



# Independent Review of Two AusAID Funded UNICEF Projects on Child Survival and Nutrition and Maternal Health in Nepal

**Draft 2**

Jenny Middleton  
Madhu Dixit Devkota  
Pete Thompson

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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](http://www.ausaidhrf.com.au)

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## Acronyms

AAMA	Action against Malnutrition in Agriculture
ANM	Auxiliary Nurse-Midwives
AusAID	Australian Agency for International Development
ARI	Acute Respiratory Illness
AWP	Annual Work Plans
BEmONC	Basic Emergency Obstetric and Newborn Care
BPP	Birth Preparedness Package
CB-IMCI	Community-based Integrated Management of Childhood Illness
CB-NCP	Community-based Newborn Care Package
CDD	Control of Diarrhoeal Diseases
CDK	Clean Delivery Kit
CHD	Child Health Division
DAC	Development Assistance Committee
DACAW	Decentralised Action for Children and Women
DDC	District Development Committees
DFID	Department for International Development
DHO	District Health Officers
DoHS	Department of Health Services
DPHO	District Planning Health Office
EDP	External Development Partner
EHCS	Essential Health Care Services
EOC	Emergency Obstetric Care
EPI	Expanded Program on Immunisation
FCHV	Female Community Health Volunteers
FHD	Family Health Division
GESI	Gender Equity and Social Inclusion
GoN	Government of Nepal
HFOMC	Health Facility Operational Management Committee
HMIS	Health Management Information System
IHP	International Health Partnership
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MCHW	Maternal and Child Health Workers
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MNP	Micronutrient Powder
MNCH	Maternal, Newborn and Child Health
MoHP	Ministry of Health and Population
MoU	Memorandum of Understanding
NFHP	Nepal Family Health Project
NHSP	Nepal Health Sector Programme
NHSP-IP 2	The NHSP Second Implementation Plan (2010 – 2015).

NHSSP	National Health Sector Support Programme
NNCC	National Nutrition Coordinating Committee
NPC	National Planning Commission
NTAG	Nepali Technical Assistance Group (for nutrition)
NVAP	Nepal National Vitamin A Program
OECD	Organisation for Economic Cooperation and Development
ORT	Oral rehydration therapy
PHCC	Primary Health Care Centres
QAI	Quality at Implementation
RTC	Regional Training Centres
SBA	Skilled Birth Attendant
SUNITA	Scaling up Nutrition in Nepal
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker

## Executive summary

- This report provides the findings of an Independent Review of two projects being supported by the Australian Agency for International Development (AusAID) and implemented by the United Nations Children’s Fund (UNICEF) Nepal.
- The report is in two main sections. Section 3, Review findings, contains an Independent Review of the projects. Section 4, Key findings, reviews the technical assistance and context of the support in the wider setting of AusAID support to the developing health sector in Nepal and against the developing SWAp (Sector Wide Approach) process.
- Small projects implemented by UNICEF, such as these under review, contribute to an overall program. Thus, attribution of individual achievements, assessment of lost opportunities, or value added can be difficult to isolate from the larger program. However, UNICEF’s overall contribution to policy, planning and implementation at the sector level in Nepal has been documented, and this is set out in Annex 5. It is significant. This has the advantages for AusAID of synergistic leverage of the AusAID funding.

## Review findings

### Relevance

- The projects were relevant, and supported AusAID country and health policy and the goals and activities of the Nepal Health Sector Programme Second Implementation Plan (2010 – 2015) (NHSP-IP 2) and, specifically, commitment to achievement of Millennium Development Goal (MDG) 4 and MDG 5. They are reflected in NHSP-IP 2 and support significant initiatives of NHSP-IP 2.
- While harmonised, the support was not aligned, being implemented through UNICEF annual work plans as a part of the UNICEF program.

### Effectiveness

- The objectives were clear and limited in scope, and likely to be attained in the time. Countrywide improvements in health indicators support the effectiveness of the interventions.
- The interventions had a strong evidence base and have been shown to be scalable models for addressing the key issues in maternal, newborn and child health and in nutrition. The activities are supported by evidence from the work into the Investment Case for Financing Equitable Progress towards MDGs 4 and 5, co-funded by AusAID with the Gates Foundation and UNICEF and by the work through SUNITA, co-funded with World Bank.

### Efficiency

- The projects have been administered in accordance with UNICEF’s rules and regulations and would appear well managed.
- The UNICEF approach is considered by some senior Ministry of Health and Population (MoHP) staff to be not value for money, due to the additional management and administrative fees payable to UNICEF. Without access to the detailed budget breakdown of the UNICEF program, it is not possible to assess the degree to which AusAID funding has funded core UNICEF program support. Funding of regionally-based consultants would seem to imply at least some degree of program support.

- Given the project nature of the AusAID support, some fiduciary risks exist given the manner in which UNICEF accounts for its disbursements.

### **Monitoring and Evaluation**

- Project monitoring and evaluation is undertaken as part of the regular UNICEF program monitoring and evaluation (M&E). UNICEF provides results to AusAID in reports against the two project proposals. AusAID is not routinely invited to join formal annual UNICEF monitoring missions.

### **Sustainability**

- The project outputs are not sustainable in the short-to-medium term, but are potentially sustainable in the longer term as the capacity of the Government of Nepal (GoN) is developed. The recommendations set out below should address this, and those which contribute to sustainability are flagged.
- While the proposals and reports of both projects identify significant constraints to sustainability, the documentation does not address these. This seems to be on the assumption that the interventions are in the nature of a 'holding operation' until government has the capacity to take on the responsibilities.
- As the projects have primarily concentrated on improving service provision, the deaths and disability avoided by the project interventions is a sustainable gain.

### **Gender equity and social inclusion**

- Gender equity, access, decision making, women's rights and capacity building is enshrined in UNICEF's mandate and guides their approach to targeting the most marginalised and disadvantaged groups. In general, UNICEF has made a concerted effort to ensure that the MoHP's gender equity and social inclusion (GESI) strategy objectives are addressed.

### **Other key issues**

#### **AusAID strategy**

- The AusAID strategy for support to health and nutrition in Nepal is consistent and implementation modalities are rational. This has however resulted in some 'trade-offs', principally in the areas of cost-effectiveness and sustainability. These strategic trade-offs seem to have been reasonable decisions, but now need to be revisited.
- During, and following, the civil conflict, the overriding priority was to ensure that disadvantaged communities were able to access key services. AusAID supported nutrition by supporting the Nepal National Vitamin A Program (NVAP) and supported Integrated Management of Childhood Illness (IMCI) through the Nepali Technical Advisory Group (NTAG).
- Following peace in 2006, the changing political climate, and the development of the health SWAp, there was a progressive shift in implementation modalities from a focus on parallel 'project' support for service delivery, to moving towards support to strengthening and consolidating government systems to take on that role. As part of this process in 2007 UNICEF led a strategic program review of the NVAP.
- Following this AusAID transferred support to be implemented through UNICEF. This was for three primary reasons:
  - UNICEF is an internationally regarded expert organisation in the technical areas, guaranteeing technical rigour.

- UNICEF was following a program based on district level strengthening and service delivery, harmonised with Government of Nepal plans.
- UNICEF had access to the GoN and MoHP at the highest levels and was assessed as an appropriate agency to provide technical support in policy development and ensure priority of focus on these key issues as the Nepal Health Sector Programme Second Implementation Plan was developed.
- To support the evidence base for policy development for NHSP-IP 2 and to support attainment of MDGs 4 and 5, AusAID also co-funded Scaling up Nutrition in Nepal (SUNITA) with the World Bank and work on the Investment Case with the Gates Foundation and UNICEF that addressed cost effective interventions.
- While transferring funding from NTAG to UNICEF did achieve an element of increased harmonisation, it did not address the issue that is increasingly becoming a concern of government – the coordination of TA – nor does it resolve the issue of AusAID being required to monitor its support to UNICEF outside the harmonised external development partner (EDP) / MoHP mechanisms which have been set up around the SWAp.

### **UNICEF TA**

- While the tranches of support through UNICEF are AusAID projects, these are not pieces of support that AusAID has agreed with government and then looked for the best implementer, but rather are parts of the UNICEF Country Program, which UNICEF has agreed with GoN and then asked AusAID to fund.
- While the UNICEF Health and Nutrition program is negotiated with the MoHP during the planning stage, implementation is through UNICEF Annual Work Plans (AWP). These are prepared in December each year following the UNICEF annual program review, and approved by counterparts (for health the relevant parts of the MoHP) before implementation from January.
- The UNICEF country program approach is not ideally suited to a ‘funding the parts of the national health plan that are unfunded’ approach, rather than a ‘here is what we are working on, and it fits the national plan’ approach. This latter approach by EDPs is identified as an ongoing issue in NHSP-IP 2.
- The projects as such do not address the sustainability of the support, and the UNICEF program approach is not ideally suited to long-term capacity building across all sectors of essential health service delivery at the district and below levels in the health sector<sup>1</sup>. Nor is the UNICEF program approach ideally suited to address the HR, financial management and other constraints which form significant blockages to further progress, although has considerable additional strengths at the community level.
- While support has been given to district teams, the main capacity building has tended to equate to skills training.
- While efficiency – particularly cost efficiency – has been questioned, given the strategies, which seem valid at that time, the only choice was UNICEF. Given the information supplied by UNICEF it is not possible to make comments on the cost effectiveness of the support.
- The methodology of fund disbursement used by UNICEF while developmentally sound, relies on the financial capacity of district management, which has been questioned by some EDPs.

