district or facility managers.

All units had section job descriptions but not individual job descriptions. This was not seen as a problem, but rather it allowed sections flexibility in assigning work according to the skills of their staff. Appointments are made both by merit and by allegiance.

Other challenges identified include long administrative processes such as tippani (a procedure for approval of budget release for particular activities explaining rationale and process of detail activities) for programme activities delays work. In addition political instability, changes in higher officials can also delay decision making and budget release.

Outline of Coordination Structures

Reproductive Health

Post Cairo, a structure to support coordination, policy and planning within reproductive health was established, and has since grown further. It now consists of:

1. **RH Steering Committee,** under the chairmanship of the Health Secretary, meets annually. It is mostly responsible for policy related decisions with representation by members from Education Ministry, Law Ministry, Women and Children Ministry, Local Development Ministry and related divisions and centres. The DG sits on this committee, as do a number of EDPs.
2. **RH Coordinating Committee (RHCC),** under the chairmanship of the DG, is represented by RH partners and related divisions and centres and meets biannually.
3. Safe Motherhood and Newborn Health (SMNH) Sub-committee, meets one every two months and as needed
4. Family Planning Sub-committee, meets two to three times a year and as needed
5. Adolescent Health Sub-committee, meets two to three times a year and as needed
6. FCHV Sub-committee, meets two to three times a year and needed
7. Safe Abortion Advisory Committee, meets once a year and as needed
8. Child Health Sub-committee, meets two to three times a year and as needed
9. CB-NCP Technical working group, meets two to three times a year and as needed
10. Medical Abortion Technical working group, meets as needed
11. Misoprostol Technical working group, meets as needed
12. Maternal and Perinatal Death Review committee, meets as needed

13. There are also **Reproductive Health Coordinating Committees (RHCC)** at district level, many of which are active and provide a useful mechanism for bringing together key local stakeholders.

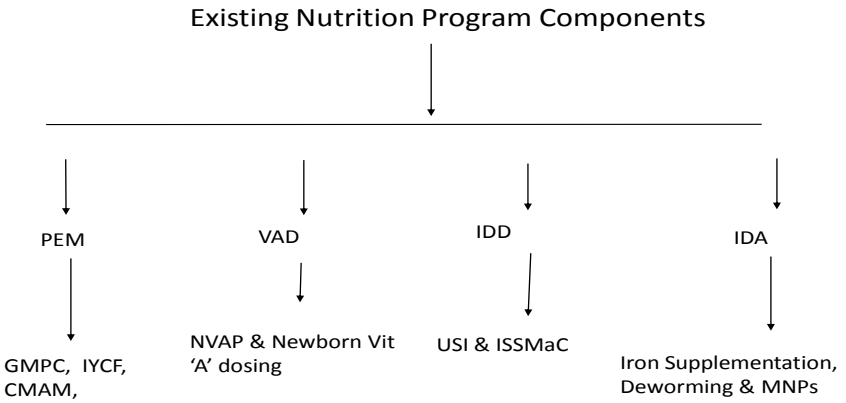
HIV/ AIDS

A number of national bodies play major roles in HIV programmes in Nepal including:

- Country Coordinating Mechanism (CCM), responsible for the Global Fund and chaired by the Health Secretary.
- National HIV/AIDS and STD Control Board (NHCB)
- National AIDS Council
- National AIDS Coordinating Committee (NACC), established in 1992, this does not sit under RHCC. There are also district (DACC) and village level coordinating committees (VACC), with those in most districts active
- National AIDS Working Group (technical working group), in which a number of partners (mainly UN, vulnerable groups and a few I/NGOs) are involved
- UN initiated bodies – Children Affected By AIDS (CABA) in Nepal

Nutrition

The diagram below shows current programmes under the DoHS Child Health Division.



Critical Review

Overall, improved coordination and integration is needed to ensure efforts to meet the MDGs and deliver the objectives of NHSP-2 are efficient, focused and aligned to the GoN Health Strategy. The RHCC is the appropriate body to provide the necessary coordination between the various sub-committees and to harmonise efforts. However, there are opportunities to strengthen the role of the RHCC to help improve coordination and integration between the sub-committees. They currently function vertically, with

coordinators for the sub-committees funded by different EDPs. This model can lead to sub-committee agendas being driven to a large extent by the policies and preferences of the funding agency. As an example, some agencies prefer not to talk about abortion with the result that safe abortion is rarely, if ever, included on the agenda of the SMNH Sub-Committee Coordinator and the safe abortion programme is obliged to work in parallel with this group. Providing secretariat support to the RHCC and selected sub-committees is therefore considered an essential first step to facilitate aid effectiveness and enable joint planning that is aligned to government objectives.

We did not establish whether or how there is coordination between the DACCs and RHCCs at district level, but this is important area for further investigation, as an opportunity for stronger coordination to improve the continuum of care.

Opportunities for Coordination between FHD and CHD

A number of community based vertical programmes for maternal, new born and child health are implemented through FCHV by CHD, FHD and NCASC. Most programmes were implemented using a cascaded training starting from district level supervisors to FCHV. All these programmes also are supervised and monitored including through regular annual review and monitoring meetings. FCHV quarterly review meeting also is held at health facility level. In practice this results in duplication of effort and is not conducive to improved coordination or logical integration. Over the last three years there have been discussions about the logic of integrating this process, and the Director General (DG) agrees that the reviews need to be better streamlined. The technical working group for CB-NCP has recommended to integrate maternal and new born health care and a strategy for integration has been formulated but not yet shared to the wider community. TA will need to focus on developing capacity to support this process. There is opportunity to integrate these vertical programmes during supervision, review monitoring and alo during training. Example, Misoprostol training could be integrated with CBNCP and thus FCHV can provide misoprostol to a mother after delivery of baby as the FCHV attends the delivery to take care of the new born.

There would be additional efficiencies in travel time, per diems, person time for practitioners attending both reviews three times a year, as well as other efficiencies likely to be identified by bringing the content of the two reviews together. Implementation of such a change would require a change in national guidelines. The proposed long term TA posts would be well positioned to build the capacity of the FHD and CHD to support coordination.

In some districts public health and hospital programmes are separated, led by a District Public Health Officer and a Medical Superintendent, respectively. In practice this often results in a lack of effective integration between community and institutional services, and the issue needs to be further explored by comparison with districts where there is not such a division.

b) Monitoring

The GoN has invested significant effort and resources into improving the efficiency and utility of health information systems. Research such as the five-yearly NDHS and the MMM

Studies of 1998 and 2008-9, as well as the Health Management Information System (HMIS) have significantly contributed to knowledge of health system use and quality, helping to inform programming. However, routine reporting is typically designed to extract data from local levels and pass it up for centralised decision making. With the move towards more decentralised governance and local accountability, there is now a need to design information systems that enable greater availability and use of reliable data at district and regional levels, with a focus on population outcomes and local resource/ facility use, especially if health strategies vary by area (as, for example, enabled by the remote area guidelines). This should also facilitate greater information sharing and cooperation between the hospital and health centre managers at district level. Improving monitoring within the private and NGO sector will also be critical to any plan to increase their role in a national health strategy.

