Child Survival and Nutrition in Nepal 2010-2015

Scoping Report

John James

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AusAID HRF
HLSP in association with IDSS
GPO BOX 320
15 Barry Drive
Canberra City ACT 2601
Tel: +61 (2) 6198 4100
Fax: +61 (2) 6112 0106
www.ausaidhrf.com.au

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Acronyms

AED	Academy for Educational Development
AusAID	Australian Agency for International Development
AWPB	Annual workplan and budget
BCC	Behaviour change and communication
BEmOC	Basic emergency obstetric care
CB-IMCI	Community-based integrated management of childhood illness
CB-NHP	Community-based newborn health package
CEmOC	Comprehensive emergency obstetric care
CHD	Child health division (MOHP)
CIDA	Canadian International Development Agency
CMAM	Community-based management of acute malnutrition
DFID	Department for International Development (UK)
EDF	External donor funding
EDP	External donor partner
FCHV	Female community health volunteer
GAVI	Global Alliance for Vaccines and Immunisations
GTZ	Deutsche Gesellschaft für Technische ZusammenarbeitGer German Society for Technical Cooperation
HKI	Helen Keller International
HMIS	Health management information system
HR	Human resources
IMCI	Integrated management of childhood illness
INGO	International non governmental organization
IYCF	Infant and young child feeding
MDG	Millennium Development Goal
MI	Micronutrients Initiative
MMR	Maternal mortality ratio
MMP	Multiple micronutrient powder
MoHP	Ministry of Health and Population
NAGA	Nutrition Assessment and Gap Analysis
NAPN	National Action Plan for Nutrition
NDHS	Nepal demographic health survey
NFHP	Nepal Family Health Programme (NGO)
NHSP-IP	Nepal health sector programme – implementation plan
NNCC	Nepal Nutrition Coordination Committee
NPC	National Planning Commission (GoN)
NS	Nutrition Section, CHD, MoHP
NTAG	Nepal Technical Assistance Group
ORS	Oral rehydration solution
PLW	Pregnant and lactating women
RUTF	Ready to use therapeutic food
SBA	Skilled birth attendant
SWAp	Sector wide approach
TA	Technical Assistance
ToT	Training of trainers
UNICEF	United Nations Children's fund
USAID	United States Agency for International development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

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Executive Summary

Background

Australia has been providing support to the health sector in Nepal since 1999. In addition to the assistance through the Health Sector program Sector Wide Approach (SWAp), Australia has provided programmatic support focused on child health and nutrition. This has contributed significantly to the improvement in child health and nutrition outcomes achieved over the past decade. Australia wishes to sustain the gains made and has committed approximately AUD 2.5 million to continue this support over the next five years (2011 – 2015).

Activities

John James, nutrition expert, visited Nepal 4th to 10th July 2010. The objectives of the assignment were to analyse current and planned activities relating to child health and nutrition in Nepal, and to provide AusAID with prioritised options for the best use of its assistance in the next five years. The assignment involved a review of relevant documents, meetings and discussions with key stakeholders, including MoH, UN agencies, bilateral and multilateral donors, international and national non governmental organisations, and a field trip to Kavre district.

Findings

Child survival and nutrition is a top priority for the Government of Nepal (GoN) and the Ministry of Health and Population (MoHP). The Nepal Nutrition Assessment Gap Analysis (2009) identified the need for a multi-sectoral approach to undernutrition, and, based on the report, GoN will publish the Nepal Action Plan for Nutrition (NAPN) in late 2010. MoHP presented the Nepal Health Sector program – Implementation Plan II 2010 – 2015 (NHSP-IP II) in April 2010. The child health and nutrition sections outline a comprehensive and evidence-based plan to address child survival and nutrition, but are ambitious. All nutrition activities are coordinated by the Nutrition Section, in the Child Health division, MoHP. Within the health sector program SWAp, donor partners contribute to a pooled fund; this includes earmarked funds for technical assistance. SWAp partners are due to release a five-year program of work for support and a Technical Assistance plan to complement NHSP II in September 2010.

Key findings were:

- MoHP has made significant gains in child health and nutrition (and is set to achieve MDG 4), but addressing high rates of child undernutrition and the high neonatal mortality rate remain a challenge
- MoHP has a clear and ambitious strategy and implementation plan (in NHSP-IP II) for child health and nutrition
- Lack of capacity in the Nutrition Section, MoHP
- Inadequate human resource capacity at district level to manage nutrition programmes
- The need to introduce comprehensive, integrated, community-based training programmes, workplace supervision, monitoring and evaluation for health workers in child health and nutrition
- Ongoing need for external development partner (EDP) support to maintain and introduce child health and nutrition interventions

Options and recommendations for AusAID support

The funding envelope and technical assistance available to address child survival and nutrition in Nepal has not been finalised. This will be determined towards the end of 2010, when the NAPN, the Annual Work Plan and Budget, AWPB, and the Technical Assistance plan are finalized and available. Hence, given these contraints and uncertainties, it is recommended that AusAID adopt a proactive stance, providing short-term support, until, with the anticipated clarification of stakeholder roles it is possible to plan for longer-term support. AusAID support should take into account the stated aim of all external development partners to ensure all donor support will be coordinated and harmonised by 2013.

The options are listed below. However, in the short-term, until the uncertainties are resolved, it is recommended that AusAID continue to provide nominal support to UNICEF in order to ensure continuity of the delivery of the priority interventions. With greater clarity over the key gaps, AusAID should be well-positioned to engage in discussions with MoHP (and donors) to agree longer-term support, based on the options described.

Summary options:

- AusAID continues support for UNICEF to provide technical support to MoHP, and continue to manage current nutrition interventions, pilot interventions with a view to roll-out nationally.
- AusAID provides technical support to MoHP Nutrition Section, through the longterm, full-time placement of an international expert, conditional on MoHP appointing additional staff to the section.
- AusAID provides technical support to district nutrition managers (management and technical training in nutrition); again, conditional on MoHP appointing additional staff.
- AusAID supports the introduction of integrated community-based training (training, refresher training, workplace training and supervision) either through an NGO or contracted through MoHP.
- Support to the roll-out of community-based management of acute malnutrition (CMAM) - provided that the ongoing CMAM pilots are positively evaluated.

These options are not mutually exclusive. Given the available funding, and the emergence of gaps, it may prove possible for AUSAID to fund elements of several of the options.

1. Introduction

Australia has been providing support to the health sector in Nepal since 1999. In addition to the assistance through the Health Sector program Sector Wide Approach (SWAp), Australia has provided programmatic support focused on child health and nutrition addressing key elements on the MoHP's strategy (the National Vitamin A program and Community Based Integrated Management of Childhood Illness). This has contributed significantly to the improvement in child health and nutrition outcomes achieved over the past decade. Australia wishes to sustain the gains made and has committed approximately AUD 2.5 million to continue this support over the next five years (2011 – 2015).

Nutrition expert Dr John James was contracted to provide a situational analysis by AusAID and visited Nepal 4th to 10th July 2010. The terms of reference for the activity are found in Annex I. In summary, the consultant was to:

- Analyse current and planned activities relating to child health and nutrition in Nepal;
- Provide AusAID with prioritised options for the best use of its assistance in the next five years.

Consultant activities

Preparatory work:

- Desk review of key stakeholder documentation including policy documents, reports, surveys, and records. A full list is found in Annex III
- Literature review of relevant child nutrition research papers.

In country:

- Meetings were conducted with key representatives from a wide range of stakeholders. Their names are listed in Annex II.
    - AusAID
    - Government of Nepal (GoN): National Planning Commission
    - Ministry of Health and Population (MoHP)
    - World Bank (WB)
    - UNICEF Nepal
    - Department for International Development (DFID)
    - International non government organisations ((I)NGOs)
        - Helen Keller International (HKI)
        - Nepal Family Health Programme (NFHP II)
        - Nepal Technical Assistance group (NTAG)
        - Micronutrients Initiative
- Field visit to Kavre district: details, Annex II
- Attended the Joint Planning Workshop for the Health Sector.
- Round-table meeting attended by representatives from Save the Children, World Vision, MaxPro, CARE and Plan International.