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<sup>1</sup> Nor is it designed to do.

## Systems strengthening.

- It is the MoHP view (NHSP-IP 2) that whatever form of federal system Nepal will adopt in its new constitution, the need for preparing the country's institutions for the transition to federalism has already arisen. Notably, the federal structure will affect every area of the health system, from planning to service delivery.
- There continues to be significant capacity weakness at the district level and below. The major issues are around creating a functioning health system rather than weaknesses in any one technical area. The review of the support in maternal health highlights this. There is now a rational MoHP plan in place to address this capacity issue through a phased approach in NHSP-IP 2, supported by significant TA through the National Health Sector Support Programme (NHSSP).

## AusAID value added and comparative advantage

1. AusAID is a valued member of the pool fund and its technical support is respected.
2. AusAID's value added at the moment is that it is both a pool donor, and has access and experience of the practical problems at district level – albeit more recently in a limited way. This informs the policy debate within the pool donors. There is some value in retaining this.
3. The value added of the UNICEF relationship has been strengthened at the HQ level as Australia has more actively engaged with UNICEF on the international level. Similarly, it has been strengthened at regional level by the work through the investment case. However, of late this has weakened at the country level as AusAID staff have had increasingly conflicting demands on their time, as the pool funding has increasingly become the major method of support. If the relationship with UNICEF in Nepal is to be revitalised, significant additional management and technical time and resources will need to be allocated to this.

## Recommendations

1. The district level and below is going to remain the key area for service delivery and access, especially for the most inaccessible and disadvantaged areas.

**It is recommended that AusAID continue to focus at least some of its support on capacity building at the district level and below.**

2. A main focus of effort in NHSP-IP 2 is going to be around capacity building at district level and below for improved service delivery, and the efforts are going to be in building overall capacity. To properly take forward the successes to date in achieving MDG 4 and 5, and in particular accelerate progress towards MDG 5, more holistic support to the health sector will be required.

**It is recommended that in future AusAID focus on broader support to the health sector at district level rather than on focused support as in the past.**

3. The primary MoHP route to achieve this is the planned capacity building support being implemented through NHSSP. This has a sustainable basis.

**It is recommended that AusAID reopen negotiations with MoHP and pool partners to explore options for contributing to the support of NHSSP.**

**All these three recommendations should contribute to the longer term sustainability of AusAID's support, and address the concerns raised in the report.**

4. While there are arguments against 'putting all of one's eggs in one basket' given the continuing fragile nature of political development in Nepal it is likely that pool funding and sectoral support will, increasingly over time, become the primary

method of support. AusAID should strategically consider if its knowledge of district level problems is of significant value to its role in supporting the pool funders and consider the value of continuing support through UNICEF. AusAID will also need to review its managerial and technical capacity in this decision.

**It is recommended that if AusAID decides to continue support through UNICEF that it take a 'whole of health program' funding approach. This means supporting UNICEF's Nepal program as a whole, and not individual components. In effect this would be providing general budgetary support to UNICEF in Nepal. This will increase leverage with UNICEF, but will have significant resource implications for AusAID to ensure value added engagement.**

**However if this approach is taken it could be provided to UNICEF on the basis that UNICEF contributes this money to the pool funding. This would bring in UNICEF as a full partner and ensure its engagement at a strategic level.**

The Department for International Development (DFID) have developed program funding instruments based on their HQ level agreements with UNICEF for funding country programs from the bilateral program, and if such instruments are not presently available within AusAID, DFID could be approached to share examples with AusAID. This would also address some of the fiduciary concerns, which could be raised by a project funding methodology.

## 1. Introduction and structure of the report

This report provides the findings of an Independent Review of two projects being supported by the Australian Agency for International Development and implemented by the United Nations Children's Fund Nepal. The initial fieldwork, including district visits, took place in November 2011, with further follow-up work in January 2012. The Terms of Reference (TOR) are at Annex 1. A schedule of meetings is provided in Annex 2.

Following the background and introduction, the report consists of two main sections. **Para 3, Review findings**, contains an Independent Review of the projects, while the second section, beginning **Para 4, Key findings**, reviews the technical assistance and context of the support in the wider setting of AusAID support to the developing health sector in Nepal and against the developing SWAp process.

## 2. Background

### 2.1. Country context

Nepal is one of the poorest and least developed countries in the world, with almost a quarter of its population living below the national poverty line and about half living on less than \$2 a day<sup>2</sup>. A third of the country consists of the most rugged mountains in the world, making access and service delivery extremely difficult.

The political situation in Nepal is fragile. After the ten-year civil conflict, which ended in 2006, complex issues relating to the structure of the state are still not resolved. In particular, the degree of federal or decentralised government is not yet agreed. The future allocation of responsibilities between levels could imply significant changes to the financing, organisation, and management of health services<sup>3</sup>.

### 2.2. Australian support to Nepal

Australia's development cooperation program with Nepal began in the 1960s<sup>4</sup>. Total Australian Official Development Assistance is increasing, reflecting Australia's strengthening bilateral ties with Nepal<sup>5</sup>. In support of a more aligned approach to aid delivery, Australia is increasingly providing its assistance for health and education through the Government of Nepal's systems, and support to these sectors has increased in recent years. Approximately one third of all present Australian support to Nepal is focused on health and health-related assistance.

Support through United Nations (UN) agencies is provided both through Australian core funding (at HQ level) and regional support, for example through UNICEF. Relevant regional support through UNICEF includes funding with the Bill and Melinda Gates Foundation to finance the work on an Investment Case including ten Nepal districts with particular reference to maternal, newborn and child health (MNCH) cost analysis and budgeting.

Increasingly Australian support to Nepal is being channelled through the bilateral country program. Bilateral support in health is programmed primarily through three mechanisms:

- Partnering with other agencies – for example, the partnership with the World Bank, to provide support for Scaling Up Nutrition in Nepal to address malnutrition.

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<sup>2</sup> Nepal Ministry of Finance, 2010,

<sup>3</sup> Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015. Ministry of Health and Population Government of Nepal. 1 June 2010.

<sup>4</sup> [http://www.dfat.gov.au/geo/nepal/nepal\\_country\\_brief.html](http://www.dfat.gov.au/geo/nepal/nepal_country_brief.html) updated November 2011.

<sup>5</sup> Australia Profile. <http://www.dfat.gov.au/geo/nepal/>

- Project or program support funding through a third party – for example, this project support through UNICEF.
- Sectoral ‘budget support’ through the Nepal Health Sector Plan SWAp pool fund.

### **2.3. Maternal, newborn and child health**

Nepal has one of the highest maternal, newborn and child mortalities in the region. Although the maternal mortality ratio (MMR) in Nepal has declined by 32 per cent during the last decade, a rate of 281 deaths per 100,000 live births is still unacceptably high. Under-five mortality has also been reduced over the last decade by 61 per cent, to 61 deaths per 1,000 live births, but progress in preventing infant deaths has been slower. More than half of all under-five child deaths now occur during the first four weeks of life.

The Government of Nepal is committed to reducing maternal, newborn and child mortality and illness and is on-track to achieve Millennium Development Goal 4 (Reduce Child Mortality) and (with focus) MDG 5 (Improve Maternal Health)<sup>6</sup>. Yet, there are challenges. There is evidence of demographic transition<sup>7</sup> and as child mortality rates improve, more child deaths are in the first weeks of life. While neonatal morbidity<sup>8</sup> remains high, skilled birth attendance is low (32 per cent); there is a high unmet need for family planning among some pockets of the population; low levels of literacy, poverty, malnutrition among women and children; acute respiratory infections (ARI), diarrhoea, other communicable and vaccine preventable diseases remain problems; and there is inadequate and unreliable access to maternal and child services<sup>9</sup>.

### **2.4. Nutrition**

Improvements have also been made in nutrition status, particularly in the last five years. Child stunting has fallen from 57.1 per cent in 2001 to 40.5 per cent in 2011, while wasting rates declined from 11.3 per cent in 2001 to 10.9 per cent in 2006. Nevertheless, under-nutrition rates remain high and the second Nepal Health Sector Program 2010-2015 (NHSP II) therefore prioritises nutrition. In addition, a Multi-sectoral Plan for Nutrition is under development, following an assessment and gap analysis in 2009 that highlighted the need for nutrition interventions in other sectors in addition to health. This introduces a National Nutrition Coordinating Committee (NNCC) under the National Planning Commission (NPC). The NNCC and NPC are to oversee the development of the Multi-sectoral Plan under which interventions would be implemented by each sector and which will combine to improve maternal and child nutrition<sup>10</sup>.

### **2.5. The projects**

AusAID has provided \$AUD 2.6 million for two projects:

- Child Survival and Nutrition Initiatives (Phases I & II) – \$AUD 1.6 million.
- Communities as Change Agents: Providing Maternal Health Services to the Disadvantaged – \$AUD 1.0 million.

UNICEF has implemented both projects.

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<sup>6</sup> Nepal Millennium Development Goals. Progress Report 2010. Government of Nepal, National Planning Commission/United Nations Country Team of Nepal. September 2010.