There is a particular need to strengthen monitoring for nutrition. Although HMIS provides data on Vitamin A and de-worming, with some other micronutrient related indicators such as maternal iron supplementation, its ability to capture broader issues related to maternal and child nutritional status is limited. HMIS also does not collect indicators related to infant and young child feeding, which are critical to enable the Government to monitor factors contributing to the prevalence of underweight. All stakeholders interviewed as part of the Nutrition Assessment agreed on the need for improved nutrition monitoring and data.

Currently the most widely used M&E tool for nutrition is the NDHS and micronutrient surveys, data from which is widely used and accepted. The limitation is the five-year interval between surveys, as there is no mechanism to assess nutritional status or trends between surveys. Government therefore relies on EDP lead efforts, such as the NFHP mini-survey for supplementary information, but these are not scheduled routinely.

Refer to the Monitoring and Evaluation Capacity Assessment

c) History and Current and Future Technical Assistance

The history of TA to safe motherhood (through NSMP, SSMP and NFHP) is well recorded elsewhere as is the Health System Support provided by RTI. EDPs have provided a range of inputs across the broader EHCS health areas some of which are referred to above.

Capacity Development Strategy

The NHSSP approach will focus on the close relationship between maternal, neonatal and child health, nutrition and reproductive health, targeting increased utilisation of services by lowest and second lowest wealth quintiles. This includes deliveries by SBA, antenatal care, postnatal care, use of modern methods of contraception, use of timely emergency obstetric care for life threatening complications, comprehensive knowledge among women of reproductive age of HIV/AIDS, treatment of children with acute respiratory infection and under-five diarrhoeal cases, nutrition interventions and increased vitamin A coverage in children 6–59 months.

The evidence reviewed during this capacity assessment indicates a policy environment that is conducive to improving EHCS health outcomes. A few areas of strategic focus for capacity building were identified. Strengthened integration and coordination, improvements in quality of care, referral and a area planning to help prioritise and focus efforts to meet the needs of underserved and remote populations underpin the approach. Suggested areas of focus include :

- Pilot, evaluate, implement and embed additional service components of existing EHCS packages prioritised in NHSP-2
- Improved integration of MNCH and nutrition services (EHCS) including integration of a newborn component in the CB-IMCI package and orientation of CB-NCP in SBA
- Implementing remote area guidelines for expanding access to integrated EHCS, focusing on continuum of care
- Strategically scale up SBA training, based on a review of current targets and consideration of what is appropriate for different geographical areas, for example remote areas and the Terai and identify strategy to expand training withing private sector and contracted out staff
- Scaling up CB-NCP, based on the final results of the pilot evaluation, with integration of child and maternal health care. Assessment of how CB-IMCI review could be integrated with CB-NCP training and later with FCHV quarterly review
- Improving referral systems for integrated EHCS delivery including, for example, development of referral site package for management of sick newborns and CEOC
- Improving quality of care, including child health issues and care provided by SBAs
- Improving supplies, equipment and infrastructure for integrated EHCS
- Enable further reduction of pneumonia and diarrhoea mortality in 1 to 59 month olds especially among underserved populations
- Refocusing family planning, integration of family planning in other services and increasing the number of training sites
- Adolescent health – establishing adolescent friendly services
- Establishing one stop crisis service with in health facility to provide care, counselling and further support to women suffering from gender based violence and services for post-natal depression
- Improve coordination within the public sector, with NGO and private sector providers and EDPs, to align efforts most efficiently with NHSP-2 priorities
- Develop and implement an area plan as the basis for coordinating health system and EDP inputs (supporting the remote area strategy and focusing efforts to meet the needs of other underserved populations)
- Strengthen institutional arrangements to support the delivery of the above.

Proposed Technical Support

It is proposed that technical support be provided through a mixture of long-term embedded, short-term ongoing but not embedded, and ad hoc strategic short term TA.

Long term TA

Embedded long term positions are proposed within the DoHS (a MNH Adviser within FHD and an EHCS Adviser within CHD/NHTC). In addition the post holders within the DoHS will be supported by non-embedded TA, including specific inputs from HKI and SAVE (proposed below). HKI and SAVE have identified a programme of capacity development priorities for their support, as part of this EHCS capacity assessment. This will ensure continuity of expertise and focus for nutrition, child and neonatal health.

The rationale for placing long term embedded support within the FHD and CHD/NHTC is to ensure sufficient resources for capacity development in priority areas of the NHSP-2 across the continuum of care. These post holders will work closely to promote coherence and coordination between the two divisions and their related areas of focus, improving integration and efficiency in parts of EHCS which are currently not fully aligned. CHD/NHTC embedded TA will help to drive forward the SBA and family planning training programme, which is an urgent priority, and improve quality and coordination. The imperative to increase the number of SBA trained staff is clear, but different models may be appropriate for this (the current review may identify alternative pathways). The post holder will also work to support wider efforts to review and develop the capacity of the NHTC.

The post holders will provide critical capacity development to priority areas of NHSP-2 needing focused support (see TA plan), and should report to the Health Policy and Planning (HPP) National Lead, who will be based within the MoHP. This will ensure the leverage and connection necessary for support to policy and institutional structures identified in this capacity assessment as requiring review. The HPP National Lead will also provide the vital link to relevant thematic leads at Ministry level, whose work portfolios will need to be well integrated to support the DoHS and regions in implementation (HR, Infrastructure and procurement, HF, GESI, M&E).

The proposed MNH Adviser would further develop the capacity of the existing safe motherhood coordinators (existing Red Book posts at regional level). An additional EHCS post within each of the five regional teams is recommended in the Regional Assessment, managed by the EHCS Adviser. This will support development of regional capacity for monitoring and mentoring EHCS and ensure embedding at regional and/ or districts levels the implementation of new, updated or revised ways of working (resulting from introduction of new services, piloting or scaling up of new approaches, and increased integration/ coordination). This level of EHCS focus would ensure the NHSP-2 capacity development plan works effectively through the system and supports development of government capacity, at all levels, to deliver the change necessary to meet the results framework targets.

The division of responsibility between the MNH and EHCS Advisers will reflect the priorities of the FHD and CHD (see job descriptions). Their attendance at sub-committees would be defined by the committee agendas. They would need to play an active role on the RHCC, supporting the Chair to improve coordination of agendas between sub-committees and alignment with NHSP-2 priorities. The Advisers will have an important part to play in improving aid effectiveness and will need to work closely with the Team Leader and relevant

core team and government counterparts and partners to support integration and coordination of EDP TA. The EHCS Adviser based in CHD will coordinate and focus HKI and SAVE inputs.

The Advisers would be supported by an EHCS mentor (Dr Louise Hulton) and additional TA as per the TA plan.

Please refer to proposed Job Descriptions.

Short Term Non-Embedded Support

A part-time team from HKI and a team from SAVE, with considerable experience in Nepal and strong relationships with key personnel in DoHS, are expected to have rapid start-up capacity and be effective through productive relationships. These two part time teams would support the LTTA advisers in developing the capacity of Government to achieve key EHCS outcomes. Refer to TA plan for Nutrition and Child Health in Annex 1. These reflect the first 6 month priorities and the plans will be refreshed in collaboration with counterparts during this time so activities are indicative beyond 6 months.

A key finding of the nutrition capacity assessment was the need to increase the number of staff available to support the nutrition goals of the NHSP-2. Stakeholders also broadly agreed that support for new and current staff is needed, but ownership would be better developed through a part-time TA team, and the chances of dependency reduced.