Draft recommendations for AusAID support were submitted on the 14th July, with a follow-up teleconference with AusAID (Kathmandu and Canberra offices) for initial feedback held on the 16th July.

The in-country activities were carried out in conjunction with the AusAID Nepal and Bangladesh desk manager and the Post program managers.

Overview of the report

The report first provides background information on mother and child health and nutrition indicators in Nepal, describes GoN's multisectoral approach to undernutrition, and considers MoHP's Nepal Health Sector Programme II (2010 – 2015). The report goes on to describe current and proposed interventions to address child nutrition, and how MoHP manages nutrition services. The section that follows describes external donor support to nutrition in the health sector. Following a discussion of the issues, the final section outlines, in tabular form, options for AusAID support to child survival and nutrition in the health sector.

2. Background

2.1 Nepal set to achieve the MDG target for child mortality

Nepal has made significant progress in reducing maternal and under-five mortality, and is set to meet the child-health related MDGs (Table 1). If the fall in maternal mortality ratio (MMR) is maintained, Nepal could also achieve MDG 5. The improvements are attributed to: the implementation of high-impact, community-based interventions, notably community-based IMCI; addressing the management and treatment of pneumonia and diarrhoea; the increased uptake of antenatal care; and institutional delivery by skilled birth attendants (SBAs) with 33% of deliveries being attended by a SBA in 2009. Instrumental in the success has been the role of the 50,000 female community health volunteers working in every area of the country. However, the neonatal death rate remains high - accounting for 53% of deaths of under-fives.

There has been little change in the prevalence of underweight in the under-fives; achieving the MDG target remains elusive (Table 2). This is of concern. Underweight contributes to one third of all deaths in under-fives; nutritional deficiencies in children under 24 months result in irreversible psychomotor delay.

Table 1: Nepal is set to meet child health-related MDGs by 2015

Millennium Development Goal	1991[3]	1996[3]	2001[3]	2006[3]	2009[1,2]	MoHP Target 2011	MDG Target 2015
MDG 5 MMR / 100,000 live births	539	539	415	281	229[1]	250	134
MDG 4 U5 mortality rate	158	118	91	61	50[2]	55	53
Infant mortality rate	106	79	64	48	41[2]	44	32
Neonatal mortality rate		50	43	33	20[2]	30	16
MDG 1 Underweight children %		49%	48%	39%	40[2%]	34%	29%

[1] Maternal morbidity survey 2008-9, MoHP
[2] Family planning, maternal and newborn health situation in (forty districts) in rural Nepal
[3] NDHS reports

2.2 Status of child nutrition in Nepal

Nepal has made considerable progress in the control of micronutrient deficiencies. Vitamin A distribution coverage is 96%, and iodisation of salt has led to a fall in iodine deficiency disease. The prevalence of anaemia in the under-fives has fallen (through de-worming), but remains high at 48%; 80% of under-twos are anaemic. Iron-folate

supplementation has seen a fall in the prevalence of anaemia in pregnant women from 75% (2001) to 42% (2006).

Table 2: Prevalence of undernutrition in under – fives (Z scores)

	Height for age (stunting)		Weight for age (underweight)		Weight for height (wasting)	
	- 3 Z	-2 Z	-3 Z	-2 Z	-3Z	-2Z
National	20.2%	49.3%	10.6%	38.6%	2.6%	12.6%
Urban	13.7%	36.1%	4.8%	23.1%	1.2%	7.5%
Rural	21.1%	51.1%	11.4%	40.7%	2.8%	12.6%
Ecological zone						
Terai	18.0%	46.3%	12.6%	42.3%	3.4%	16.6%
Hills	21.0%	50.3%	8.1%	33.2%	1.6%	8.4%
Mountains	28.9%	62.3%	11.5%	42.4%	2.9%	9.4%

Source: NDHS 2006
-2 Z scores correspond to 2 standard deviations below the norm (“moderate and severe”)
-3 Z scores correspond to 3 standard deviations below the norm (“severe”)

However, there has been less progress in reducing underweight – protein-energy malnutrition. As shown in Table 2, 49% of under-fives are stunted (reflecting chronic malnutrition), 39% are underweight, and 13% are wasted. There are wide disparities in the distribution between socio-economic groups and ecological regions. The high prevalence is in no small part due to poor maternal nutrition (24% pregnant women have a body mass index below 18.5 kg/m^2); 21% of babies are low birthweight (wt <2,500g). Falling levels of exclusive breastfeeding to six months (74% in 1996, and down to 53% in 2006), inadequate weaning diet (cultural beliefs, food security issues) and poor water and sanitation are the major contributing factors. There is considerable variation between these multifactoral determinants between individual districts.

3. How is GoN addressing malnutrition?

3.1 GoN multisectoral approach to malnutrition

Recognising the need for a multisectoral approach to addressing malnutrition, the National Planning Commission will finalise a Nepal Nutrition Action Plan to guide the development and scaling up of a revitalised effort to address undernutrition. A technical Steering Committee for Nutrition was established in 2006, the “National Nutrition Coordination Committee”. Committee membership comprised representatives from Ministeries of health, education, social welfare, local development and agriculture, as well as invited nutrition experts. Until now the committee has never met. However, the committee has been reconvened and the first meeting will take place in August 2010.

Nepal Nutrition Assessment and Gap Analysis (NAGA), November 2009

The NAGA was undertaken to provide the synthesis of mother and child nutrition data to develop the Nepal Action Plan for Nutrition. The process was led by the Child Health division of MoHP supported by WB, UNICEF, WHO, USAID, World Food Program (WFP), HKI and others. The recommendations (endorsed by MoHP) are summarised in Box 1 below:

Box 1: Summary recommendations from the NAGA report 2009

Establishing a Multisectoral nutrition architecture
- National Planning Commission to finalise a Multisectoral Nutrition plan of action; the Nepal Nutrition coordinating committee (NNCC) to be reconvened to ensure multisectoral commitment and coordination
- Nutrition section (CHD, MoHP) to provide guidance to districts across sectors

Strengthening human resource capability
- Expanding the HR base dedicated to nutrition – within the Nutrition section (additional posts), and at district and community levels
- Expanding nutrition capacity at district levels with dedicated staff

Ensuring food availability, access and affordability
- Introduce agricultural interventions to enhance nutrition
- Expand food aid where food deficits create a humanitarian crisis

Improve food and care-related programmes
- Counselling to improve infant and young child feeding (IYCF) – strengthening and expanding current training programmes
- Effective BCC through multiple channels
- Supporting new technologies (Multi-micronutrient powders, ready-to-use therapeutic food, RUTF), but ensuring they are incorporated in comprehensive programmes
- Strengthen community-based identification and management of severe malnutrition

Ensuring food quality/ micronutrients
- MoHP to establish permanent mechanisms to maintain Vitamin A, iron intensification, universal salt iodisation, fortification of wheat flour
- Ensuring more sustainable financing for the programme (through MoHP and SWAp / pooled fund)

Improving food absorption and utilisation
- Reduce risk or infection from unprotected water sources
- Scale-up of zinc in the management of diarrhoea
- Improving CB- IMCI programmes

Strengthening the design, targeting and monitoring of nutrition interventions

Nepal Nutrition Assessment and Gap Analysis. Final report: November 2009 Nutrition Assessment Team: MoHP 2009

Nepal Action Plan for Nutrition (NAPN)

A draft concept paper for the NAPN has been circulated for comment (April 2010). It is anticipated that the final draft will be published September / October 2010. Once endorsed by the National Planning Committee, the plan will be costed, and ready for implementation early in 2011. The focus of the action plan will be recognition that most districts will have multiple determinants for undernutrition, with significant variation between districts. Priorities will vary. The action plan (personal communication from Nepal Family Health Programme) could provide a framework that:

- Defines the specific interventions that address a given determinant
- Defines the lead Ministry tasked with implementing a given intervention(s)
- Defines partner strengths and how they can assist the Ministry with implementation
- Describes interventions for which further work is needed to determine the most efficient approach

It is anticipated that the action plan will prioritise interventions for individual districts based on the specific determinants for undernutrition.