<sup>7</sup> Health System in Nepal: Challenges and Strategic Options. WHO. November 2007

<sup>8</sup> 20 per 1000 live births – Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal. (2009)

<sup>9</sup> Nepal Demographic and Health Survey (NDHS) 2006.

<sup>10</sup> Accelerating Progress in Reducing Maternal and Child Undernutrition in Nepal. Karen Codling, World Bank Consultant. October 2011

## 2.6. Approach and limitations to the review

The projects have previously been subject to a joint Quality at Implementation Review (QAI)<sup>11</sup>, and therefore this approach is taken in this report. This also seems appropriate given the implementation modalities adopted by UNICEF.

Small projects implemented by UNICEF, such as these under review, contribute to an overall program. Thus, attribution of individual achievements, assessment of lost opportunities, or value added is difficult to isolate from the larger program. This was flagged as an issue in the inception report. While this has the advantages for AusAID of synergistic leverage of the AusAID funding, it creates difficulties in reviewing 'the AusAID projects'<sup>12</sup>. To address this issue the UNICEF work plan and Memorandum of Understanding (MoU) with government was requested from UNICEF, however during the November visits this workplan was not available.

The rationale for visiting the two districts of Dang (UNICEF well established) and Darchula (remote area, and UNICEF present for only 15 months) was to allow a comparison. It was not possible to fully compare the two very different districts in such a short time frame, other than to say that UNICEF presence in Dang over an extended period had strengthened the delivery of health services; and the short presence in Darchula was beginning to show results. UNICEF did identify districts where AusAID had funded maternal health activities. Darchula was a district implementing similar activities to those that were identified as having received AusAID funds and where the same programs were being implemented.

## 3. Review findings

### 3.1. Description

Within AusAID the two funding streams are both 'projects' with a budgeted funding proposal submitted by UNICEF for each, with costed activity areas to be funded.

#### 3.1.1 Child Survival and Nutrition Initiatives, Phase I and II

The Child Survival and Nutrition Initiatives were implemented over two Phases. Phase 1 commenced in April 2009 and was completed in March 2010. Phase 2 commenced in June 2010 and ended in May 2011. Total cost \$AUD 1.6 million.

AusAID began support to the NVAP in 1999 and Community-based Integrated Management of Childhood Illness (CB-IMCI) in 2002. At first support was implemented through NTAG, a non-governmental organisation supported by the United States Agency for International Development (USAID). Following review recommendations in 2007, and anticipating the implementation of the health SWAp, the implementation of the assistance was transferred to UNICEF. In addition to supporting the piloting and scaling up of these essential programs the transfer of implementation to UNICEF aimed to increase the degree of harmonisation of the AusAID support.

#### **Objectives summary**

The overall objective of the initiatives was to provide the children of Nepal with increased access and opportunities to utilise high-quality, high-impact child and newborn health and nutrition interventions and practices, thereby contributing to improved child survival and development. Sub-objectives are:<sup>13</sup>

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<sup>11</sup> QAI Report for INJ 241 and INJ 396. AusAID internal documentation. January 2011

<sup>12</sup> This issue is considered in more depth in Para 4 – Key findings

<sup>13</sup> Funding Proposal (to AusAID), Child Survival and Nutrition Initiatives-2. UNICEF. May 2010.

### Child survival

- Support the maintenance of quality CB-IMCI program at district and national level.
- Continue the pilot of Community-based Newborn Care Package (CB-NCP) in three districts, and achieve a sustainable increase in the adoption of healthy newborn care practices and a reduction in prevailing harmful practices.
- Strengthen the quality of promotive, preventive and curative newborn health services from the community level to health facility level.
- Provide technical support on planning, monitoring and analysis of the CB-IMCI program as well as the CB-NCP.

### Nutrition

- Expand community-based promotion of Infant and Young Child Feeding (IYCF) package linked with Sprinkles<sup>14</sup> supplementation.
- Support promotional and social mobilisation activities for the biannual Vitamin A distribution, with special emphasis on increasing coverage of children aged 6–11 months and in municipal areas.
- Expand national communication initiative to promote key breastfeeding practices.
- Provide technical and coordination support to the government to conduct national advocacy and system-building activities.

AusAID contribution to this project was leveraged to support child survival activities across Nepal. UNICEF reports<sup>15</sup> that the majority of AusAID funds were spent in three districts, Chitwan, Kavre and Dang, where funds from AusAID, USAID and Johnson & Johnson were also used to support the program.

#### **3.1.2 Communities as change agents: Providing maternal health services to the disadvantaged**

The Maternal Health Services Project commenced in June 2010 and was due for completion in December 2011. Total cost was AUD\$ 1.0 million. The program supports safe motherhood initiatives in five districts focusing on a community-based approach to increase access to safe delivery care for disadvantaged women. This also involves training and capacity building for Skilled Birth Attendants.

Whilst improvements in maternal health have been made, there is some concern in Nepal over attaining MDG 5 (Maternal Health). DFID had previously provided project support in Safe Motherhood at District Level and, as this project support ended, and in the context of the evolving SWAp, there was concern that there could be shortfalls in this area. This support was requested as one-off gap filling.

#### ***Objectives summary***

The overall objective<sup>16</sup> is to contribute toward further reduction of maternal mortality by expanding coverage of high evidence-based maternal health services and initiating new innovative approaches in five districts.

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<sup>14</sup> Sprinkles are sachets containing a blend of micronutrients in powder form, which are easily sprinkled onto foods and were developed to prevent and treat micronutrient deficiencies among young children and vulnerable groups at risk. [http://www.sghi.org/about\\_sprinkles/index.html](http://www.sghi.org/about_sprinkles/index.html)

<sup>15</sup> Final Report (2011) Strengthening and Expanding Child Survival Nutrition Initiatives (PBA SC 2010 0343) (PBA SC 2010 0343). Submitted by UNICEF Nepal to Australia AusAID July 2011

<sup>16</sup> Communities as Change Agents: Providing Maternal Health Services for the Disadvantaged. UNICEF Nepal. Proposal for funding to AusAID May 2010

- Reduction of maternal mortality through increased access to skilled birth attendant at birth, increased coverage with uterotonic<sup>17</sup> agents for prevention of post-partum haemorrhage at birth, and increased access to quality maternal health services.
- Strengthening the continuum of care from community to the service site, through increasing knowledge and awareness of the pregnant woman and her family, and creating demand at the community.
- Strengthening of referral system for emergency obstetric care service in the district.
- Capacity building of service providers and strengthening of the GoN health system.

In addition, the project's Technical Assistance (TA) focuses on capacity building of the District Health Officers (DHO) and their teams, especially in the planning, supervision monitoring and reporting of the government's maternal and newborn health (MNH) program.

### **3.2. Relevance**

#### **Australian and partner government priorities**

- The objectives and activities of the projects support the AusAID Nepal Country Program development objectives and directly support the key development objective of Australia's investment in health<sup>18</sup>.
- The activities supported by the projects are relevant to the goals and activities of The NHSP Second Implementation Plan (2010 – 2015), and specifically to the government's commitment to achievement of MDG 4 and MDG 5. They are reflected in NHSP-IP 2 and support significant initiatives of NHSP-IP 2.

#### **Context and needs of the beneficiaries**

- Community-level review confirms that the support is relevant to the realities of the main beneficiaries, who are women, newborns, children, their families and communities.
- District level review (although limited) confirms that the support is highly valued by the districts, particularly in the context of limited resources and limited capacity to implement activities at district level.

#### **Harmonisation and alignment**

- The support is harmonised with government priorities, with NHSP and its implementation plans and with other EDPs. While it simplifies AusAID procedures compared with using a managing agent, it is not as simple as, for example, pool funding.
- The support is not aligned with government systems.

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<sup>17</sup> A uterotonic is an agent used to induce contraction or greater tonicity of the uterus. Uterotonics are used both to induce labor, and to reduce postpartum hemorrhage. Wikipedia.

<sup>18</sup> Health policy note. Guiding Australia's investment in health to 2015. Australian Government. AusAID. 2011.

### International commitments (Table 5.1 from NHSP-IP 2, pg. 52)

#### PARIS DECLARATION

Ownership - Developing countries set their own strategies, improve their institutions and tackle corruption.

Alignment - Donors align behind these objectives and use local systems.

Harmonisation - Donors coordinate, simplify procedures and share information to avoid duplication.

Results - Developing countries and donors shift focus to development results and results get measured.

Mutual Accountability - Donors and partners are accountable for development results.

#### THE ACCRA AGENDA FOR ACTION (AAA)

Predictability – donors will provide 3-5 year forward information on their planned aid to partner countries.

Country systems – partner country systems will be used to deliver aid as the first option, rather than donor systems.

Conditionality – donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.

Untying –relax restrictions that prevent countries buying the goods and services they need from whomever and wherever they can get the best quality at the lowest price.