It is recommended that support to TCIC (previously funded through SSMP) be continued, to further strengthen safe abortion and expand access, and to help ensure effective positioning of the programme. A key focus of the MNH Adviser will be to work closely with TCIC to ensure good coordination and help fill identified gaps in delivering the NHSP-2 priorities.

Regional Level Capacity Development

It is envisaged that regional level capacity development for maternal, child and newborn health interventions, for example to support scale up of CB-NCP, and more integrated and coordinated working, will be through an embedded EHCS post within each of the five regional directorates, working in close coordination with the existing Red Book funded regional safe motherhood coordinators. Regional EHCS posts would be managed by the EHCS Adviser based in CHD, while the existing Red Book posts would report to the MNCH Adviser in FHD. Additional strategic TA support at regional level will be required to support the design of mechanisms for developing district level capacity to improve implementation of newborn care interventions.

<u>Specific Recommendations</u>

- **Review and revitalise committee structure and coherence to align with NHSP-2 EHCS targets; improve coordination and integration.**

This recommendation extends from the Steering Group down to the district RHCCs, including the coordinating committee within the DoHS and all sub-committees. This will require a review of Terms of Reference (ToR), membership and effectiveness, against the NHSP-2 priorities. It is proposed that this piece of work be led by the HPP Adviser.

In the meantime the embedded TA posts would be responsible for building capacity of the DoHS to improve coordination within the existing structure.

There is a clear opportunity to review the scope of the RHCC to better align this with the Results Framework. As a short term measure, it is recommended that NHSP-2 provide secretariat support to the RHCC and selected sub-committees, with the aim of incorporating this support into the Red Book within two years, or writing it into the job descriptions of existing staff within the respective divisions. Secretariat support should be considered to support community based newborn care and the CB-NCP Technical Working Group once Saving Newborn Lives ends in September 2011, with a view to this support being institutionalised as described above.

This would ensure the RH (and potentially broader EHCS following review and update of ToRs) coordination is firmly embedded and driving the national strategy and policy to meet NHSP-2 outputs for this area.

While the sub-committees are functional, there is a need for greater coherence among them, with the Steering Group ensuring relevant parts of the structure work as a whole. Leadership of the DG will be instrumental in enabling and driving integration and focus. Better coordination (and if necessary a rationalisation) between the committees will help support efforts to align existing government initiatives and activities with NHSP-2 priorities. A refreshed structure would also facilitate alignment of EDP TA.

This review would include the ToRs of the district RHCCs, to explore whether and how their scope might be expanded to broaden membership to align better with those EHCS outcomes which relate specifically to women of reproductive age, newborns and children. There is a real opportunity to build on the success of these committees, rather than introducing a raft of new bodies (unless this is recommended by the proposed review).

- **Develop a medium term plan to secure Red Book resources to fund the coordination function of committee structures.**

This will help ensure that the committee structure remains aligned with the National Health Strategy priorities and reduce the potential for EDPs setting agendas based on their priorities. The FCHV sub-committee will be particularly important for the introduction of new services and improved integration between MNH and NCH, as well as the broader EHCS priorities, as all community based maternal, newborn and child health interventions are piloted and/or scaled up through this committee. FCHVs will also be critical to implementation of components of the remote area guidelines. Although this sub-committee falls under FHD, it is proposed that EHCS advisers attend on the basis of the agenda, and where necessary both will attend, to ensure effective coordination.

- **Develop capacity integrate safe abortion with FP/RH and adolescent services**

This will also include efforts to develop a safety net mechanism for poor and marginalised women (MoUs with health management committees to ensure poor women receive services free of cost, which will be reimbursed by government); roll out of the physician and nurse training programmes (pre-service and in-service) and inclusion of medical abortion in the SBA training course. As part of the broader effort to improve access for the underserved, expansion of the availability of medical abortion services into more remote areas and at community level will be an important area of focus.

Priorities for 2011 and 2012

- **Drive forward piloting and wider implementation of the remote area strategy** Facilitate FHD, CHD and Revitalisation to work effectively together to develop a remote area package based on currently implemented programmes (such as CB-NCP , CB-IMCI, PNC, Misoprostol, birthing centres, obstetric first aid for health workers, CEOC, referral, telemedicine), with an implementation strategy, following piloting in two to three districts. Establish referral networks that support and link different components of the RAG. Work closely with M&E colleagues to document learning. The RAGs currently focus on safe motherhood, further develop these to incorporate wider essential components of MNCH/EHCS.
- **Pilot and expand misoprostol, to reduce the risk of post-partum haemorrhage in areas with poor physical access to facilities.** This NHSP-2 commitment is an important element of the remote area strategy and TA support to develop capacity to support this pilot and subsequent scale up will be important. Misoprostol is currently being integrated into the BPP, but capacity is insufficient within FHD to move this forward sufficiently quickly. Evaluation of this innovation will be important. Piloting of the rural ultrasound programme and telemedicine will form a core component of the implementation of the remote area strategy and will also require specific TA support and solid documentation and evaluation.
- **Develop area planning to provide a framework to support coordination of inputs and enable targeting of underserved areas and populations with poorest health outcomes.** With clarity about national priority areas and populations, it will be easier to coordinate efforts and resources so that infrastructure improvements; supply and equipment and medicine; SBA training selection; posting and transfer of SBA trained staff; GESI strategies and EDP inputs are aligned geographically. Such planning would also facilitate coordinated scale up for new services and strategies. Targeting support to areas with the poorest child health outcomes will be an important part of any area based approach. An area approach (which would incorporate a remote area strategy) would need to enable the flexibility for context specific planning. Planning will require pooling of knowledge about health outcomes; current EDP and Government district investment and services, and need. Support for such an approach and decision making to agree priority areas and populations would require strong coordination and leadership, which needs further discussion but it would seem a sensible way of helping to coordinate scarce resources and target underserved populations and areas.
- **Carry out a critical review of pathways for health providers who come into contact with women during their antenatal period and the opportunities opened up**. Mapping

pathways from the perspective of women's health seeking is recommended, recognising that when women travel to seek care, they may have to cover considerable distances. Ensuring face to face opportunities are used efficiently is therefore particularly important. Referral between all parts of the EHCS network needs to be better coordinated, so that providers responsible for safer pregnancy and delivery are well connected to other services to which they may refer their users (such as mental health, child health, family planning).

- **Assess the strength of referral knowledge and practice to related essential services and develop a referral plan for each district.** Recent guidelines for referral focus on women with complications in pregnancy, childbirth and postpartum. This approach needs to be expanded to cover other services and ensure health workers know what is available within their district and neighbouring districts; opening hours; contact details and so forth. It would make sense to consider the district RHCC as the main vehicle through which to develop such a plan. Capacity assessment of CHD/FHD staff to deliver NHSP 2 result, in terms of planning, monitoring and supervision, is recommended.