3.2 Ministry of Health and Population

Nepal Health Sector Programme – Implementation Plan II 2010 - 2015 (NHSP– IP 2)

MoHP published the NHSP IP 2 in April 2010. It builds on the experiences and lessons learned from the previous NHSP – IP 1 (2005 – 2010) and, based on analysis of the current situation, presents a comprehensive implementation plan. The findings and health sector recommendations from the NAGA have been incorporated. Improving the nutritional status of children and women is identified as a top priority in NHSP-IP 2.

The nutrition section of the NHSP IP 2 describes a two-pronged approach: addressing disease load through health interventions and micronutrient interventions, and through behaviour change to improve maternal and child feeding practices. In summary:

- Community-based nutrition programme (currently piloting, with planned scale-up to 45% districts by 2013). A focus on improved feeding and health practices (pregnant and lactating women, PLW, and under-fives); oral rehydration therapy (ORT) and zinc for diarrhoea; growth monitoring. FCHVs and health workers will manage these programmes.
- Community-based management of severe acute malnutrition, using ready to use therapeutic foods (RUTF). Pilots are under way.
- Large scale introduction of food supplementation for malnourished children and PLW. Options include vouchers, direct cash transfers, and direct provision of food supplements. Pilot schemes are under way (supported by EDPs). It is anticipated the the Ministry of Women, Children and Social Welfare will ultimately take the lead if the programmes are implemented country-wide

The child health section recognises the importance of CB-IMCI, the need to maintain programme quality by training new entrants and conducting refresher training, supervision and monitoring. MoHP plans to incorporate the piloted community-based newborn health package, CB-NHP, into the current CB-IMCI package.

In the human resource section of the NHSP IP 2, plans for recruiting additional health workers are outlined (including an additional 5,000 FCHVs). The programme recognises that the success of the FCHV programme has resulted in increased responsibilities and workload (the community-based neonatal care package will further add to their work), and has proposals for introducing financial incentives/ income generation activities. Training, refresher training and supervision for FCHVs is a priority.

The health budget for 2010 – 2011 is NR 24,250 million (US$330 million), an increase of 45% from the previous year, and representing 7.4% of the national budget. The budget for nutrition and IMCI has increased 110% - from $3.8m to 8.1% (source: MoHP budget analysis FY 2010/11, MoHP June 2010). Detailed breakdown of the nutrition and IMCI budgets is not presented in the document.

3.3 Nutrition Section, Child Health Division, MoHP

The MoHP Nutrition Section is based in the child health division, and is responsible for directing nutrition services for child and women's health (although women's health falls under the family health division). The nutrition section comprises three staff members responsible for directing policy and strategy and planning, overseeing

implementation, and monitoring progress. At district level, one member of staff is assigned the responsibility for nutrition services. However, this is not a full-time responsibility; nutrition would be one of a portfolio of the individual's day-to-day responsibilities. The director of the Child Health Division acknowledges the need for technical support – and additional staff appointments at both central and district levels.

UNICEF works closely with the Nutrition Section on a part-time basis, and has provided technical training (including study in the US) for the nutrition specialist, as well as support to planning and the preparation of documents (NAGA, NHSP II-IP II).

3.4 Nutrition interventions in the health sector

The current and planned interventions to address child survival and nutrition in the health sector in Nepal are comprehensive and evidence-based. They are at different stages of development: many are well established (eg Vitamin A programme), others are in the process of being evaluated (prior to intended national role-out), and others are at the planning stage. It is important that the established interventions are maintained, that newer interventions are carefully evaluated before roll-out, and that resources are available to ensure that planned interventions are introduced. The interventions are listed below:

Vitamin A programme
- The biannual vitamin A programme (together with de-worming) is well established. MoHP plans to support the entire programme by 2015; until then external funding will be required (UNICEF);
- Vitamin A for the newborn: this programme is currently being piloted with a view to national role-out. EDP funds will be required to roll out, monitor and evaluate the programme (NTAG, through CIDA).

Infant and Young Child Feeding (IYCF) community promotion linked with micronutrient powder (UNICEF supported by AusAID, CIDA and USAID)
- Piloted and evaluated in two districts; now roll-out to six districts planned. MoHP has endorsed a five-year strategic plan to expand the programme country-wide. Funding has been secured until 2012 (UNICEF); thereafter, funding should come through MoHP and the pooled fund.

National IYCF behaviour change campaign
- Ongoing programme disseminated through public service announcements and through popular radio programmes (UNICEF, MoHP).

Treatment of diarrhoea with zinc
- Currently introduced in five districts: national roll-out planned.

Intensification of the iron/folate tablet distribution for pregnant women (introduced in 67 districts) (Micronutrients Initiative, CIDA)

Community-based management of acute malnutrition
- Introduced in three districts; plans to introduce into two more districts 2010 – 2011 (UNICEF supported by DFID).

Decentralised action for children and women (DACAW)
- Growth monitoring, counselling and handwashing: 23 districts (UNICEF).

Nutrition Rehabilitation Centres supported with therapeutic foods (f-75, F-100, Re-samol and Plumpy nut (WFP)

- Plans to expand the programme with the introduction of more centres 2010 – 2015;
- Initiative for public-private partnership to introduce "Champion" complementary feeds (Micronutrients Initiative).

Iron fortification (flour)

- National programme (NTAG).

School health programme

- Adolescent nutrition, hygiene and sanitation (HKI).

4. External donor support to the health sector

4.1 Health Sector SWAp and the donor pooled fund

The first Nepal health SWAp was established in 2005. Within the SWAp, AusAID, DFID and the World Bank contribute to a pooled funding mechanism. Within the pooled fund, £16 million of DFID's £70 million contribution over the next five years is for technical assistance. The second health SWAp 2010 – 2015 (aligned with NHSP II) begins later this year. GAVI Alliance and KfW will join the SWAp, contributing to the pooled funding mechanism. The SWAp partners are currently working with MoHP to agree an AWPB (the funds are non-earmarked) closely aligned with NHSP IP 2. A Technical Assistance plan (led by GTZ) is also under development (£16 million - $24 million – over five years). The focus will be on maternal and child health, and on addressing malnutrition. A proportion of the pooled funds will be allocated to child health and nutrition, but the detailed plan and budget will not be available until September 2010. No further details are available at this time.

4.2 Donor support to nutrition activities in the health sector

AusAID, DFID, World Bank, USAID and CIDA have provided significant support to addressing nutrition in the health sector. EDPs are contributing $221.6 million to the health sector 2010 – 2011. The pooled fund within the health SWAP (supported by AusAID, WB, DFID, GAVI Alliance, KFW) is providing $50.7 million – 23% of EDP funding. Current activities, and future plans are summarised in Box 2 below.

Box 2: Summary of nutrition activities supported by key donors

AusAID

In addition to support through the health sector SWAp, AusAID has supported:

- National vitamin A programme;
- CB-IMCI .

Support was through NTAG (1999 – 2007) and through the UNICEF "child survival and nutrition activity (2008 – 2011)

World Bank

- Capacity support to MoHP (including developing NAGA and the Nepal Action Plan for Nutrition
- Consolidation of existing vertical nutrition interventions
- Scale-up of behaviour change communications (BCC) to promote breastfeeding and fortified complementary foods
- Scaling up zinc supplementation and oral rehydration therapy (ORT) for diarrhoea
- Researching the feasibility of providing food vouchers (to be exchanged for fortified wheat flour and fortified blended food) for PLW.

DFID
Outside the pooled fund mechanism, DFID is/ will provide support for:
- Community-based management of acute malnutrition, CMAM, (through UNICEF) pilot in three districts
- Supporting MoHP in developing a strategy to address food security in West and far-West Nepal
- Ethnographic research into determinants of undernutrition in the Terai, with good agricultural potential
- Social protection: supporting GoN in developing/ implementing effective social protection mechanisms to deliver on nutrition outcomes

USAID
USAID aims to enhance its nutrition portfolio to provide more comprehensive multi-sectoral support to women and children. A design mission visited Nepal in April 2010; the findings and recommendations are not available at this time.