- The support is consistent with AusAID, GoN and UNICEF commitments as signatories to the Nepal International Health Partnership (IHP) 'Compact'<sup>19</sup>, which accepts that not all External Development Partners will pool fund. That being said, it is clear that pool funding is the preferred option of the MoHP<sup>20</sup>.
- UNICEF support is based on a three-year Country Program Action Plan agreed between UNICEF and the GoN<sup>21</sup>. Annual Work Plans are prepared in December each year. The AWP in health are decided through workshops with the MoHP, relevant Ministries, District Development Councils and donor partners. The support is aligned with and supports the NHSP-IP and common results framework, and national district coverage for maternal, neonatal and nutrition support is coordinated between the MoHP and other funding EDP (cf USAID), but implemented in parallel through the UNICEF AWP.
- UNICEF-supported activities are included in district-level workplans, and funding of activities is through district level government accounts – in other words there is a degree of harmonisation at district level.
- While the overall UNICEF Country Program does indicate that it will contribute pooled funding in health, the large majority of the UNICEF Health and Nutrition program is funded in parallel in support of the MoHP-owned NHSP Plans and, as part of this, AusAID support through UNICEF is implemented in parallel to the MoHP plans.
- The UNICEF Health and Nutrition Program does not cover all districts, nor does the AusAID support cover all 'UNICEF' districts (nor is it designed to). The selection of UNICEF districts is to a greater or lesser extent based on the wider non-health UNICEF program and, as such, Districts for Health and Nutrition interventions are not necessarily selected only on health priorities.
- Technical assistance is designed to focus on strengthening government systems and developing the capacity of government health staff to implement specific activities, which are part of the District Health Plans. That being said, a degree of the UNICEF TA is focused on managing and implementing the UNICEF workplans.

<sup>19</sup> Nepal Health Development Partnership. International Health Partnership 'Compact'. February 2009

<sup>20</sup> See NHSP-IP 2, MoHP. Particularly, paras 5.7 and ff. Also personal communications.

<sup>21</sup> See Country Programme Action Plan 2008-2010

Children's Fund. Signed 25 Feb 2008 by Ministry of Finance and UNICEF.

- Support for nutrition was previously coordinated through the Nepali Technical Advisory Group, a Nepalese non-governmental organisation, created to assist the MoHP in implementing the NVAP<sup>22</sup>. Nationally, coordination is now moving towards being the responsibility of the NNCC and NPC, while within the MoHP there is a small (but growing) number of staff focused on coordination of support to nutrition. UNICEF works closely with the MoHP staff to coordinate activities, and remains responsible for the purchase and supply of Vitamin A supplements to support Nepal.

### 3.3. Effectiveness

- Overall, the objectives as set out in the proposals are clear and likely to be achievable in the time frame. Throughout the review, feedback from beneficiaries and stakeholders was positive.
- However, it is difficult to assess the degree of contribution of AusAID support for sub-objectives, as there are multi-partner contributions; changes have been made since the original proposals; and 'AusAID districts' were not visited.
- The interventions have a strong evidence base and have been shown to be scalable models for addressing the key issues in maternal, newborn and child health and in nutrition, both globally and in Nepal. The activities are supported by evidence from the work into the Investment Case for Financing Equitable Progress towards MDGs 4 and 5, co-funded by AusAID with the Gates Foundation and UNICEF and by the work through SUNITA, co-funded with World Bank<sup>23</sup>.
- Countrywide indicators support the effectiveness of the interventions supported.
- The TA support provided supports the government's MNCH program, but is not harmonised. There does not appear to be duplication of efforts at the district level at present, but there is some duplication at regional level. UNICEF has regional support offices that are not necessarily covering the same geographical areas as MoHP Regional Offices, or co-located with the Regional Offices of the MoHP. These are staffed by TA that supports the UNICEF district programs.

#### 3.3.1 Child survival and nutrition initiatives

Goal 4: Reduce Child Mortality. *Targets likely to be achieved.*

A well-coordinated scale-up of highly effective child survival interventions, such as Vitamin A distribution, immunisation and pneumonia treatment, has contributed to the fact that the mortality rate among children under five years has been halved during the past ten years. The largest challenge today is addressing mortality among newborns, now accounting for 54 per cent of all deaths among under-five children.

Meeting the MDGs in Nepal<sup>24</sup>

#### **Child survival initiatives**

Integrated Management of Childhood Illness is an integrated package of child-survival and nutrition interventions that address major killer diseases in children two months to five years. The package was first introduced into Nepal in 1997. Following a pilot, a community-based component was introduced (CB-IMCI), enabling mobilisation of community health workers – including Village Health Workers (VHWs), Maternal and Child Health Workers (MCHW) and Female Community Health Volunteers (FCHV) to

<sup>22</sup> The Nepal National Vitamin A Program: prototype to emulate or donor enclave? John L Fiedler. Health Policy And Planning; 15(2): 145–156. April 2000.

<sup>23</sup> See Executive summaries of: Equity Report, Scale-Up Report (August 2011) and others, and: Accelerating Progress in Reducing Maternal and Child Undernutrition in Nepal. A review of global evidence of essential nutrition interventions for the Nepal Health Sector Plan II and Multi-Sectoral Plan for Nutrition. Karen Codling, October 2011

<sup>24</sup> . <http://www.undp.org.np/mdg/goals/goal4.php>. January 25, 2012.

provide Control of Diarrhoeal Diseases (CDD), ARI, nutrition and immunisation services to the community.

Australian support for Child Survival and Nutrition Initiatives through UNICEF started in January 2009. As CB-IMCI had been scaled up to most districts by January 2009, AusAID Phase 1 support focused on capacity building and maintaining the quality of CB-IMCI in UNICEF-supported districts. Phase 2 continued to maintain the quality of CB-IMCI and provided support for monitoring, planning and strengthening service delivery from the community to facility level.

Specific examples of support include:

- Training support for new and transferred staff/FCHVs. This is regarded as a key intervention for maintaining quality, and feedback from District Health Office staff in Dang District confirmed this.
- Regular and annual CB-IMCI review meetings at both health facility and community levels. Feedback from district managers was that if UNICEF support was not available these meetings would not be held regularly.
- A CB-IMCI 'Focal Person' review meeting in Pokhara for the Western Development Region. At the end of the meeting a workplan was prepared for strengthening the CB-IMCI program in Western Districts.

#### Piloting of a community-based newborn care package

Increasingly over the life of the support, mortality of newborns has become proportionately a greater problem (see box above). AusAID funding for Phase 2 supported the piloting of a CB-NCP in three districts, in partnership with national non-governmental organisations. This package supports the adoption of healthy newborn care practices and the reduction of prevailing harmful practices. AusAID funds are reported to have been used in three districts: Chitwan, Kavre and Dang<sup>25</sup>.

The AusAID contribution helped implement a training package and national guidelines that had been developed at a central level. After training, FCHVs and health workers were required to record pregnant women, take care of newborns and maintain records.

The quality of promotive, preventive and curative newborn health services has also been strengthened from community level to health facility level. During the field trip the review team was able to observe how CB-NCP training has been complemented by the distribution of training materials, manuals, recording/reporting tools, IEC/BCC materials, equipment and drugs for delivering the services at the community level. Health workers in facilities and FCHVs in communities were able to demonstrate the recording and reporting of data indicating the number of newborns attended and the outcome of attendance.

The CB-NCP that was piloted with AusAID Phase 2 support in three districts has now been scaled up to 25 districts; the government is responsible alone for 15 districts; five districts are supported by UNICEF and five districts by other donors.

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<sup>25</sup> The project proposal includes these three districts and the final report submitted by UNICEF gives preliminary data for the districts. However the budget does not fully reconcile with this. A request was made to UNICEF for additional information but at the time of writing this report the information requested has not been received.

**Table 1: Performance against Key Indicators for CB-NCP in three Pilot Districts<sup>26</sup>**

	Combined Baseline 2008	July 2010 – March 2011		
		Chitwan	Kavre	Dang
No. of newborns enrolled	NA	41.3%	26%	69%
Birth Preparedness Package (BPP) counselling by FCHV	NA	92.0%	100%	100%
Health Facility delivery	32%	75.4%	57%	60%
Delivery conducted at home	66%	25.5%	39%	40%
<b>For Home Delivery</b>				
Delivery conducted by SBA	8.10%	25.0%	9%	11%
Clean Delivery Kit (CDK) used during delivery	18.50%	58.7%	69%	60%
Presence of FCHV during delivery	5%	73.6%	95%	70%
<b>Immediate Newborn Care by FCHV</b>				
Dried and wrapped with clean and soft cloth	51%	75.8%	100%	100%
Breastfeeding within 1 hour	57%	76.6%	100%	72%
<b>For Asphyxiated Baby</b>				
Asphyxiated baby identified when FCHV at home delivery	NA	4.6%	7%	7%
<b>Birth Weight taken by FCHV</b>				
Weight taken within three days of birth	14%	88.2%	86%	91%
Low birth weight identified by FCHV	4%	23.5%	8%	5%
Very Low birth weight identified by FCHV	0%	1.7%	2%	1%
<b>Neonatal Outcome</b>				
Newborn deaths reported (per 1,000 live births recorded)	18 per 1,000	17 per 1,000	8 per 1,000	4 per 1,000

#### Support for planning and monitoring of child survival activities

The field trip to Dang<sup>27</sup>, and early results (see table) show the effectiveness of the low-cost interventions, which are part of the package. All indicators show improvement including the reduction of deliveries at home (66 per cent–44 per cent) and increase in institutional deliveries (32 per cent–60 per cent) and reduction in neonatal deaths (18 per 1,000 to 4 per 1,000) in a relatively short period of time.