- **Pilot implementation of the referral guidelines in different contexts, to inform a scale up strategy.** It is recommended that a pilot be designed for three different types of area, from which learning can be shared and solutions and approaches scaled up. Good innovations research will be necessary to capture evidence to support scale up. Improved telecommunications and wider use of telemedicine will play an important role in improving referral practices and supporting health providers on location. The guidelines will need to include referral for sick infants, which is identified as an area in need of further attention.
- **Develop capacity of FHD and CHD to deliver against existng commitments detailed in annual plans (refer to annual plans for detail) and within the NHSP-2 implementation plan.** For example, support and coordinate NPHL/ NRCS to scale up and quality assure implementation of blood transfusion standards. This will require capacity to develop the training package, and implement a strategy of quality assurance to ensure up to date protocols exist at service sites and are implemented effectively. Strengthening and expansion of CEOC will continue to be one of the major focuses. QA and supervision will need to be integrated into the district reviews.
- **Develop capacity and provide specific TA as necessary to develop and implement standards for accreditation of private/NGO hospitals.** The development of these standards is also important in relation to the current and further proposed inclusion of NGO and private sector in incentive schemes, as well as to consistency in quality of services and training. *Cross reference HF CA.*
- **Draw from learning from SSMP to identify potential for scaling up to include wider health outcomes**. For example, appreciative enquiry was evaluated as successfully improving MNH services, and this approach could be expanded to support quality improvements for whole site and service areas core to broader EHCS and to strengthen accountability.
- **Work closely with the HR Adviser and the post holders at the DoHS to design an effective capacity development plan for the NHTC, and expansion of SBA training sites (in and pre-service) and a quality improvement plan for training**. The quality improvement plan will need to highlight opportunities within training to support efforts

to integrate core components of MNCH/EHCS and reinforce efforts to strengthen referral and follow up after training.

Areas identified as having particular resource constraints and where it will not be possible for NHSP-2 to provide substantial direct capacity development support include: adolescent health; mental health; GBV; HIV and FP. Specific areas for attention are highlighted above and will remain a focus for the scope of LTTA positions in collaboration with other members of the NHSP-2 team (eg GESI adviser). Attention to coordination and integration of TA planning across EDPs will also be a core part of NHSP-2 strategy to assist Government to achieve core maternal, neonatal, child and related EHCS health outcomes.

d) Risk and Risk Mitigation

Change of leadership including Directors with every change of political administration weakens capacity building efforts and can disrupt or delay efforts already underway. To reduce disruption from changes in leadership it will be important to ensure that capacity building efforts are well distributed across teams the National, Regional and District Level. In addition working to ensure good communication and buy in early on with key individuals will be important to facilitating smooth working relationships.

There is a risk that there is not sufficient support for the proposed Area plan approach among all relevant stakeholders and also that EDPs are not flexible or supportive enough to match programming to National Area Priorities. To mitigate this risk it will be very important to establish broad agreement in principle to this proposal and engage individuals and groups in a meaningful way to ensure that there is broad agreement and their views and priorities are appropriately reflected. Workshops and strong communication and relationship building will be important modes of working in this respect. In addition area planning of the type envisaged will need more flexible funding arrangements at district level if districts are to prioritise programmes and populations (as opposed to a universal approach). Financial rules will have to support implementation of area plan. Early NHSSP engagement with the Planning Commission and Finance Ministry will be important. In the meantime using TA to support pilots and evaluations to help make a robust case for a more targeted and context specific approaches will be critical.

The recommendations within this Capacity Assessment and associated TA plan are based on an understanding of current GON / MOH and EDP priorities (as stated in NHSSP 2) and financial commitments. If these were to changes significantly within the life of this programme (eg toward a greater focus on non-communicable disease) this may result in a diversion of funding from the core areas of EHCS that NHSSP capacity building proposes to focus on. EDP representatives will need to be prepared and able to focus their efforts to help maintain the current focus and NHSSP will need to help ensure good monitoring, progress and impact information is regularly available to help justify such commitments.

The private sector is an important part of any national strategy to improve service provision and health outcomes. They provide important opportunities but currently the legislative and regulatory arrangements and ability to implement such legislation are important areas in

need of attention before these opportunities can be effectively exploited. From the EHCS perspective building relationships as part of work to strengthen referral and as part of context specific planning will be an important component of this work theme. Using this knowledge and experience to help advocate for and inform efforts at the Ministry Level to strengthen the framework for public private partnerships will help further efforts to date.
There is risk that if current regulations and training policy are not changed regarding training of contracting out staff then it will not be possible to meet SBA training targets. There is a good opportunity during the review of National Health Training Strategy to make the case for a change to address this as well as during any review of the National Health Policy. Our approach will be to help ensure that this issue remains high on the agenda and good evidence is used to make the case for a change in the near future.

An important risk relates to staffing at CEOC sites. Currently HR and procurement regulations and shortages at CEOC sites pose a real risk to ensuring sites are functional as posts either cannot be filled, or are being filled by expensive private providers. This situation is not sustainable and new flexible approaches to help ensure CEOC sites are effectively staffed are urgently needed. It is suggested that a CEOC study is required immediately to help identify and analyse the current bottlenecks and challenges. This study would need to make a range of innovative recommendations to address the current real challenges of staffing CEOC sites.

The approach outlined in this capacity assessment assumes that continuum of care approach is optimal and this will require improved integration and coordination. In order to operationalise this it is critical that all stakeholders (EDPs, Divisions and relevant Ministries) support this principle and are willing to make changes to help facilitate this in practice. Workshops, strong relationships and good communication as well as using strong evidence and coming up with practical proposals for change to facilitate this will be used tactically to ensure this principle is well supported. In practice leadership on integration will need to come from a number of levels and stakeholders.

There is a risk that the increasing interest and funding from EDPs for nutrition activities is not matched by the capacity and leadership of the Nutrition Section, as well as the regional and district offices. In addition Capacity of the community level health workers and volunteers needs careful exploration with regard to CHW workload and effectiveness for nutrition interventions.

The NHTC has plans to become an Academy (not within the DoHS). This would result in the introduction of fees for training so that it might become more self sufficient. There is a risk that this may result in a change in focus away from national priorities to training in areas that are more lucrative for service providers in the private sector. These plans are in the early stages. A thorough capacity assessment of NHTC in line with a review of training needs against NHSP 2 will help inform plans for such a transition to an Academy to help ensure that the outcome best supports Nepal's health training needs. This assessment is scheduled for year one of TA.