Current activities:
- Technical support to MoHP - development of NHSP-IP II
- Action against malnutrition through agriculture (HKI)
- IYCF with micronutrient powders (UNICEF, NFHP)
- Social Marketing and Franchise project (AED); newborn care, family planning, zinc/ORS, water treatment
- Child survival - community-based newborn care. (Plan International, CARE).

Anticipated future activities:
- Family planning, maternal and child health, hygiene;
- Research: ethnographic evidence surrounding food-related beliefs to inform future BCC activities.

UNICEF
AusAID support
- Ongoing technical support to Nutrition section, CHD MoH (strategy and policy: nutrition training courses for Nutrition Section staff
- National vitamin A programme;
- Piloting newborn vitamin A dosing (4 districts);
- IYCF community promotion with MNP (2 districts), and national roll-out programme developed with MoHP (2011 – 2015);
- National IYCF BCC;
- Ongoing support to GoN/ MoHP: NAGA report; Nepal national nutrition plan;

In addition
- Piloting CB-NHP (3 districts);
- CMAM (3 districts: expansion to 2 further districts planned)
- Expansion of treatment of diarrhoea with zinc (five districts)
- National EPI programme.

CIDA
Micronutrient Initiative
- Multi-micronutrient powders “Sprinkles”
- Vitamin A programme

AusAID contribution to child survival and nutrition 1999 – 2011

AusAID has made a significant contribution to child survival and nutrition in Nepal. Underpinning AusAID’s approach has been the development of close working with MoHP and SWAp partners in agreeing specific areas of support. Support has therefore addressed areas considered essential by MoHP, but for which Ministry funds were not available. The activities were harmonised with those of other donors, ensuring there was no overlap, and that similar approaches to the activities were adopted. Support was flexible, ensuring specific needs of MoHP could be met as they arose.

From 1997 to 2007 AusAID supported the Nepal Technical Assistance Group (NTAG) in delivering, with other donors, the National Vitamin A programme. This was highly successful; uptake now exceeds 97%. Latterly, NTAG was instrumental in delivering the CB-IMCI training programmes that have been introduced in all 75 districts. NTAG's contribution has been highly regarded.

From 2007, AusAID has been supporting UNICEF (AUD 4 million over 5 years), Box 2 above. UNICEF has continued to provide support for the Vitamin A programme, and more recently is piloting newborn vitamin A dosing. Funding has enabled UNICEF to pilot IYCF promotion with MMPs, and develop a five-year roll-out plan with MoHP. UNICEF has played an important role in providing ongoing technical support to the MOHP Nutrition Section – both by providing strategic and technical advice (and training), and joint preparation of key documents, eg NAGA 2009. MoHP regard their input highly. UNICEF has enabled NS staff to study abroad (unfortunately absenting the chief, NS, from the July 2010 JAR planning meeting). Whilst MoHP has recognised UNICEF's contribution, many EDPs consider that UNICEF – whilst providing unquestionably effective support – could better harmonise with donor support to child survival and nutrition. AusAID Nepal express a degree of dissatisfaction over their submission of reporting.

AusAID's support through technical and service delivery agencies had proved successful. NTAG had an established reputation for training and research, and was able to deliver on specific tasks. Again, UNICEF has an international reputation for expertise in child health and nutrition, as well as strengths in strategy, policy and planning. It is unlikely that MoHP would have had the capacity to provide these services as effectively (MoHP particularly values UNICEF's capacity support to the Nutrition Section). AusAID has contracted highly-effective providers; ensuring the providers are able to deliver effective services is of critical importance. It is important, however, that the service providers ensure that they are building Ministry capacity at all levels, and not simply delivering an intervention utilising their own staff.

Harmonisation of external funds for nutrition

NHSP IP II and the multisectoral NAPN (although still in draft form, and not yet published) outlines a clear strategy and implementation plan for addressing child health and nutrition. Nutrition experts from UNICEF, USAID, World Bank, HKI, NFHS II and others have, and continue to, provide well-received technical support to MoHP in determining effective nutrition interventions. In terms of developing an appropriate strategy, this mechanism appears effective. Coordinated implementation, however, remains a problem.

Donors liaise with MoHP over their support to child health and nutrition (for example, the nutrition schemes being piloted), but there is no formal mechanism for ensuring that support is wholly harmonised with MoHP strategy. Major donors expressed concern that smaller NGOs (with lower budgets) were introducing activities that were not necessarily aligned with MoHP strategy. The major donors are working towards ensuring that all donor support is coordinated and harmonised by 2013.

The Nepal Action Plan for Nutrition should provide an agenda for ensuring a multi-sectoral approach to nutrition. From the health perspective, setting up a donor nutrition group – attended by all donors wishing to/ supporting nutrition activities and by MoHP - could go some way to ensuring activities are harmonised, and identified gaps in service provision met. In addition the bi-annual Joint Annual Review (JAR) provides a forum for all donors to contribute to MoHP plans for the health sector, and to review progress. It is suggested that the process of undertaking the JAR could

be better utilised to ensure less fragmentation and enhanced collaboration under MoHP leadership.

Monitoring nutrition performance

Building greater momentum around the JAR could also influence the wider development partner community to work more closely with MoHP processes and systems for monitoring nutrition performance. NHSP-IP 2 identifies clear process and outcome indicators for child health and nutrition. Many are based on the five-year NDHS (next due 2011). Process indicators rely on the health management and information systems, HMIS. Many donors monitor their own activities, using their own monitoring systems; their data may not be compatible with the national HMIS. All donors should provide the necessary data required by MoHP, in order for it to be entered on the HMIS.

5. Discussion

As described above, GoN strategy to address child survival and undernutrition is comprehensive, and evidence based (see Annex IV, evidence-based interventions to address maternal and child undernutrition). The NAGA report provides a detailed situation analysis, and makes clear recommendations which have been incorporated in NHSP-IP 2. The forthcoming Nepal Action Plan for Nutrition should form the basis for a truly multisectoral approach to undernutrition. The AWPB, to be finalised shortly, will outline the extent of pool-fund donor support to childhood nutrition. The key issue is whether the implementation plan is realistic, achievable and affordable.

There are two principal areas for concern:

5.1 Inadequate human resources in nutrition in the health sector

Weak capacity and understaffing in the MoHP Nutrition Section and at district levels

The nutrition section is understaffed, and consequently ill-equipped to plan, implement and monitor a complex range of programs. The technical capacity of the staff (who are reliant on support from UNICEF and others) is considered weak. At a district level, MoHP recognises that taking responsibility to implement, monitor and supervise nutrition activities will require significant input. The task demands more than part-time support, and requires significant technical and managerial expertise; coordination of activities (Ministry and EDPs), supervision, monitoring and evaluation. Some donors (eg Micronutrient Initiative) have addressed this through delivering their programmes with their own staff; effective, but not sustainable in the longer term.

Increasing reliance on FCHVs

Almost all the health-related interventions rely heavily on the FCHVs. The proposed enhanced package of community care, incorporating support to PLW, CB-NHP, CB-IMCI and growth monitoring (combined with community based management of acute malnutrition), will significantly increase their workload. To address this, MoHP has introduced a number of financial incentives (e.g. small profits from dispensing vitamin A), and proposes more. It is unclear where the additional funds will be sourced; no specific funding stream is identified in the MoHP Budget Analysis 2010-11. NHSP-IP 2 recognises the need for further training (seen in itself as an incentive).

Acute need for enhanced and integrated health worker training

Although CB-IMCI has been introduced country-wide, few staff have had (the intended) refresher training, with consequent impact on programme achievement. Staff turnover, and the proposed recruitment of additional health workers in the community, place further demands on training. The current CB-IMCI focuses principally on treating pneumonia and diarrhoeal disease, with less emphasis on nutrition. The introduction of additional programmes has placed further demands on training: CB-NHP is being piloted, as is community-based management of acute nutrition, CMAM. All are delivered as separate, rather than integrated training packages. Furthermore, the impact of any training is maximised through regular workplace supervision and monitoring. MoHP recognises this, and proposes to expand training (and district training capacity). It is questionable whether MoHP does have the resources – financial and human - to deliver these programmes, as well as introduce continuous professional development. MoHP recognises the need to integrate CB-NHP with CB-IMCI; the nutrition (and growth monitoring) component of the latter is weak, and requires strengthening. Revising and developing the combined syllabus will place further demands on technical expertise.