From field visits and UNICEF reports the review team was able to verify that AusAID contributions have supported:

- The development of indicators to measure the performance of IMCI in different districts.
- A colour-coded supervision model and accompanying software which in the initial phase of piloting in Chitwan and Dang. The colour coding system is being used to track the performance of health workers and provide support as needed.
- UNICEF TA provided support across all partners, supporting IMCI training for 1,000 Health Workers where the training was funded by different partners (400 by

<sup>26</sup> UNICEF, Nepal. 2011; Final Report: Strengthening and Expanding Child Survival and Nutrition Initiatives in Nepal. (PSA SC 2010 0343) Submitted to AusAID July 2011

<sup>27</sup> Dang is listed in the project proposal and the final report. However during the field trip it was obvious that other donors had been making contributions to other activities in the district e.g. USAID to EmONC

Government of Nepal, 350 by USAID, 80 by UNICEF, 80 by WHO, 30 by PLAN and 60 by SAVE)<sup>28</sup>.

### Direct Technical Assistance

AusAID funds were used to place two CB-IMCI consultants in two regional field offices and Public Health Office to provide technical backstopping for strengthening the quality of the CB-IMCI program along with monitoring and technical support visits to the health facilities and Community Health Workers. The review team raised the recruitment of additional local staff as an issue with DHOs. The response was that these were not permanent positions but were filling a gap until sanctioned positions in the district plan could be recruited.

### ***Nutrition initiatives***

The initiatives have achieved their broad objectives. However, there were multiple donors contributing to activities, and activities in the original proposal are difficult to reconcile with the final budget<sup>29</sup>. It is difficult to determine the actual contribution of AusAID and the extent to which sub-objectives have been achieved.

Nonetheless, there is tangible evidence that Australia has **contributed to** the achievements of Child Survival and Nutrition countrywide and particularly in districts where the CB-NCP was trialled. Nutrition activities include: expansion of an IYCF package; promoting breastfeeding practices and the supply and distribution of Vitamin A.

### Community-based promotion of Infant and Young Child Feeding package

AusAID funding was used to support the piloting of the IYCF Community Promotion Program, linked with Sprinkles distribution, in six districts of Nepal (Makawanpur, Palpa, Rasuwa, Gorkha, Rupandehi and Parsa).

Communication tools including television and radio public service announcements were developed. Support was also given for district level review and planning meetings and capacity building training to health workers to support the IYCF pilot districts.

### National communication initiative expanded to promote key breastfeeding practices

AusAID funds were used to revise information, education and communication materials and training manuals based on findings of a feasibility study which was undertaken in consultation with the government and nutrition experts to promote good breastfeeding practices across Nepal. During the visit to Dang the review team were able to review media developed to support this initiative. During Breastfeeding Week (August 2011) a national campaign was launched. Famous actors, high-profile doctors and senior government officials were mobilised to advocate on the importance of breastfeeding.

### Social mobilisation and promotional activities for the biannual Vitamin A distribution

Amongst other initiatives, AusAID has contributed to the development of promotional materials for the November 2010 and April 2011 rounds of Vitamin A distribution and the production of documentation to support a newborn Vitamin A dosing pilot in Tanahu and Nawalparasi Districts.

By agreement, UNICEF at present provides 9.5 million Vitamin A capsules to the government. In return the government covers the cost of transporting the capsules from Kathmandu to District Health/Public Health Offices. AusAID funds contributed to the purchase of Vitamin A capsules for distribution across Nepal.

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<sup>28</sup> UNICEF, Nepal. 2011; Final Report: Strengthening and Expanding Child Survival and Nutrition Initiatives in Nepal. (PSA SC 2010 0343) Submitted to AusAID July 2011

<sup>29</sup> The review team has requested more information from UNICEF while writing this report but is yet to receive a response.

### Procurement of supplies and equipment

AusAID funds were also used to procure equipment and supplies to support CB-IMCI and CB-NCP, including:

- 3,200 ambu bags for resuscitation of asphyxiated babies, and funds to print manuals, guidelines and flex-charts.
- Procurement and distribution of 5,000 ARI timers for FCHVs to diagnose respiratory rate, which is an important indicator for identifying pneumonia among children.
- 20,000 blue plastic cups for use in health facilities and for FCHVs and mothers to measure water required for preparing a treatment for diarrhoea.

### **3.3.2 Maternal Health Project**

Goal 5: Improve Maternal Health. *Targets possible to achieve if changes are made.*

Maternal mortality has fallen by about 50 per cent from the mid-nineties, from 539 to 281 cases per 100,000 births. However, only one out of five births are attended by a skilled birth attendant, linking clearly to the high mortality rates of newborns. Access to maternity and reproductive health services should be made universal and free of cost, as provided by the Interim Constitution. The provision and retention of skilled staff, and equipped and functioning facilities in rural areas, is key to this.

Meeting the MDGs in Nepal

The Maternal Health Project has been implemented for just over 15 months. It is too soon to say if there has been a reduction in maternal mortality through increased access to Skilled Birth Attendants (SBA). During the field visit to Darchula, a district implementing similar activities to the five AusAID supported districts, there was some evidence that the interventions being supported are having a positive effect on maternal health and it is reasonably to be expected that by the completion of the project there will be an increase in uterotonic coverage for prevention of post-partum haemorrhage at birth and increased access to quality maternal health services. The capacity building provided by the project ensures this.

Annex 3 shows progress against logical framework outputs. Achievements include:

- Needs assessments have been completed in service sites across the five project districts and 175 facilities have been upgraded to provide Basic Emergency Obstetric and Newborn Care (BEmONC) services.
- To date, 50 Skilled Birth Attendants have been trained, 90 per cent of services providers (mainly Auxiliary Nurse Midwives) have received refresher training and village health workers, including Female Community Health Volunteers (FCHVs), have been trained in the prevention of post-partum haemorrhage at home birth with Misoprostol according to the national program.
- Coordination workshops between peripheral and referral sites will be completed by the end of the year. Mobile phones and SIM cards and have been supplied to birthing sites. This has strengthened the referral system.
- The continuum of care between the home and health facility has been strengthened through health education of FCHVs and a social auditing process, WATCH groups and funds for emergency obstetric care have been established.

### **3.4. Efficiency**

- The projects have been administered in accordance with UNICEF's rules and regulations.
- The UNICEF approach is considered by some senior MoHP staff not to be best value for money, given the additional management and administrative fees payable

to UNICEF. Without access to the detailed budget breakdown of the UNICEF program it is not possible to assess the degree to which AusAID funding has funded core UNICEF program support. Funding of regionally-based consultants would seem to imply at least some degree of program support.

- Given the project nature of the AusAID support, some fiduciary risks exist due to the manner in which UNICEF accounts for its disbursements. This is addressed further in paragraph 4.6.

### **Management**

- Given the project design, the overall management of the UNICEF program appears to be of good quality. Needs assessments were undertaken at the beginning of projects and changes made based on assessments.
- The MoHP and Department of Health Services (DoHS) at central and district level have been actively involved in management decisions related to the implementation of the UNICEF program. At the central level, there have been frequent meetings at various levels to discuss UNICEF support to the MoHP and to develop workplans on an annual basis. MoHP officials interviewed were in general satisfied with the responsiveness and collaborative arrangements with UNICEF.
- At the central level, there are intensive consultations about activities to be supported by UNICEF, including decisions of which districts will be involved in national pilots and where various activities will be focused. Once decisions are reached annually, they are passed to DHOs. District health managers interviewed by the review team generally felt adequately involved, although some had complaints about why they were left out of particular pilot projects (for example CB-NCP), a decision usually tied to national DoHS agreements with UNICEF.
- Management was flexible and made changes to project implementation as needed. However these changes were made without notification of AusAID. This, and the fact that multi-donor funds were leveraged for particular outputs, contribute to final reports not reconciling with project proposals.

### **Implementation**

- Child Survival and Nutrition Initiatives were reported as expended on budget and on time. Phase 1 commenced April 2009 and was completed by March 2010. Phase 2 commenced in June 2010 and ended May 2011. The cost for Phase 1 was \$USD 575,536.00. Balance of funds at end of Phase 1 was \$USD 303.00. For Phase 2 the cost was \$USD 627,251.00. Balance of funds at end was \$USD 2,817.00.
- However, tracing donor inputs and operational costs and specific activities is difficult. This is because of the UNICEF program approach. AusAID has endeavoured to address the issue – the reporting has improved – but budgets are still not easily reconciled against original proposals. The maternal health project is the only project that has a logical framework and budget that aligns with activities in the project proposal.
- The maternal health project commenced in June 2010 and is on track to be implemented on budget (\$AUD 1 million). UNICEF has requested a no-cost extension of five months for a delay related to the implementation of training packages. This will extend the timeline from December 2011 to May 2012.
- There were no constraints on staffing or resources. Again, this accepts that the projects were part of a larger program and as such utilised the program resources available to facilitate implementation.

### **Impact**

The project has **contributed to** improvement in indicators across a number of MoHP Programs. CB-IMCI is now being implemented in all 75 Nepal Districts and has saved an estimated 15,000<sup>30</sup> Nepali children. The CB-NCP package has been scaled up to 25 districts and Vitamin A and de-worming tablets are being provided annually to more than 3.4 million children and pregnant women. Pregnant and breastfeeding mothers are being provided with folic acid and iron supplementation.