Annex 1 – Summary of Child Health and Nutrition Recommendations

Child Health - Key Recommendations

Gaps/Issues	Actions needed	TA need
Child Health		
• Sustaining the coverage of Measles, pertussis (in DPT), and Hib immunization and preferably seeking to increase coverage in populations with low coverage, and continuing to ensure program quality.	Develop strategies and plans to improve the coverage particularly in unreached population (This will be integrated under area planning approach – LTTA will share area planning concept paper once it is discussed with Louise) RAG for child health expansion	Develop capacity to review existing information system ensuring adequate disaggregated data reflecting equity gaps (geographical coverage gaps, equity gaps with a defined geographical area will be mapped with the support of M&E) .
	Develop strategies to improve the quality of immunization program	Develop capacity to analyze the data to identify low coverage population. Provide technical support to develop strategies and plans to improve the coverage and quality of service
• National Immunization program does not include newer vaccine with enough evidence (eg. rotavirus and pneumococcal conjugate vaccines)	Gradual introduction of Rota virus and pneumococcal conjugate vaccine in the National Immunization Program (SAVE will not focus in this area)	Provide Technical support to assess the cost-effectiveness and feasibility of the vaccine introduction.(SAVE will not focus this area)
• Access to appropriate providers for pneumonia and diarrhea case management not adequate.	• Develop the strategy to assess and improve the low coverage pneumonia and diarrhea case management (Under area planning approach) will also focus on How to reach urban unreached children	Develop capacity to analyze the data to identify low coverage population and implementation strategy to improve the coverage.
• Lack of awareness for prompt care seeking for pneumonia and diarrhea case management	• Develop effective behavioral change communication and community mobilization activity to improve the prompt care seeking for case management. (SAVE Yr 1-3)	Technical support for a formative for identifying and development of effective BCC tool and techniques to improve care seeking (SAVE Yr 1-3)
• No standard pneumonia and diarrhea case management particularly at referral site and private sectors	• Develop and implement protocol and guide for standard case management of pneumonia and diarrhea at referral site and private sectors (SAVE Yr 1-3)	Provide Technical support to develop protocol and guide for standard case management of pneumonia and diarrhea at referral site.
• Referral system for case management of diarrhea pneumonia poorly functional	• Develop and implement functional referral system for case management of diarrhea and pneumonia (will be part of referral system/network for MNCH development)	
• National Child Health program not incorporated in the in-service and pre-service curricula (including physicians, Staff Nurses, Health Assistants, AHWs, and ANMs).	• Review the existing in-service curricula to integrate the national IMCI protocols Yr 2 & 3 • health assistants, AHWs and ANM) to integrate the national IMCI protocols in the pre-service curricula Yr 2 & 3	Facilitate the process to review the existing in service curricula and strategy to integrate IMCI protocols in the curriculum bringing in National Health Training Center (NHTC)
•	• Review the existing pre-service curricula (physicians, staff nurses,	Facilitate the process to review the existing in service and pre-service curricula and strategy to integrate IMCI protocols in the curriculum bringing in National Health

Gaps/Issues	Actions needed	TA need
		Training Center (NHTC) and Ministry of Education also.
•	• Develop a strategy to implement the curricula Yr 2 & 3	Technical support to develop the strategy to implement the curriculum
Newborn Health		
• Funding for Scaling up of Community-Based Newborn Care Program not secured	▪ Evaluation of Community Based Newborn Care pilot implementation and secure funding for scale up. Yr 1 (Funded under SNL)	Technical support to evaluate CB-NCP pilot implementation and lobby for securing funds for scale up.
• Scale up strategy for effective implementation of the program not done.	▪ Develop strategy and plan for the modification and scale up of program Yr 2 & 3	Build the technical capacity to develop strategy and plan for modification and scale up of CB-NCP
• Strategy for newborn referral system not developed	▪ Development of strategy and plan for effective system of referral for newborn. Yr 2 & 3	TA to develop strategy and plan for effective referral of newborn building on the report of "Assessment of Health Facility for Newborn" (PESON-2010)
Weak linkage between CB-NCP and CB-IMCI package	Develop strategy for integrating newborn health into IMCI Yr 2 & 3	Technical support for identifying area of integration of newborn health intervention in CB-IMCI in line with recommendation from CB-NCP pilot final evaluation Technical support to develop strategy for implementation
Newborn interventions and CB-NCP not addressed in SBA package	Develop strategy and plan to integrate newborn health in SBA Yr 2 & 3	Technical support for assessment for areas of integration of newborn health in SBA in line with recommendation from CB-NCP pilot final evaluation. Identifying area of integration of newborn health intervention and CB-NCP in SBA Technical support to develop strategy for implementation

Nutrition - key recommendations

Proposed area	Program Strategies/Activities	6 month plan
Integrated life-cycle approach to address malnutrition	Maternal nutrition • Explore strategies to improve caloric intake during pregnancy such as food supplementation, BC activities • Implement program to improve maternal dietary diversification • Improve maternal nutrition counseling in current government programs such BPP, CB MNC esp. during ANC visits Adolescent nutrition • Explore piloting adolescent iron supplementation programs in schools • Integrate key adolescent nutrition messages in Adolescent Friendly Reproductive Services program districts Child nutrition • Scale up IYCF/MNP activities in Nepal • Utilize existing multi-sectoral community groups to disseminate IYCF messages • Integrate IYCF counseling messages national programs such as CBIMCI, iron intensification	Central level discussion workshops series with key nutrition stakeholders to identify and refine program strategies. Identify topics for operations research with CHD/Nutrition section and finalize research plan Revise and Refine the school health and nutrition strategies to include nutrition issues relating to adolescents Assist the NPC/NNCC to finalize the multi-sectoral nutrition action plan Ensure NHSP-2 Results Framework includes more nutrition indicators and is aligned with the text of the document.
Enhance the capacity of current and future staff on national, regional and local levels	Provide STTA based on technical gaps raised by the nutrition section at CHD Support nutrition section to train district level nutrition focal persons on issues such as IYCF, maternal nutrition etc Hold biannual technical update meetings at the central level	Together with the nutrition section/CHD Identify key technical gaps and human resource needs Facilitate discussions with IOM/academic institutions and DOHS for short-term in-service programs implemented for government staff
Assist the government to increase the number of technical as well as managerial staff allocated to nutrition functions	Discuss institutional strengthening including restructuring of nutrition section with key stakeholders at the ministry esp on establishing central level nutrition center under Department of Health Services Facilitate discussion with the Institute of Medicine(IoM)/ academic institutions for short term placement at nutrition section/CHD	Facilitate discussion with the MoHP to explore ways to restructure nutrition section Facilitate discussion with IoM for short term programs at CHD

Annex 2 – Job Descriptions

Essential Health Care Services Adviser

EMPLOYER:	Options Consultancy Services Ltd
REPORTING TO:	Team Leader & Director, CHD
DURATION:	Until the 31st August 2013
LOCATION:	Based in the Child Health Division (CHD) / Department of Health Services (DOHS), Kathmandu.
COUNTERPART:	Director, CHD
PERFORMANCE MANAGEMENT:	Advisor's performance will be measured against workplan activities and deliverables

Background

The Government of Nepal is committed to improving the health status of Nepali citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), began in July 2004, and ended in mid-July 2010. NHSP-1 was a highly successful programme in achieving improvements in health outcomes. Building on its successes, the MOHP along with External Development Partners have designed the second phase of the Nepal Health Sector Programme named as NHSP-2, a 5 year programme, which will be implemented from mid-July 2010. The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women, the poor and excluded. The purpose is to improve utilisation of essential health care and other services, especially by women, the poor and excluded. Options Consultancy Services Ltd (Options) and partners are providing technical support to the GoN to implement NHSP-2.

Role Objective

The post holder will work closely with the CHD and NHTC, and coordinate with Family Health Division (FHD) and other divisions and centres of the DOHS, focusing on **improving delivery of MNCH services at community level focusing on reaching remote and underserved populations**. The post holder will work closely with NHTC and other stakeholders to **develope, implement and monitor appropriate and sustainable training capacity building for equitable delivery of MNCH services** as stated in NHSP II result frame work.

The Essential Health Care Services (EHCS) Adviser will lead capacity enhancement technical inputs to enable the GoN to deliver NHSP-2 priorities within newborn and child health. The EHCS Adviser will be responsible for working collaboratively across the DOHS and with external development partners to strengthen delivery of health within a continuum of care framework. S/he will focus efforts strategically to strengthen service delivery and improve access for women and their newborn and children. While the focus of this role will be newborn and child health the post holder will be responsible for supporting improved coordination between CHD and FHD and integration with MNCH services. This will require close working relationships across the DOHS and MOHP and related Ministries as required. The post holder will be supported in this role by Helen Keller International

(HKI) for Nutrition. Additional ad hoc technical support will be drawn on as appropriate. The Adviser will be responsible for coordinating technical inputs from the technical support and HKI.