5.2 Funding gaps for nutrition interventions in the health sector

MoHP for child survival and nutrition is unlikely to be able to support the existing, piloting, and planned nutrition interventions (no detailed funding data is available in the NHSP-IP 2). Additional funding for the IYCF and MNP programme, CB-IMCI and CMAM programmes will be required; the CB-IMCI training budget is unlikely to meet demand (and will not cover all-important workplace training, monitoring and supervision). EDP funds (both inside and outside the health sector SWAp) will help address the anticipated shortage. Pooled fund partner plans are currently under development; publication is anticipated in September.

6. Options and recommendations for AusAID support to child survival and nutrition

In identifying the possible options, the following considerations have been taken into account:

- AusAID support for nutrition is limited to the health sector alone and hence will not address the broader multi-sectoral approach necessary to address all elements of undernutrition.
- AusAID Nepal currently does not have the capacity to manage a series of individual projects, thereby limiting the scope of its support to the nutrition sector.

Furthermore, the funding envelope and technical assistance available to address child survival and nutrition in Nepal has not been finalised. This will be determined towards the end of 2010, when the NAPN, the AWPB, and the Technical Assistance plan are finalized and available. Hence, given these contraints and uncertainties, it is recommended that AusAID adopt a proactive stance, providing short-term support, until, with the anticipated clarification of stakeholder roles it is possible to plan for longer-term support. AusAID support should take into account the stated aim of all external development partners to ensure all donor support will be coordinated and harmonised by 2013.

As described above, the key gaps are focused around the limited capacity of MoHP (specifically the Nutrition Section), the need for comprehensive and ongoing training

programmes for health workers (especially FCHVs), and ongoing support for those nutrition interventions that are not provided for my MoHP.

Short-term recommendation: continued nominal support to UNICEF
In the short-term, until the uncertainties are resolved, it is recommended that AusAID continues to provide nominal support to UNICEF in order to ensure continuity of the delivery of the priority interventions being piloted. With greater clarity over the key gaps, AusAID should be well-positioned to engage in discussions with MoHP (and donors) to agree longer-term support, based on the options described.

As outlined above, donors aim to harmonise all support to the health sector by 2013; AusAID is committed to this approach. For this reason, there is a strong case for AusAID to adopt a more pragmatic, iterative, shorter-term approach to contracting out support for several of the options. Possible approaches are described in more detail within each of the options.

The options are summarised in Table 3, as follows:

Option 1: Continued support to UNICEF to support nutrition interventions and to support the Nutrition Section

Summary:
- Continue to provide support for specific, ongoing nutrition interventions
- 1 year contract with clear outputs, timelines and monitoring framework
- Six-monthly progress review, ensuring activities harmonised with EDPs' support
- Specific interventions: IYCF with MMPs, newborn vitamin A, and CMAM

IYCF with MMPs: this in a key intervention that is showing promise in addressing protein- energy malnutrition as well as providing micronutrients. As described earlier, the principal cause of stunting is inadeqaute follow-on feeding from six months of age

Newborn vitamin A: this intervention has been shown to impact on neonatal infections – one of the principal causes of neonatal deaths.

CMAM: this programme provides the means for addressing acute malnutrition in the community – Nepal does not have the resources to manage all cases in health facilities. The programme is still undergoing evaluation; it is important that the pilots continue as the results could demonstrate a practical, community-based approach to the problem.

UNICEF has played an important – and successful - role in in piloting all three interventions. All require ongoing funding. A short-term (12-month) contract, with clearly defined outputs, timelines and a monitoring framework could address earlier concerns over UNICEF's reporting.

In terms of UNICEF's support to MoHP, this appears an ad hoc arrangement involving, principally, UNICEF's chief nutrition adviser. UNICEF are not dependent on AusAID for this support; it must be assumed that this arrangement will continue. However, as described in option 2, formalising full-time technical support directly to the Nutrition Section would address the perceived limited capacity of the NS – more so appropriate now that nutrition is a national priority.

Continuing support to UNICEF will ensure that funding for the pilot interventions is assured. Transaction costs to AusAID are minimal, as these activities could be delivered through a single contract.

Option 2: Capacity building for the Nutrition Section, MoHP

Summary:

- Support the appointment of a full-time technical expert to the MoHP Nutrition Section
- Ideally conditional on MoHP appointing additional staff to the Nutrition Section
- Decision dependent on EDP pooled fund TA plan (as this position may be supported by the plan)
- Decision to be made after publication of the TA plan, and in discussion with EDPs late 2010/ early 2011
- Option will require detailed discussion with MoHP

As described earlier, MoH capacity is weak, and there is a clear need for technical support to the Nutrition Section. The view of MoHP is that the NS does need more technical staff, and that "more training is required". Training (provided through UNICEF) has taken the form of attendance at training establishments outside the country (eg the US). A more effective – and cost-effective – mechanism would be the long-term placement of an international expert in the NS, working alongside MoHP colleagues, effectively in a mentoring role. Technical areas would include planning, implementation, coordination, and monitoring and evaluating nutrition interventions (Box 3). For sustainability, one option would be to place a full-time expert in the section, conditional on MoHP increasing staff numbers.

Box 3: Technical support to NS

- Policy and planning
- Programme implementation
- Programme management
- Monitoring and evaluation
- Technical training in nutrition

Conditional on MoHP appointing additional staff to Nutrition Section

This approach would provide long-term benefit as the NS would have ownership of all processes. However, there would be little gain if MoHP did not appoint additional staff; the nutrition expert would otherwise simply function as an extra member of staff. Ideally, implementation would be conditional on MoHP agreeing additional staff appointments (their declared intention).

At present it is unclear whether the EDP pooled fund TA plan may consider supporting NS capacity building. If support is not planned, AusAID could consider liaising with GTZ (TA fund) in order to discus possible contracting mechanisms (i.e., AusAID supports the capacity-building TA, and the TA fund manage the contract).

This option is strongly supported by DFID, but was not discussed in detail with MoHP – although they were clear that more training was needed. Further discussions with MoHP are merited; the case will be further strengthened by recognition that the greater focus on child survival and nutrition in NHSP IP II will put greater demands on the Nutrition Section, with the need for more support than currently provided.

Option 3: Capacity building at the district level

Summary:

- Short-term technical support for district staff managing nutrition services
- Dependent on MoHP making the new appointments
- 12m training programme (classroom and workplace based training, mentoring)
- Decision cannot be made until MoHP confirm interest, and the district appointees are in post (early 2011?)

Box 4: Technical support to the District nutrition officers:

- Technical training in nutrition
- Financial management
- Programme implementation and management
- Overseeing effective provision of CB-NHS and CMAM training
- Programme management
- Monitoring, evaluation and supervision

As discussed earlier, with MoHP policy focused on devolving services to districts, and the plans to expand community child survival and nutrition services, there will be a significant demand on human resources. This will require the appointment of additional district staff, charged with managing nutrition services (Box 4). Intensive managerial and technical training and support will be required. This support would be distinct from the community-based training provided for health workers outlined in option 4.

This option is only viable if MoHP created new district nutrition posts. Again, it is unclear whether the EDP pooled fund TA plan will support this activity. This option would be short-term, as is likely that the training could be completed within 12 months. The long-term gains would be significant, as district capacity would be enhanced. AusAID could contract out the training to an external organisation, such as NTAG (preferable to the alternative of MoHP contracting out the services, as there is a question over their capacity to do so).

Option 4: Support for the Community-based IMCI training programmes through NTAG

Summary

- Ongoing support to CB-IMCI, CB-NHP training (integration of the training programmes?)
- Syllabus development, training of trainers
- Roll-out, refresher training, workplace training and supervision

The success of all child survival and nutrition interventions in dependent on effective delivery at the community level. FCHVs have been instrumental in the successes to date. The need for increased provision of training, and increased capacity for delivering the training has been highlighted. NHSP-IP 2 recognises this, and states that capacity will be developed, and that training will be delivered (and district-level training capacity developed). Again, there is a question over MoHP capacity (and funds) to deliver this. AusAID could play a key role in providing additional support to the training (including syllabus development, possible integration of the three

community-based training programmes – and certainly integrating CB-IMCI and CB-NHP). NTAG has a proven track record in delivering effective training (which was supported by AusAID). However, stakeholders have expressed concern over the future of NTAG, as changes in senior management are imminent. Alternatively, AusAID could provide earmarked funding to MoHP to contract out the services themselves. This raises two issues which warrant further exploration: ensuring that the funds are earmarked, and whether MoHP has the capacity to contract out the services. The provider would work with the IMCI division (CHD, MoHP) in revising/ integrating the syllabuses, and agree a training (ToT etc) plan to be delivered at district / community level.