**Table 2: Selected Relevant Project MNCH Indicators**

MDG/Impact Indicator	Achievement					Target	
	1991	1996	2001	2006	2009	2010-11	2015
Maternal Mortality Ratio	539	539	415	281	229	250	134
Total Fertility Rate	5.3	4.6	4.1	3.1	2.9	3.0	2.5
CPR (modern methods)	24	26.0	35	44	45.1	48	67
Under-five Mortality Rate	158	118.3	91	61	50	55	38
Infant Mortality Rate	106	78.5	64	48	41	44	32
<b>Neonatal Mortality Rate</b>		<b>49.9</b>	<b>43</b>	<b>33</b>	<b>20</b>	<b>30</b>	<b>16</b>
% of underweight children		49.2	48.3	38.6	39.7	34	29

Nepal Health Sector Program - Implementation Plan II

The proportion of malnourished children decreased from 4.67 per cent to 3.77 per cent from 2008-2010; skilled birth attendance has increased from 14.3 per cent in 2007-2008 to 26.17 per cent in 2009-2010; and Post Natal Care first visit has increased from 37.7 per cent to 49.72 per cent in the same time period. The table above, reproduced from the NHSP-IP 2, provides an overview of the substantial progress to which the projects have contributed.

From the field trip it was evident that there have been some additional impacts. Technical Assistance and transfer of learning has been a motivational force to some government staff. A District Health Manager explained how the Public Health Nurse had been changed from someone with no confidence to a confident person who took pride in her work, was motivated and more productive.

### 3.5. Monitoring and Evaluation

- Project monitoring and evaluation is undertaken as part of the regular UNICEF program monitoring and evaluation. UNICEF provides results to AusAID in reports against the two project proposals. AusAID is not routinely invited to join formal annual UNICEF monitoring missions.
- For the Child Survival and Nutrition Initiatives project there is a results framework in the original proposal. There was no updated version of this available to the review team for Phase 2. The Project was completed in July 2011 and baseline and administrative data from three districts is provided in the final report.
- The maternal health project has a logical framework. However the Project has only been going for 15 months. Progress against the log-frame indicators is provided in Annex 3 of this document. Given the short timeframe the extent to which these can be used to show achievements is limited.
- Regular joint supervision and monitoring is conducting by UNICEF along with the Child and Family Health Division (FHD) and district health staff. For UNICEF,

<sup>30</sup> AusAID; (2010); Nepal Development Cooperation Report

during field visits, Regional Offices and nationally-based staff ensure that the projects are running smoothly according to the AWP.

### **Project monitoring**

In Dang District UNICEF has worked with the District Planning Health Office (DPHO) to develop an innovative approach to performance-based monitoring<sup>31</sup>. This has involved the development of software along with a colour-coded checklist for monitoring equipment and supplies, the knowledge and skills of health workers and knowledge and practice of VHW/MCHW and FCHVs.

To help integrate the approach into the health system, at the request of the District Health Manager, UNICEF mobilised three technical advisors to collect data and to support the new system. At the same time, the government Health Management Information System (HMIS) is being strengthened at central level, and when complete this new supervision and monitoring system will be merged with the HMIS system and the technical advisor positions supported by UNICEF will be phased out.

The colour-coding system allows the user to see at a glance if a particular health facility is performing well. There are three colours: red, orange and green. If a facility is red this indicates that action needs to be taken immediately – for example, supplies or equipment are needed or there is a gap in the skills and/or knowledge of a particular health worker and the DHO needs to take action immediately. If orange, then there is something that needs to be attended to as soon as possible. If green, the health facility is performing well.

### **Analysis of learning**

Evidence-based, low-cost interventions supported by the projects are embedded in design of the project and GoN health sector program. Ideally these interventions should be refined based on implementation. However the Community Based Newborn Care Package, like many other pilot packages, has already gone into rapid scale-up. Lessons learned from the pilot and how 'the Package' will be integrated into the health system to strengthen MNCH service delivery has not been considered. As a consequence there is lack of integration of packaged MNCH services in the health system. This has resulted in the delivery of services that are fragmented and incomplete. As all activities implemented by UNICEF are within the health system there was general agreement from all those interviewed that this matter needed to be addressed.

## **3.6. Sustainability**

When it comes to improving basic services to the poor, sustainability depends on functioning budget systems; a skilled, capable and committed workforce; and capacity to ensure funds are spent appropriately and effectively<sup>32</sup>.

- Using the above criteria the project outputs are not sustainable in the short-to-medium term, but are potentially sustainable in the longer term. This is because at present:
  - Staffing levels and retention of skilled and capable staff at district level are not ideal.
  - District level planning, budgeting and financial management systems are, as yet, poorly developed and poorly functioning.

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<sup>31</sup> Some of the costs of this system were covered by AusAID funds.

<sup>32</sup> AusAID Office of Development Effectiveness. Improving the provision of basic services for the poor: Linkages with broader public sector reform [www.ode.usaid.gov.au/news/news14.html](http://www.ode.usaid.gov.au/news/news14.html)

- However, plans led by the GoN, the MoHP and supported by EDPs are in place to address these constraints, even if it is accepted that these are long-term endeavours.
- On the basis that the projects have contributed to preventing avoidable deaths and morbidity through service provision – where there might have been none – those benefits are sustainable, that is, those significant benefits to the individuals and to their families and communities from individuals not having experienced avoidable death, suffering and disability.
- The strategies for sustainability are not explicit in the project documentation for either project.
- Specific constraints to sustainability are identified in the reports from both projects, but are not addressed.

The primary outputs of both projects are couched in terms of activities and increased service provision, without analysis linking activities to expected results. The proposal for the Child Survival and Nutrition Initiatives – 2 does not specify methodologies at all and while identifying sustainability issues:

*‘...[s]ome important weaknesses include imbalance in the deployment and retention of human resources, slow and inadequate decentralisation, problems in supply and maintenance of equipments and physical infrastructure. Geographical remoteness has caused difficulty in access and resulted in inequitable distribution of health services and health outcomes.’*

This seems to identify inadequate government funding as the primary cause:

*‘Scaling up of the Community Based Newborn Care Package to the newer districts is a challenge due to concern on some of the interventions proposed in the package as well as the cost of the package.’*

*‘Though funding for the health sector increased over the last couple of years, the available resources from the public sector continue to be inadequate to provide equitable access even to basic health service to the people.’*

The funding proposal for the *Communities as Change Agents: Providing Maternal Health Services for the Disadvantaged* project does have as its fourth key activity (of four): *‘Capacity building of service providers and strengthening of the government health system’*. On closer examination of the proposal this is training of FCHVs to deliver maternal care messages and enhance their capacity to transfer knowledge and bring about behaviour change through training on adult learning and communication processes. Specifically on the issues of sustainability the Maternal Health proposal states:

*‘...while the Government theoretically could implement the planned activities of this project, it lacks adequate and necessary technical capacity, human resources, and expertise and this hampers the implementation of safe motherhood activities in most districts as has been seen so far in NHSP I. If left on its own, it will take years to implement activities in all districts and those denied access and services are likely to be the poorest, most marginalised, dalits and the poor. The project besides provision of technical support will therefore help in filling up the gaps, will focus on most needy and will also motivate the communities to invest its own resources (decentralised funds, VDC funds, et.) and find local solutions in the spirit of sustainability. Over time it is hoped that the government capacity will be enhanced and will be able to manage on its own’.*

The most recent reports of both projects are similarly couched in terms of activities supported, although they detail considerable training activities.

## Implicit assumptions

The above being said, the stated overall methodology adopted by UNICEF is to implement activities (of which the AusAID-funded projects form part) in support of, and as part of, NHSP-IP 2 and supported by the UNICEF consultative planning processes with GoN. Furthermore, the activities are embedded in the government system through local government or district planning.

The argument is then, even though the project documentation does not specifically address sustainability, that this is 'a given' of UNICEF support by its mode of operation. This could only be assessed or validated by considering the program as a whole.

Clearly, new skills and tools have been developed and are being applied to benefit MNCH programs and management. In some cases, systems introduced by UNICEF have been institutionalised into the system (for example performance monitoring), while in other areas (for example quality improvement) efforts by UNICEF will not be sustained unless external support is continued.

Any future support should seek to establish clear indicators for measuring progress toward institutionalising these systems and exit points need to be identified which will allow UNICEF to withdraw slowly but allow efforts to be sustained.

## Environment, biodiversity, climate and disaster challenges

These challenges are not explicitly mentioned in any of the project documentation, nor does this review identify that these projects have any negative effects in these areas. Indeed the UNICEF Health and Nutrition program forms part of UNICEF's Decentralised Action for Children and Women (DACAW), UNICEF Nepal's primary program for channelling a range of interventions to rural communities in 23 districts across Nepal<sup>33</sup>. In particular, DACAW is designed to contribute to the peace and nation building efforts. DACAW is a part of the UN's Development Assistance Framework (UNDAF) and follows the UN internal rules regarding environmental and biodiversity protection. The UN is assisting the GoN in disaster preparedness planning, especially considering the high earthquake risk.