The post holder will be supported by a Mentor from Options Consultancy (Dr Louise Hulton). The post holder will work closely with colleagues within the NHSP-2 team (HR, Procurement, Gender Equity and Social Inclusion (GESI), M&E and Health Financing) and will report to the Health Policy and Planning Adviser. It is envisaged that the post holder will manage EHCS posts/support to the Regions (posts TBC).

Key objectives for this post will include:

- Improve coordination within the public sector, with NGO and Private sector providers and External Development Partners (EDPs) to align efforts most efficiently against NHSP-2 priorities (with a focus on the improvement of NCH outcomes);
- Address existing gaps in the continuum of care (with a focus on NCH);
- Improve integration, reduce duplication and improve efficiency (with a focus on NCH);
- Work with relevant NHSP-2 and Government Counterparts to improve synchronisation of essential inputs (HR, finance, supplies, equipment and infrastructure) to enable more integrated EHCS delivery and access;
- Work collaboratively with GESI adviser and relevant partners to increase demand for essential services;
- Work closely with NHTC and other stakeholders to develop, implement and monitor appropriate and sustainable training capacity building for equitable delivery of MNCH services as stated in NHSP-2 result frame work.

Specific Areas of Responsibility (with technical support from HKI or Options as appropriate)

- Advisor will prepare a workplan with clear deliverables and agree it with counterpart and will work in accordance with workplan
- In collaboration with the GESI and MNH Adviser assist FHD/CHD/PHCRD to develop **area planning** guidelines and implementation plan to stage inputs and provide framework for context specific plan which will provide GON a framework for selection of focus areas and issues for EDP support; facilitate the development and implementation of an area plan as a basis for coordinating health system and EDP inputs:
    - pilot a local area planning process which applies need based planning with local participation; that addresses key supply and demand side constraints with emphasis to continuum of care, good referral network and community mobilisation; aiming to increase coverage and use of services for remote and underserved populations; (and for scaling up nationally based on evidence learned);
    - develop tools for area planning focusing on remote and underserved population including urban areas;
    - expansion of remote area guidelines for safe delivery and family planning for broader EHCS;
    - collaborate closely with Health Financing post holders to support government in the development of a GESI policy and implementation plan to ensure it best supports efforts improve access and quality.
- In coordination with MNH advisor assist FHD in **operationalization of Remote Area Guidelines (RAG)** - piloting RAG components as in 2010-11 annual work plan – Misoprostol, rural antenatal ultrasound, referral transport fund, HFOMC strengthening and scaling up as necessary. Facilitate for expansion of RAG to other areas of EHCS/MNCH;
- Coordinating technical inputs from HKI and Options in supporting CHD to improve the institutional and technical capacity to increase child health, new born and nutrition services

overage; emphasising on reaching the underserved population including urban areas and **improve integration of MNCH and nutrition services** (EHCS): **(Link with HKI STTA);**
    - explore and facilitate integration of MNH into 'integrated review for child health' and later with FCHV quarterly review;
- Working closely with the HR and MNH Advisers to critically review the capacity of the NHTC, map the content and reach of current training across those areas core to MNCH and overlapping EHCS, investigate and design an effective capacity development plan for the NHTC and support capacity to develop a quality improvement plan for training:
    - Contribute in efforts to scale up SBA training - revises SBA training strategy in line with Human resource strategy for safe delivery ad current need; maintaining a focus on strategies to scale up SBA training; integration of SBA skills in pre-service training of ANM/ SN;
    - explores, develops and strengthens Family Planning training sites emphasising on IUCD and Implant;
    - revise national health training strategy in line with the training need of NHSP 2 and beyond;
    - Capacity assessment of NHTC keeping in mind the transition from NHTC to national health training academy
    - implement quality management system for safe motherhood and new born training programmes including follow up;
    - build effective partnerships related to training activities between NHTC, FHD and other relevant technical agencies and professional councils and associations working in SMNH; work with them to develop shared positions and policies on training issues of common concern;
    - in coordination with HPP/ Finance / Procurement advisers, support NHTC in developing, managing and monitoring contracts with training institutions (public and private) as required for SMNH skills development.
- In coordination with GTZ, link with MNH advisor to, support FHD to revise and expand of **Adolescent friendly services (AFS)** nationally especially to underserved population and explore for integration of other EHCS including nutrition;
- Support MNH advisor to develop capacity to pilot and scale up **expanded referral guidelines**; develop networks and partnerships across the health system to support delivery of these; improve referral systems for integrated EHCS delivery building on strategic points in the care pathway (e.g. antenatal and postnatal care contacts);
- Support MNH advisor in assisting MD and other DPs to strengthen **service quality** through establishment of a culture of following protocols and supportive supervision by coordinating with related divisions (CHD) to assure all NCH services are up to current national/ international standards, have adequate equipment and adequate drugs/supplies;
- Support GESI advisor to develop better **mass communication** that actually reaches the poor and underserved and results in increased use of home based and institutional based safe motherhood, new born and child health care services not just awareness;
- Collaborate with M&E counterparts ensure **impact assessments and operations research** are delivered where appropriate to ensure evidence based programming and scale up is possible
- Support the Health Policy and Planning Adviser effect change necessary to strengthen institutional arrangements to support the delivery of the above;
- Aid effectiveness - work closely with the MNH advisor and relevant core team and government counterparts will support the better integration of EDP TA to enable the delivery the above strategies in the most effective way. At the Regional Level, support government counterparts to harmonise and integrate efforts of EDPs at the regional and district level to coordinate efforts behind improvements in health outcomes within the Results Framework. (relationship building, meetings, seminars, workshops);

- Recruit and manage Regional EHCS posts/support consistent with the Regional Capacity Assessment;
- Manage additional TA inputs as required to support delivery of the above (with support from Mentor).
- Advisor is expected to travel for up to 30% of his / her time for up to 2 weeks at a time

Person Specification

Specification	Essential	Desirable
Education and training	• Medical/ Nursing with Public Health Degree	
Experience	• Working experience with government health system – at least 5 years • Working with EDPs and I/NGOs	• Working in EDPs
Skills & abilities	• Application of various planning tools • Budgeting • Reporting • Monitoring - Critical analysis of health system performance focusing on MNCH • Evaluation • Computer – word, excel, power point, • Technical areas in maternal, newborn, child health • Excellent and demonstrable written and spoken English and Nepali	• Nepali language skills
Special aptitudes	• Learning, relationship-builder, mature • Excellent interpersonal skills	
Interests	• An understanding of the issues affecting women's health and access to service in Nepal	
Disposition	• Willing to work closely in a team	
Circumstances	• Willing to travel to rural areas with Nepal	

Maternal and Neonatal Health Adviser

EMPLOYER:	Options Consultancy Services Ltd
REPORTING TO:	Team Leader & Director FHD
DURATION:	Until the 31st August 2013
LOCATION:	Based in the Family Health Division (FHD) /Department of Health Services (DOHS), Kathmandu. Some travel within Nepal is likely.
COUNTERPART:	Director, FHD
PERFORMANCE MANAGEMENT:	Advisors performance will be measured against workplan activities and deliverables

Background

The Government of Nepal is committed to improving the health status of Nepali citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), began in July 2004, and ended in mid-July 2010. NHSP-1 was a highly successful programme in achieving improvements in health outcomes. Building on its successes, the MOHP along with External Development Partners have designed the second phase of the Nepal Health Sector Programme named as NHSP-2, a 5 year programme, which will be implemented from mid-July 2010. The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women, the poor and excluded. The purpose is to improve utilisation of essential health care and other services, especially by women, the poor and excluded. Options Consultancy Services Ltd (Options) and partners are providing technical support to the GoN to implement NHSP-2.