This option would ensure the sustainability of the IMCI programmes which have been instrumental in improving child health indicators, and which have the potential to address undernutrition. It will be important that MoHP have ownership of the programme to ensure long-term sustainability.

Option 5: Technical and material support to national roll-out of CMAM

Summary:
- Provide technical support for national roll-out of CMAM
- Dependent on positive evaluation of the pilot programmes

Early results of the CMAM pilots are encouraging; CMAM provides the means for effectively managing acute malnutrition at the community level (facility-based management is impractical in Nepal). If confirmed by the final evaluation, there will be significant benefits in rolling-out the programme country-wide. Funding for CMAM has not, as yet, been secured. Furthermore, it is unlikely that MoHP has the capacity to deliver the training with its own human resources. AusAID could provide technical support for CMAM training – ideally through an external provider (eg, NTAG, but see concerns about NTAG above), rather than through MoHP
.

Table 3: Options for AusAID support to child survival and nutrition in Nepal

Option	Benefits	Issues	Management of the support	Comments	Risks and assumptions
Option 1. Continue AusAID support to UNICEF with ongoing projects • Neonatal Vitamin A programme • IYCF promotion with MNP supplementation • CMAM pilot projects.	• UNICEF has provided effective implementation of these programmes, • High calibre of UNICEF nutrition staff • UNICEF well-regarded by MoHP	• UNICEF reporting mechanisms to AusAID considered poor • UNICEF support not considered well-coordinated with EDP support • Issues over UNICEF capacity building/ training approaches at central MoHP (UNICEF experts providing the TA themselves) and districts (using their own staff): has capacity of MoHP improved?	• Short-term (1 or 2 year) contract: • Single, prescriptive contract with UNICEF • Need to improve reporting mechanisms to AusAID	• Short term contract ensures AusAID is positioned to be involved in discussions over medium-term options when financial and EDP TA programme has been confirmed • Ensures key nutrition pilots are sustained • Interventions would have a high chance of success • Visibility for AusAID	• UNICEF reporting mechanisms improved • UNICEF maintains its strong relationship with MoHP • UNICEF coordination with EDPs improves
Option 2: Capacity building for Nutrition Section, CHD, MoHP Long-term expert TA provided to current NS CHD staff (TA placed in CHD)	Potential for capacity building and strengthening CHD/ NS over the longer term	• Inadequate staffing levels NS CHD at present. • Improved modality over current	• MoHP involved in the selection process • Expert contracted by AusAID	• Important area to address if not addressed by other EDPs • Might this option be	• MoHP/ NS accept the external expert proposal/ appointment • MoHP agree to

Option	Benefits	Issues	Management of the support	Comments	Risks and assumptions
		UNICEF ad hoc support	• Aternative is for AusAID to support the appoint ment through the pooled fund TA (dependent on the final TA plan/ negotiations with poled fund EDPs. • Potential to integrate with district health department capacity building option?	included in the pool fund TA plan (still under discussion)? If so, unnecessary duplication • Less visibility for AusAID if contracted through MoHP	appoint additional staff to NS • EDP pooled fund TA does not finance this TA
Option 3: Capacity building at district health departments Training for district nutrition officers responsible for managing nutrition progrmmes • Nutrition, supervision, monitoring training • HMIS training • Financial, management training	• Ensure effective monitoring evaluation and supervision of nutrition interventions at district level • Sustainability of the nutrition programmes	• Success dependent on willingness of MoHP to appoint nutrition staff to districts	• Workload implications if AusAID contract the support • MoHP to manage the contract (capacity building, sustainability; does MoHP have the capacity?) • Integrated with nutrition section TA option?	• Important area to address if not addressed by other EDPs • Impact dependent on MoHP supporting additional nutrition posts in district health departments • Less visibility for AusAID if contracted through MoHP	• MoHP appoints the district nutrition officers • MoHP recognise that TA support is required • Pooled fund TA does not support this option
Option 4: Contract NTAG to provide integrated CB training, supervision, and	Long term benefits				

Option	Benefits	Issues	Management of the support	Comments	Risks and assumptions
project evaluation • CB – IMCI refresher training including workplace supervision • CB – NCP • CMAM • Training for district nutrition personnel	• Ensures maintenance of CB IMCI programmes • Effective delivery of IYCF promotion with MNP training • NTAG's proven effective provision of training • ToT with follow-up supervision methodology ensures sustainability	• Will NTAG maintain its capacity if changes at senior management? • Alternatively, does MoHP have the capacity to contract out IMCI training?	• Direct contract with NTAG? Workload implications for AusAID • MoHP manage the contract (capacity building, sustainability; but does MoHP have the capacity?)	• Important as NTAG training will maximise impact of the interventions	• NTAG maintains its capacity after the anticipated changes at senior management level • NTAG has the resources to deliver the training country-wide • MoHP budget cannot support the training outlined in NHSP-IP II
Option 5: Technical support to CMAM roll-out • CMAM training, supervision and monitoring	Long term benefits • Aim to address acute malnutrition at community level	• MoHP funds not currently allocated to this programme	• Direct payment to MoHP: must ensure funds are earmarked	• MoHP responsible for organising/ contracting / delivering training;	• MoHP ensures adequate human resources for providing monitoring / contracts out the training effectively

Annex I: Terms of reference

Terms of Reference for consultant to Scope an Options Paper for AusAID assistance to addressing Child Survival and Nutrition in Nepal (2010-2015)

1. Introduction

AusAID is seeking to appoint a consultant to conduct analysis and provide options for AusAID's assistance to maximize impact in child health and nutrition for the next five years. Options should be aligned and consistent with the national health strategy (& national nutrition program), and coordinated with other donor & Government of Nepal (GoN) activities. It will be a short term (20-25 days) contract for the specified scope of work outlined in section 4 of this document.

2. Background

Australia has been supporting the National Vitamin A program (NVAP) and Community Based Integrated Management of Childhood Illness (CBIMCI) since 1999 and 2002 respectively. The total assistance of approximately AUD 4 million till 2007/08 was administered by the Nepal Technical Assistance Group (NTAG). From 2008/09 AusAID continued its assistance for NVAP and CB/IMCI through UNICEF's 'Child Survival and Nutrition Initiative'. AusAID's assistance has been critical in the expansion and maintenance of both the NVAP and CB/IMCI program.

The National Vitamin A program started in 1993 with 8 districts and was scaled up to all 75 districts by 2002. Similarly, the CB/IMCI program started in 1998 with gradual expansion to all 75 districts by 2008/09. The current coverage of both programs is at 90%. The nationwide outreach and coverage of biannual vitamin A supplementation, community based treatment of pneumonia and management of diarrhoea, and high immunization coverage has lead to a significant reduction in child mortality in Nepal over the past 10 years. The under five mortality has reduced from 91 per 1000 live birth in 2001to 61 in 2006, and infant mortality reduced from 64 in 2001 to 48 in 2006.

While there has been significant improvement in the control of micronutrient deficiencies, protein energy malnutrition (general malnutrition) is an enduring problem. In the past 25 years, there has been a very slow decline in the level of general malnutrition and almost half of the children in Nepal are still underweight. An AusAID funded strategic review of the Vitamin program completed in 2007 reported that the average Nepali diet does not meet the adequate dietary intake. The causes of malnutrition in Nepal vary from inadequate nutrition intake by mothers during pregnancy, to child feeding practices, inadequate access to basic health services, and lack of clean water and sanitation.