UNICEF is probably better positioned to identify and address any issues arising in these areas than many implementing agencies.

## 3.7. Gender Equity and Social Inclusion

Gender equity, access, decision making, women's rights and capacity building is enshrined in UNICEF's mandate and guides their approach to targeting the most marginalised and disadvantaged groups. In general, UNICEF has made a concerted effort to ensure that the MoHP's GESI strategy objectives are addressed. The main avenues for doing so have been by ensuring:

- The Health Facility Operational Management Committees (HFOMCs) have female members as well as those from disadvantaged and minority groups, all of whom are encouraged to be actively involved in decision making.
- MNCH services have a strong focus on providing access to women, particularly those from disadvantaged castes.
- Ensuring capacity of village health workers is developed within disadvantaged and marginalised groups.
- Disadvantaged groups who would otherwise hesitate to seek services are being encouraged to access health facilities, and clients include disadvantaged groups.

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<sup>33</sup> Improving Lives for Children and Women in Nepal. Decentralised Action for Children and Women (DACAW). UNICEF and the government of Nepal.

Considering UNICEF's mandate and scope of work, the review team concluded that even though effective steps were in place to address GESI issues, better targeting could be considered. A recent study by UNICEF highlighted the need to collect disaggregated data which better profiles socially excluded groups including gender, poverty, caste discrimination, and geographic and social isolation. The finding of this study will be used to improve the targeting of these groups.

## 4. Other key issues

### 4.1. AusAID strategy

The AusAID strategy for support to health and nutrition in Nepal is consistent and implementation modalities are rational. It has however resulted in some 'trade-offs', principally in the areas of cost-effectiveness and sustainability. These strategic trade-offs seem to have been reasonable investments, but now need to be revisited.

In particular, there is now substantially greater focus on introducing program-based approaches across the Australian aid program. AusAID is moving away from using discrete projects, designed and delivered through managing contractors, as its dominant model of aid delivery. The reform is fundamental to AusAID and the challenges accompanying it cannot be understated<sup>34</sup>.

During, and following, the civil conflict, the overriding priority was to ensure that disadvantaged communities were able to access key services. In discussions with GoN, MoHP and partners, AusAID identified three priority areas of support: Maternal Health for children, the National Vitamin A Program; and nutrition and the IMCI program. These were, and remain, among the highest priorities for the MoHP<sup>35</sup>. As at that stage DFID was providing significant project support to safe motherhood, AusAID agreed to support the NVAP and IMCI. With institutional capacity of the health services low, at that stage the primary focus was on delivery of key services. The implementation methodology was NTAG with funding for the NVAP from AusAID, UNICEF and USAID.

With peace in 2006, the changing political climate, and with the development of the health SWAp, there was a progressive shift in implementation modalities from a focus on parallel 'project' support for service delivery, to moving towards support to strengthening and consolidating government systems to take on that role. As part of this process in 2007, UNICEF led a strategic program review of the NVAP.

In summary, while identifying the strengths of the program, the review concluded that:

*'In the past external partners had carried out many of these activities to a large extent, but with the maturation of the program, the role for stakeholders the MoHP should evolve to make the program better integrated into the overall health system.'*<sup>36</sup>(sic)

To support the process of transferring responsibility for service delivery more fully into government hands, AusAID transferred the funding it was giving to allow its programs to be implemented through UNICEF. This was for three primary reasons:

- a) UNICEF is an internationally regarded expert organisation in the technical areas, guaranteeing technical rigour.

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<sup>34</sup> Australia update for the evaluation of the implementation of the Paris Declaration Phase 2. AusAID. December 2010.

<sup>35</sup> NHSP-IP 2 states: *Sustaining community-based Integrated Management of Childhood Illness (CB-IMCI) in all districts and maintaining and further strengthening immunisation coverage remain high priorities. Further reductions in under-five and infant mortality will be accomplished by scaling up community-based newborn care and by implementing a more comprehensive nutrition program—a major focus of NHSP-2.*

<sup>36</sup> The National Nepal Vitamin A Programme. A strategic program review. UNICEF Nepal. Final Draft. Undated.

- b) UNICEF was following a program based on district level strengthening and service delivery, harmonised with GoN plans.
- c) UNICEF had access to the GoN and MoHP at the highest levels and was assessed as an appropriate agency to provide technical support in policy development and ensure priority of focus on these key issues as NHSP-IP 2 was developed.

This review was followed by strengthening of nutrition capacity within the DoHS, and development of national priorities for nutrition<sup>37</sup> supported by TA through UNICEF. To further support this policy development focus, for nutrition AusAID cofounded the SUNITA work with the World Bank, and with the Bill and Melinda Gates Foundation financed with UNICEF the work on the Investment case, a research-for-policy initiative looking at financing equitable progress in achieving MDGs 4 and 5.

The strategic approach was thus to tie the analytical work in with the district level work, and through UNICEF and World Bank leverage access at policy level to influence the content of NHSP-IP 2, which was then in preparation. This was the original strategy behind the Child Survival and Nutrition Initiatives and, in nutrition at least, seems to have had some success.

In 2009-2010, as part of that progressive shift to pool funding, DFID project support for safe motherhood transferred to the pool funding. UNICEF identified a continuing need for support in this area and requested AusAID provide stopgap support through UNICEF in this area during the transition. The SBA program is also a high priority of NHSP-IP 2<sup>38</sup>. This was the genesis of the Maternal Health support.

#### 4.2. The pool fund and aid effectiveness

A joint financing agreement was signed to formally begin pool funding in July 2004 between the GoN, the World Bank and DFID. Australia became the third pool partner in June 2009. Although AusAID financial contribution to the pool fund is smaller than that of the other two partners, AusAID is regarded as a valuable partner in the pool by the other partners. The partners value the contributions that AusAID staff bring to the regular meetings.

The balance between AusAID commitment to the pool fund (c AUD\$ 5.2 million per annum for 2011-2012) and support through UNICEF on the country projects (c AUD\$ 1.3 million per annum for 2011) is very roughly a ratio of 80 to 20, with the pool funding being planned to increase.

The fact that AusAID, as a pool funder, also passes funding through UNICEF is generally not seen as a problem by other EDPs, although government would prefer all EDPs to pool fund. NHSP-IP 2 states that:

*'Progress on the aid effectiveness agenda to which Nepal and EDPs have committed themselves through international agreements has been slow. Areas to be prioritised for faster progress in NHSP-2 are:*

- *More Ministry guidance on where non-pool EDPs should focus their support.*
- *Align EDP planning and approval cycles with the GoN budget cycle.*
- *Reduce transaction costs and rely on the SWAp planning and monitoring processes, minimise additional bilateral requirements, and conduct more joint missions, co-financing or "silent partner" arrangements.*
- *....'*

<sup>37</sup> Nepal Nutrition Situation and National Priorities. 2008-2010 Department of Health Services.

<sup>38</sup> *An ambitious SBA training strategy will be implemented, training 5,000 by 2012 reaching full coverage (7,000) by 2015. Birthing units will be added to SHPs. Safe abortion services will be extended in remote areas based on the 6-district pilot, including medical abortion. NHSP-IP 2*

### 4.3. Governance and reform

#### The constitution, decentralisation and districts

It was anticipated that a new constitution would be promulgated within the lifetime of the UNICEF implemented projects, clarifying issues of district level governance, service delivery and financing. This has not yet happened.

The Village Development Committee (VDC)/Municipality level and the District level are the key areas of institutional activity, while the other levels play secondary roles. Each ward and each village development area or town ought to have elected bodies – that is, a Ward Committee, a Village Council or a Municipal Council. The Local Self Governance Act (1999) forms the existing legal basis for local governance in Nepal and delegates responsibility for health units below hospitals to VDCs.

In 2002, the terms of office of the local bodies elected in 1998 expired, and no further election has been held since on that level. The local bodies thus became defunct. Due to the absence of elected Village Councils and VDC Chairmen, VDC secretaries have been serving as acting VDC Chairmen. Equally, Executive Officers in Municipalities and Local Development Officers at District level have been standing in for the Mayors and DDC Chairmen<sup>39</sup>.

So, for almost a decade, these bodies – District Development Committees (DDC), Municipalities, VDCs – have been virtually dysfunctional. They have been run by the government officials at the local level, which are usually over-burdened with other responsibilities. This has created a gap between plans at the national level, and programs and activities designed and implemented at the local level. The bottom-up planning process is almost defunct. It has also left a large amount of locally targeted budget unspent and unaccounted for<sup>40</sup>.

It is the MoHP view (NHSP-IP 2) that whatever form of federal system Nepal will adopt in its new constitution, the need for preparing the country's institutions for the transition to federalism has already arisen. Notably, the federal structure will affect every area of the health system, from planning to service delivery and overall health governance.

#### Health system strengthening

With the full support of partners, the MoHP is in the process of implementing a comprehensive strengthening of the health system to address capacity issues in a decentralised context. This is being supported with TA (see paragraph 4.7 below). In the absence of clarity on new district governance structures, the process has been a planned phased 'top-down' approach, starting in the MoHP and DoHS, followed by strengthening the Regional level. The plan is that strengthened Regional Offices will then be able to properly support the building of health service capacity at district level and oversee and support activities at districts and below.