Role Objective

The MNH Adviser will lead capacity development technical inputs to enable the GoN to deliver NHSP-2 priorities within maternal and newborn health. The MNH Adviser will be responsible for working collaboratively across the DOHS and with External Development Partners (EDPs) to strengthen delivery of health within a continuum of care framework. S/he will **focus efforts strategically to strengthen service delivery and improve access** for women and their newborn and children. While the focus of this role will be maternal and newborn health and reproductive health (strengthening quality of Essential Obstetric Care Services including EOC, SBA, abortion and FP services) and the post holder will be responsible for supporting **improved coordination between Child Health Division and FHD and integration with MNCH services.** This will require close working relationships across the DOHS and MOHP and related Ministries as required.

The post holder will be supported in this role by technical support from Options and Helen Keller International for Nutrition. The post holder will be supported by a Mentor from Options Consultancy (Dr Louise Hulton). The post holder will work closely with colleagues within the NHSP-2 team (HR, Procurement, Gender Equity and Social Inclusion, M&E and Health Financing) and will report to the Health Policy and Planning (HPP) Adviser. S/he will support the management of existing Safe Motherhood Coordinators.

Key objectives for this post will include:

- improve coordination within the public sector, with NGO and Private sector providers and EDPs to align efforts most efficiently against NHSP-2 priorities (with a focus on the improvement of reproductive and MNH outcomes);
- address existing gaps in the continuum of care (with a focus on reproductive health and MNH)
- improve integration, reduce duplication and improve efficiency (with a focus on reproductive health and MNH);
- work with relevant NHSP-2 and Government Counterparts to improve synchronisation of essential inputs (HR, supplies, equipment and infrastructure) to enable more integrated EHCS delivery and access (with a focus on reproductive and MNH health outcomes);
- work collaboratively with GESI Adviser and relevant partners to increase demand for essential services.

Specific Areas of Responsibility (with technical support from Options, HKI or Ipas as appropriate)

- Advisor will prepare a workplan with clear deliverables and agree it with counterpart and will work in accordance with workplan.
- In coordination with core team members assist FHD in **strengthening and expansion/ integration of maternal and new born care services** to ensure a synchronised inputs from all level to make all CEOC services functioning and expand, and expand BEOC/ BC/ Abortion/ Family planning / Newborn care services as envisioned in National Safe Motherhood and Newborn Health Long Term Plan;
    - capacity build central, regional and district level PHN to ensure functioning and expansion of CEOnC, BEOC and BC; to integrate FP services in above mentioned services and CAC services; strengthening facility based new born care at CEOC level;
    - work with HR to facilitate systems which will support policies, distribution, transfer, motivation and retention and performance of staff effectively to facilitate improved access, quality and integration;
    - supporting government to review policies in MNH (working closely with HPP) with an eye to identifying areas of overlap, opportunities for synergy and gaps that may require further attention to ensure they mutually reinforcing and facilitate integration and improvements in quality in practice;
    - draw from learning from Support to Safe Motherhood Programme (SSMP) to identify lessons which can be scaled up to integrate wider health outcomes; Support quality improvements for whole site and service areas core to broader MNCH/EHCS and to strengthen accountability; strengthen facility management through participatory planning, social audits and similarly facility focused accountability measures;
    - manage relationship with TCIC; support improved integration of CAC and PAC services with other RH and MNH services.
- Work closely with MD and other DPs to **strengthen service quality** through establishment of a culture of following protocols and supportive supervision by coordinating with related divisions (FHD/PHCRD) to assure all MNH services are up to current national/ international standards, have adequate equipment and adequate drugs/supplies.
    - update standard for maternal and new born care as necessary.
    - revising and implementing integrated EHCS supervision guideline and quality management guideline;
    - piloting and scaling up of supportive supervision for MNH.
- In coordination with EHCS Adviser develop capacity to pilot and scale up **expanded referral guidelines**; develop networks and partnerships across the health system to support delivery of these; improve referral systems for integrated EHCS delivery building on strategic points in the care pathway (eg antenatal and postnatal care contacts);

- **GBV** – assist FHD in developing, piloting and scaling up of One-Stop-Crisis services to be integrated in health services. Integrating counselling service for post-partum mental health problems;
- Support EHCS and GESI Advisers to assist FHD/CHD/PHCRD to develop **area planning** guidelines and implementation plan to stage inputs and provide framework for context specific plan which will provide GoN a framework for selection of focus areas and issues for EDP support; facilitate the development and implementation of an area plan as a basis for coordinating health system and EDP inputs;
- Support EHCS Adviser in piloting and scaling up of implementation of the **remote area guidelines** for safe delivery; work collaboratively as required to pilot and implement remote area guidelines for safe delivery (including pilot of rural ultrasound; telemedicine and misoprostol) and embed additional service components of existing EHCS packages prioritised in NHSP-2 with a focus on improving reproductive and MNH health outcomes;
- **PPP** - as MNH/EHCS are expanded into private and NGO services work with leaders of this initiative to assure service standards exist and are effectively implemented and quality assured;
- Support the Health Policy and Planning Adviser effect change necessary to strengthen; institutional arrangements to support the delivery of the above
- In collaboration with M&E counterparts ensure impact assessments and operations research are delivered where appropriate to ensure evidence based programming and scale up is possible;
- Aid effectiveness - The post holder working closely with the EHCS Adviser and relevant core team and government counterparts will support the better integration of EDP TA to enable the delivery the above strategies in the most effective way. At the Regional Level, support government counterparts to harmonise and integrate efforts of EDPs at the regional and district level to coordinate efforts behind improvements in health outcomes within the Results Framework (relationship building, meetings, seminars, workshops);
- Manage TA inputs as required to support delivery of the above (with support from Mentor) and give guidance to SM coordinators.
- Advisor is expected to travel for up to 30% of his/her time for up to 2 weeks at a time

Person Specification

Specification	Essential	Desirable
Education and training	• Medical/ Nursing with Public Health Degree	
Experience	• Working experience with government health system – at least 5 years • Working with EDPs and I/NGOs	• Working in EDPs
Skills & abilities	• Application of various planning tools • Budgeting • Reporting • Monitoring - Critical analysis of health system performance focusing on MNCH • Evaluation • Computer – word, excel, power point, • Technical areas in maternal, newborn, child health	• Nepali language skills

	• Excellent and demonstrable written and spoken English and Nepali	
Special aptitudes	• Learning, relationship-builder, mature • Excellent interpersonal skills	
Interests	• An understanding of the issues affecting women's health and access to service in Nepal	
Disposition	• Willing to work closely in a team	
Circumstances	• Willing to travel to rural areas with Nepal	