Given the complexity of nutrition issues, the recent joint multi donor Nutrition Assessment and Gap Analysis (NAGA) 2009 looked at nutrition in a holistic manner. The assessment recommendations emphasised multi sectoral coordination for nutrition interventions, and has come up with short and long term plans of action. While Nepal established the National Nutrition Coordinating Committee under the National Planning Commission in 1976 and Nutrition focal points in the four line ministries of Health, Agriculture, Education and Local Development, starting in 1979, there has been very little progress in terms of functional coordination for nutrition programs.

The recommendations from the reviews and assessment study have been taken forward by the government in its Annual Work Plan and Budget (AWPB) for nutrition and also in the second phase of Nepal Health Sector Program. However very few donors are supporting the government of Nepal's nutrition program namely USAID, AusAID, UNICEF and CIDA through their Micro nutrient Initiative (MI).The donors' support to the national nutrition program is specific to micronutrient supplementation such as Vitamin A and food fortification.

In FY 08/09 UNICEF, with AusAID support piloted the promotion of micronutrient sprinkles with Infant and Young Child feeding (IYCF) in two districts. With funding from DfID support UNICEF piloted the introduction of Ready to Use Therapeutic Food (RUTF) to treat severely malnourished children in one district. The Behaviour Change Communication (BCC) activities promoting exclusive breastfeeding have also been a focus of the current nutrition program. The success and impact of the pilot program is yet to be assessed.

Nepal is making very slow progress in nutrition, and it is unlikely that Nepal will meet the MDG target for nutrition if progress is not accelerated. With nutrition becoming a global agenda of concern, and Nepal lagging behind, many donors are currently planning to support targeted nutrition activities in the next phase of the sector program. A brief overview of what donors are considering is outlined below:-

World Bank:

The World Bank is planning an expanded nutrition program that will be implemented primarily through sector support to the MOHP. Activities will support key areas in NHSP II to improve nutritional outcomes for children under-two and pregnant and lactating women. The program will support improved capacity with the GON with a multi-sector coordination mechanism for nutrition, consolidation of existing vertical nutrition interventions (e.g., vitamin A, iron-folate supplementation, etc.), promoting infant and child nutrition by promoting breastfeeding and fortified complementary foods; scaling up zinc supplementation and oral rehydration salts (ORS) for treatment of diarrhoea; and promoting behaviour change at the community level.

In addition to support to the sector, the World Bank is exploring the feasibility of providing food vouchers to pregnant women during antenatal care visits. The vouchers would be used for commercially milled fortified wheat flour and a low-cost fortified blended food. Vouchers for both products would be provided from the first antenatal visit until the child reaches the age of six months. The food is meant for pregnant and lactating mothers as well as other household members.

DfID:

In addition to the health-related nutrition activities in the NHSP II, DFID will work with the GoN to develop an inclusive growth strategy for the Mid and Far Western Nepal to address food security and improve nutrition. This would involve initiating a dialogue on humanitarian responses to address nutrition-related shocks that is separate from approaches to chronic nutrition and poverty. It may include activities such as a regression analysis of food and non-food determinants of malnutrition according to geographical region, and ethnographic research to better understand the determinants of women and wasting in the *Terai* (Southern Nepal). Through DFID support to social protection, DfID intends to work with GoN to ensure that existing social protection mechanisms (pension, child protection grant and single women's allowance) deliver on nutrition outcomes and that the existing social transfer pilots have impact and are cost effective at scale.

USAID

USAID is seeking to enhance its nutrition portfolio to provide more comprehensive, multi-sectoral support to improve the nutritional status of women and children in Nepal. USAID is planning to undertake a design mission in April 2010 to develop a comprehensive set of nutrition activities and programs, including family planning, maternal and child health, and hygiene. One analytical study they are planning to undertake is a literature review of ethnographic evidence surrounding food-related beliefs and practices to inform the appropriate behaviour change communications plan. USAID's current support to child health and nutrition is through the Nepal Family Health Program (NFHP), Helen Keller International (HKI), UNICEF and MoHP.

AusAID

In addition to the assistance through Health Sector program SWAp, AusAID wishes to continue its support in child health and nutrition to help Nepal sustain its child health gains and accelerate progress to nutrition outcomes. While AusAID's primary objective is to support implementation of the NHSP through the SWAP/pooled fund, we also want to ensure that the support AusAID has been providing to NVAP and CBIMCI for many years is successfully transitioned into the SWAP/NHSP II implementation arrangement in a way that will empower and support the Ministry of Health and Population.

While the pooled fund has been successful in aligning bilateral and World Bank funding support, the fragmentation of technical cooperation (by a range of agencies including the UN) is undermining effective implementation of the NHSP and the policy dialogue on performance and resource allocation. Therefore AusAID would like to see the technical cooperation aligned and harmonised under the MoHP's direction.

The Technical Assistance (TA) designed will be to strengthen the capacity of the GoN to implement child health and nutrition program within the framework of broader NHSP II. It is critical that AusAID's assistance over next five years is understood and jointly planned so that it complements donors' plans of action, and aligns with Government's child health and nutrition program. The approximate funding under the TA would be AUD 2.5 million over five years.

3. Objectives of the assignment

The objective of the consultancy is to analyse current and planned activities relating to child health and nutrition within the scope of NHSP II, and provide AusAID with prioritised options for the best use of its assistance in the next five years. It is important that recommendations should compliment other donors' planned assistance on child health and nutrition, and support implementation of Government of Nepal's program.

4. Scope of Work

The consultant will:

- Review the key documents on child health and nutrition outlined in Annex 1 of this TOR.

- Meet with key donors and MoHP officials to identify priority resource, policy and programming gaps in the national programme (joining existing meetings where possible).
- Taking into consideration AusAID's history of support, recommend options for AusAID investment that would add value and impact to the Government of Nepal's child health and nutrition program in the context of NHSP II.

The consultant will do a desk review of the relevant documents and undertake an in country mission. Together with AusAID Health Program manager in Nepal, s/he will conduct one on one meetings, and/or a joint meeting with key donors and MoHP as necessary. On the basis of the review and discussion with key stakeholders, an Options Paper will be prepared by the consultant with recommendations for AusAID.

The consultant should highlight the opportunities and risks of each option considering the balance between longer term development objectives (e.g. capacity building, sustainability) and short term impact (e.g. direct service delivery; humanitarian responses). The analysis should consider the likely impact on nutrition outcomes, value for money and potential results.

Few questions to consider:-

- What the MOHP intends to do in relation to child health and nutrition and what technical support it may need to fully implement the nutrition activities within NHSP II? (e.g. for policy development, capacity building/training, support to direct service delivery to fill immediate gaps)?
- What this means for the program of work?
- How External Development Partners' child health and nutrition activities can be better harmonised? And identify current areas of collaboration.
- How nutrition can be better addressed in the joint policy dialogue ie what ongoing discussion is needed about how nutrition activities can best be structured and organised?
- How can nutrition performance best be monitored at Joint Annual Reviews/Summits?
- What is the comparative advantage of different technical & service delivery agencies in providing support on nutrition (e.g. UNICEF)?
- What sort of support does the MOHP require and what are the most appropriate modalities to use?

5. Duration and Phasing

Deliverable	Details	Maximum no. of days	Dates
Review of the key documents and preparation	- Review of key documents - Preparation for the in country visit	1 day	2 July 2010
In Country mission	- Meeting with Key donors, Ministry of Health and Population and related Divisions (the detailed itinerary will be shared at later	Travel: up to 4days In country visit:5days	3-11 July 2010

	stage)		
Situational analysis and report writing	Consolidation of findings, submission of draft Options Paper	12 working days	12 July – 13 August 2010 (TBC)
Report finalization	Feedback and revisions if required, submission of final Options Paper	2 working days	31 August (TBC)

6. Reporting

A maximum 15-20 page Options Paper (excluding annexes) with clear recommendations for AusAID's support in child health and nutrition for next five years. The identified area for AusAID support should also consider aspects of Australian visibility and profile issues. The report is due by 15 July 2010 or 30 days after completion of the in country mission.