Policies, strategies and guidelines related to Maternal Newborn Health and other EHCS

- Safe Motherhood Policy 1998
- Safe Motherhood and Newborn health Long Term Plan 2006-2017, Safe Abortion Policy and strategy 2003, Medical Abortion Strategy,2007
- National Skilled Birth Attendance Policy 1998
- National In-service training Strategy for Skilled Birth Attendant, 2006-12
- National Blood transfusion Policy 2006 and National Guideline for Blood transfusion Service 2008,
- National Adolescent Health and Development Strategy 2000
- National Neonatal Health Strategy 2004,
- Community Based Newborn Package 2007,
- National Essential Maternal and Neonatal Health care Package 2006
- National Family Planning Policy,
- Remote Area Guideline 2009,
- National Reproductive Health Strategy 1998,
- Misoprostal policy
- Guideline for Management of Prolapse Uterus
- Nepal Health Sector Programme II 2010
- **Nutrition:**
- National Nutrition Policy and strategy 2004
- National Nutrition Guidelines 2000
- Five year Plan of Action for control of Anemia among women and children 2005/06-2009/11

- **Policy and strategy related to Service Strengthening**
- Strategic Plan for Human Resource 2003-2017
- Human Resource Strategy Options for Safe Delivery 2009
- Job description of Health workers under Department of Health Service 2054
- Job description of Nurses
- Local Health Management orientation Guideline 2006

- Five year Plan of Action for control of Anemia among women and children 2005/06-2009/11
- Remote Area Guideline 2009
- National In-service training Strategy for Skilled Birth attendant 2006-2012
- Medical Abortion Strategy 2009,
- Guideline for Prevention of Postpartum hemorrhage through community based misoprostal use.
- National Guideline for Blood transfusion Service 2008
- Five Year National Strategic Plan-National Blood Programme 2009
- Infrastructure Information System
- Standards of infrastructure for CEOC,BEOC and birthing center
- Standard Package of Equipment for CEOC, and birthing center
- Policy on quality of Health Services 2007
- Health care waste Management Guideline 2065
- Mental health service in integrated Primary Health care Center Service2064
- Health care Technology Policy 2006
- Orientation book for Local Health service Management 2065
- Aama Guideline for safe motherhood service 2066
- Free Health Programme Guideline 2064
- National Medical Standards for Reproductive Health volume I-III
- National RH Clinical Protocol for different level of health workers.
- Guideline and standards for establishing Private and NGO Health Institutions 2061
- Vulnerable Community Development Plan for Nepal Health Sector Programme Implementation Plan 2004/5-2008/9
- Health Sector Gender Equality and Social Inclusion Strategy
- Governance and Accountability Action Plan

Mental Health

- National mental Health Policy (1996)

Child Health

- Technical guidelines on the control of acute respiratory infections (1994)
- Operational guidelines for the community based integrated management of childhood illness (CB-IMCI) program (2007)
- Zinc policy
- National policy for the elimination of Vitamin A Deficiency in Nepal

Adolescents Health

- Adolescent Health Strategy (2000)
- Guideline for implementation of adolescent friendly services (internal document only, not published yet)
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FCHV

- National Female Community Health Volunteer Program Strategy (2067)
- Guideline for FCHV endowment fund utilization

Quality of Care

- Policy on quality health services (2007)
- Health care waste management guideline

HIV/AIDS

- National AIDS policy (1995)
- HIV/AIDS Strategy 2006-11
- National advocacy plan on HIV/AIDS 2008-11
- National HIV/AIDS action plan 2008-11
- National guidelines for management of HIV and AIDS in children (2008)
- National guidelines on STI case management (2006)
- Monitoring and evaluation guidelines for HIV and AIDS in Nepal (2006)
- National guidelines for voluntary HIV counseling and testing (2003)
- Strengthening HIV second general surveillance in Nepal
- National VCT guidelines

Annex 4 - Interviewees

The team or individuals of the teams met with the following people to conduct this assessment:

Dr. Chet Raj Pant, NPC
Dr. Praveen Mishra, MOHP
Dr. Y.V. Pradhan, Director General, DOHS
Dr. Naresh KC, FHD Director
Dr. Shilu Aryal, RH coordinator, FHD
Dr. RP Bichha , CH Division, Director
Mr. Pursuram Shrestha , CH Division, IMCI Officer
Mr. Raj Kumar Pokharel, CHD
Dr. Purushothum Shedai, Senior medical officer, CHD
Mr. Luxmi Narayan Deo , NHEICC, Director
Dr. Bhim Singh Tinkari , Revitalization division, Director
Mr. Achyut Lamichhane, Revitalization Division
Mr. Arjun Bahadur Singh, NHTC, Director
Dr. B.K. Suvedi, Former Director FHD
Dr Mingma Sherpa, LMD Director and President of a Solukumbu Health NGO experienced in remote area health services
Dr. Ramesh Adhikari, KIST
Dr. Prakash Shrestha, IOM
Dr. Dhan Raj Aryal, NEPAN
Dr. Jyoti Ratna Dhakhwa, NEPAS
Mrs. Anne Peniston, USAID
Mr. Hari Koirala, USAID
Ms. Naramaya Limbu, USAID
Ms. Natasha Mesko, DFID
Dr.Pankaj Mehta, UNICEF
Mr. Pragyan Mathema, UNICEF
Dr. Sudhir Khanal, UNICEF
Mr. Ashok Shrestha, NFHP,COP
Dr. Robin Houston, NFHP, Senior Adviser
Mr. Dirgh Raj Shrestha ,NFHP, FP adviser

1 Kerber, K.J., de Graft-Johnson, J.E., Bhutta, Z.A., Okong, P., Starrs, A., Lawn, J.E., 2007. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet, 370, pp.1358–69.

2 UNICEF, 2008. State of the World's children: Newborn and maternal health 2009. New York: UNICEF.

[3] Evans, D.B., Lim, S.S., Adam, T., Tan-Torres Edejer, T., WHO-CHOICE MDGs Team, 2005. Evaluation of current strategies and future priorities for improving health in developing countries. British Medical Journal Online First, doi:10.1136/bmj.38658.561123.7C.

4 Adam, T., Lim, S.S., Mehta, S., Bhutta, Z.A., Fogstad, H., Mathai, M., Zupan, J., Darmstadt, G.L., 2005. Cost-effectiveness analysis of strategies for maternal and neonatal health in developing countries. British Medical Journal Online First, 331(1107).

[5] IPPF, UCSF, UNAIDS, UNFPA, WHO, 2009. Sexual and reproductive health and HIV. Linkages: Evidence review and recommendations. IPPF, UCSF, UNAIDS, UNFPA, WHO.

6 Askew, I., Berer, M., 2003. The Contribution of sexual and reproductive health services to the fight against HIV/AIDS: A review. Reproductive Health Matters, 11(22), pp.51-73.

7 Freedman, L.P., Waldman, R., Wirth, M., Rosenfield, A. and Chowdhury, M., 2005. Who's got the power? Transforming health systems for women and children. Task Force on Child Health and Maternal Health. London: UN Millennium Project.

8 Murray, S.F., Pearson, S., 2006. Maternity referral systems in developing countries: Current knowledge and future research needs. Social Science and Medicine, 62(9), pp.2205-15