7. Specifications of the team

- The consultant should have experience of working in the area of Child Health and Nutrition.
- Public health background with expertise in health systems and health delivery in a developing country context.
- Familiar with current agenda of aid effectiveness, development modalities and issues including SWAps, Millennium Development Goals, Accra and Paris declarations, donor harmonisation and International Health Partnership.
- Familiarity with the principles, guidelines and requirements of Australia's development cooperation program including an understanding of key cross cutting policy issues, in particular gender, disability and HIV and AIDS.

Annex 1

List of Key documents for Review and Preparation

1. Nepal Health Sector Program- Implementation Plan II (2010-2015)
2. Nepal Nutrition Assessment and Gap Analysis 2009
3. The National Nepal Vitamin A Program- A Strategic Program Review2008
4. National Plan for Action on Nutrition (NPAN) 2010-2014
5. Nepal Nutrition Situation and National Priorities 2008-2010
6. Comprehensive and Analytical document of Community Based Integrated Management of Childhood Illness(CBIMCI) in Nepal, 2009
7. Community Based New Born Care Package
8. Strategic Plan for initiating and scaling up Infant and Young child Feeding community promotion linked with Micronutrient Sprinkles in Nepal 2009-2014
9. World Bank paper on Nutrition in the Nepal Health Sector Program (NHSP 2), 2009
10. Annual Work Plan and Budget 2010/11 of Child Health Division (optional)

Annex II: People met, meetings attended

Individual meetings

AusAID

- Latika Maskey Pradham — Programme manager
- Tara Garung — Country manager, Nepal
- Catherine Herron — Bangladesh and Nepal desk manager, CBR

Australian Embassy

- Elizabeth Morris — First Secretary and Consul

Ministry of Health and Populations

- Dr Y V Pradham — Director general
- Dr Sudha Sharma — Secretary
- Dr R P Bichha — Director, Child health division, CHD
- Raj K Pokharel — Nutrition section chief, CHD
-

Government of Nepal, National Planning Commission

- Dr Cher Raj Pant — Director

UNICEF

- Gillian Mellsop — Representative
- Dr Pankaj Mehta — Chief, Health and nutrition
- Prgya Mathema — Nutrition Specialist
- Naveen Paudyal — Programme officer, nutrition
- Dr Asha Thopa Pun — Programme specialist, Maternal and neonatal health
- Chana Singh — Health officer, Health and nutrition sectuib

WHO

World Bank

- Bert Voetberg
- Tekabe Ayalew Belay — Senior Economist (Health)
- Luc — WB nutrition consultant (via telecom)

World Food Programme

USAID Nepal

- Dr Willian Patterson — Director, General Development office, GDO
- Clifford Lubitz — Deputy director, Office of health and family planning
- Navin Hada — AID project development specialist, GDO
- Amy Prevatt — Food security specialist, GDO

DFID

- Natasha Mesko — Maternal health and nutrition adviser

Nepali Technical Assistance Group, NTAG

- Director, and team members (PowerPoint presentation, and round-table discussion)

Helen Keller International

- David Spera — Country director, Nepal
- Pooja Pandey Rana — Director of programmes

Nepal Family Health Programme, NFPA

- Dr Robian MacDonald Houston — Deputy director
- Ashoke Shretha — Project director, NFHP –II

Micronutrients International

- Macha Raja Maharjan — Director, Nepal

Field visit to Kavre District 7 July

Discussions with the District Health Chief and UNICEF nutrition team

Dhumkharka VDC

- Meeting with mother's group

Dhumkharka sub-health post

- Meeting with PHC in-charges and FCHVs
- Visit planned birthing house

Dhulikhel primary health care centre

- Meet with PHCC staff

Meetings attended:

Joint Annual Review, JAR **6 July**

Joint planning workshop for the Health Sector

Meeting with INGO/ NGO representatives **6 July**

- Save the Children — Dr KC Ashish
- World Vision — Pradiumn Dahal
- CARE Nepal — Nirmala Sharma
- Nepalese Youth Oportunities Foundation — Mansa Bhattarai
- Plan International — Sher Bahadur Rana
- Salt trading corporation limited — Kumar Rajbhandari
- MaxPro — JBR Rajat
  Nanda Kishore Adhikari

Annex III: Documents read and selected scientific papers

Documents read

MoHP, GoN

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- Nepal Nutrition Assessment and Gap Analysis 2009 MoHP November 2009
- Budget analysis FY 2010/11 MoHP June 2010
- "AAMA programme" working guideline 2009. MoHP 2009
- Nepal: Nutrition Situation and National Priorities 2008 – 2010. MoHP 2008
- Framework document for Institutionalizing National Food Security Monitoring in Nepal (UN WFP and FAO, MoHP) MoHP January 2010
- Tracking progress on child and maternal nutrition in Nepal. MoHP 2010.
- Strategic plan for initiating and scaling up infant and young children feeding community promotion linked with micronutrient sprinkles in Nepal 2009 – 2014. MoHP 2009
- Operational guidelines for Community-based Newborn Care Package (CB – NCP) MoHP 2007
- Comprehensive and Analytical Documentation of CB-IMCI in Nepal. MoHP 2009

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World Food Programme

- The Cost of Coping: a collision of crises and the impact of sustained food security deterioration in Nepal. UN WFP 2008

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- National Nepal Vitamin A Programme: a strategic program review. Submitted to DHS, MoHP. UNICEF Nepal 2008
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- Child survival and nutrition initiative Nepal: final report submitted to AusAID March 2010. UNICEF Nepal, March 2010.
- Synopsis on AusAID and UNICEF collaboration on Nutrition. UNICEF Nepal, 2010
- Global Report on tracking progress on Child and Maternal nutrition. UNICEF 2009

Scientific papers: useful reading

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- Maternal and child undernutrition: effective action at national level. Bryce J, Coitinho D et al. Lancet 2008; 371: 9611: 519 – 526
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- Strategies to avoid the loss of development potential in more than 200 million children in the developing world. Engle PL, Black M et al. Lancet 2007: 369: 9557; 229 – 242
- The effect of micronutrient deficiencies on child growth: a review of results from community-bases supplementation trials. Rivera J, Hotz c et al. J. Nutrition 2003: 133: 4010 - 4020
- What works? Interventions for maternal and child undernutrition and survival. Bhutta ZA, Ahmed T et al. Lancet, 2008: 371; 9610; 417 – 440
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Annex IV: Evidence-based interventions to address maternal and child malnutrition

Evidence-based interventions to address maternal and child malnutrition

In 2008, based on a series of systemic reviews and best practice reports, the Lancet Maternal and Child Undernutrition Study Group identified five key challenges for addressing undernutrition at national level[1]:

- Ensuring nutrition is on its list of priorities, and keeping it there
- National programmes should focus on the period of pregnancy to 24 months of age as it is a crucial window of opportunity for reducing undernutrition and its adverse effects.
- Interventions with proven effectiveness chosen by countries should be rapidly implemented at scale (box, below)
- Not doing the wrong things; nutrition resources should not be used to support actions unlikely to be effective in the context of country or local realities (eg, growth monitoring, unless linked to nutrition counselling and referral)
- In addition to health and nutrition interventions, economic and social policies addressing poverty, trade and agriculture that have been associated with rapid improvements in nutritional status should be implemented.

Evidence-based interventions to address undernutrition (from the same Lancet series) are summarised in box below

Box : Evidence-based Interventions that affect maternal and child undernutrition

Maternal and birth outcomes

- Iron folate supplementation
- Maternal supplements of multiple micronutrients
- Iodisation of salt
- Maternal calcium supplementation

Newborn babies

- Promotion of breastfeeding
- Neonatal vitamin A supplementation

Infants and children

- Promotion of exclusive breastfeeding
- BCC for improved complementary feeding
- Zinc supplementation
- Vitamin A fortification or supplementation
- Vitamin D fortification or supplementation
- Iron fortification and supplementation programmes
- Universal salt iodisation
- Supplementation of multiple micronutrients
- Hand washing or hygiene interventions
- Treatment of severe acute malnutrition
- Additional food supplements in food-insecure populations
- Conditional cash-transfer programmes with nutritional education

Adapted from the Lancet Maternal and Child Undernutrition series, 2008. www.thelancet.com

[1] Maternal and child undernutrition: effective action at national level. Bryce J et al. Lancet 2008: 371; 510 - 526

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