At the central level, amongst other support, a Health Sector Reform Unit and a Health Economics and Financing Unit have been created within the Policy Planning and International Cooperation Division to support the reform process and a number of capacity assessments have been completed.

At the regional level, the Regional Directors are responsible for technical backstopping as well as program supervision. However, their role would more likely be promoted in the context of federalism. At the regional level, there are regional and zonal hospitals,

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<sup>39</sup> Local Self Governance. Nepal Participatory Constitution Building. Booklet Series No4. Centre for Constitutional Dialogue. Coordinated by the UNDP's Support to Participatory Constitution Building in Nepal project. Kathmandu. 2009.

<sup>40</sup> MDG Progress Report. Government of Nepal, National Planning Commission/ United Nations Country Team of Nepal. September 2010

which have been given decentralised authority through the formation of boards. In addition, there are Regional Training Centres (RTC), laboratories, tuberculosis (TB) centres (in some) and medical stores at the regional level.

At the district level, there are District/Public Health Offices to implement Essential Health Care Services (EHCS) packages. The offices monitor activities and outputs of Primary Health Care Centres (PHCC), health and sub-health posts.

While reform and capacity building has been ongoing at the central level for some time, it only got underway at regional level in 2011. Amongst other support, specific capacity building support is being provided through the Nepal Health Sector Support Programme and all regional support teams were in place by early August 2011. An important challenge is the lack of senior level staff in Regional Directorates who can act as effective counterparts to the NHSSP team. About 50 per cent of officer-level positions are vacant. This makes it difficult to develop capacity in the Regional Directorates to carry out their functions in the districts. A review of the structure and functions of the Regional Directorates is proposed<sup>41</sup>.

To summarise, it is difficult to find a more pithy description of the argument for providing key support at district level and below than that already quoted from the June 2010 UNICEF proposal for the Maternal Health support.

Thus, while the last sentence of the statement from the Maternal Health proposal, 'Over time it is hoped that the government capacity will be enhanced and will be able to manage on its own' (see sustainability), still has some relevance, there is now a plan in place to address this, supported by significant pooled EDP funding, for both TA and operating costs.

#### **4.4. Analysis of Technical Assistance through UNICEF**

While the tranches of support through UNICEF are AusAID projects, these are not pieces of support, which AusAID has agreed with government and then looked for the best implementer, but they are parts of the UNICEF Country Program, which UNICEF has agreed with GoN and then asked AusAID to fund. To assess alignment and harmonisation, it is therefore necessary to briefly consider the UNICEF programming process in more detail. This review found that the TA provided by UNICEF to MNCH policy, programming and implementation is largely in accordance with the Paris and Accra framework. UNICEF aim for:

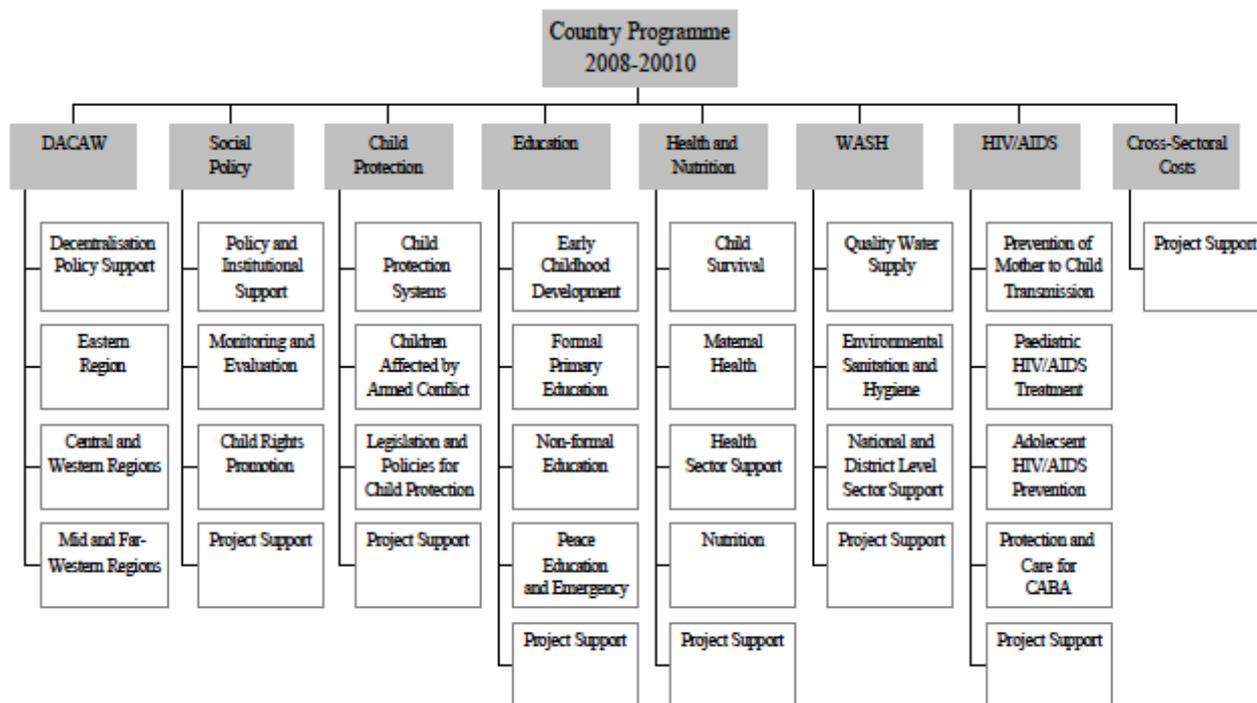
- Ownership of the TA by the MoHP through the government and district planning processes.
- Harmonisation through various MoHP thematic working groups and through parallel support to a single NHSP-II work plan and common results framework. Mutual assessment reviews are in place to assess project/program progress.
- Alignment by supporting the development of district level planning processes and by using the existing government district level financial mechanisms for funds disbursement.

The UNICEF program is part of the greater United Nations Development Assistance Framework, a program document between government and the UN Country Team that describes the collective actions and strategies of the UN to the achievement of national development. The UNICEF planning process is based on a multi-year Country Program and consists of eight programs and 34 projects. This program is agreed with the Ministry of Finance<sup>42</sup>.

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<sup>41</sup> The Nepal Health Sector Support Programme (NHSSP) Quarterly report for the period of July to September 2011.

<sup>42</sup> The overall UNICEF program is multisectoral.



The program and projects for 2008-2010 are shown in the diagram<sup>43</sup>. There are three intervention levels. The lower two levels inform the policy-level work:

- national-sector support and policy development
- district-level support to improve service delivery
- community mobilisation to enhance community knowledge and demand for quality services.

Within the DoHS, the Family Health Division is responsible for reproductive health care, including safe motherhood and neonatal health, family planning and FCHVs. The Child Health Division covers nutrition, IMCI, and Expanded Program on Immunisation (EPI), and while regional health officers report to the DoHS, district level health officials have responsibilities both to the DoHS and at district level.

While the UNICEF Health and Nutrition program is negotiated with the MoHP during the planning stage, the roles and contributions of UNICEF, the government and other partners in the implementation of this country program are specified in (UNICEF) Annual Work Plans. These are prepared in December each year (the fiscal year for the UN is 1 January – 31 December whereas for GoN is 16 July – 15 July) following the UNICEF annual program review, and approved by counterparts (for health the relevant parts of the MoHP) before implementation in January.

Thus, the AusAID support is split between different UNICEF projects with different counterpart linkages to government – both within health at central and regional level – and cross sectors and ministries at district and below. This increases transaction and management costs and makes oversight of the support more difficult for AusAID. It also makes it more complex (essentially impossible) for UNICEF to implement support *through* government, and UNICEF implements the support in a programmatic way *in support of* government. While the UNICEF support may be agreed at the planning stage with the MoHP, it is implemented through UNICEF work plans. This includes the AusAID funded components of the UNICEF projects.

<sup>43</sup> UNICEF Country Programme Action Plan 2008-2010.

The methodology used is to identify those activities in the workplan funded by AusAID and by appropriate coding, allow for expenditure against these activities to be reported back to AusAID<sup>44</sup>.

The AusAID projects under review contribute to an overall program, therefore attribution of individual achievements, or assessment of lost opportunities, is difficult to determine. This was flagged as an issue in the inception report. To attempt to address this issue the overall work plan and MoU with the government was requested from UNICEF; however, the review team was informed that the format of the workplan no longer includes the name of the individual donor. Therefore, it has only been possible to review UNICEF activities that AusAID contributed to rather than specific AusAID funded projects. Thus it is not possible to review or measure outputs of the AusAID projects alone.

To try and at least assess the quantum of AusAID financial support to the UNICEF program and the projects in which the AusAID support sits, UNICEF were asked for overall costs of the programs for financial year 2011. Similarly, this information was not forthcoming.

### **Field level operations**

UNICEF faces considerable challenges in their TA work. Unfilled government positions, frequent transfer of staff and inadequately trained personnel have led UNICEF, as well as other EDPs, to place local external staff within the government offices to undertake key functions. In order to help strengthen the managerial capacity of district level program managers, UNICEF district staff are embedded with the District Health Office structure, which gives them good access to all district health activities but also poses a danger of the DHOs becoming dependent on their additional inputs and funding.

TA differs from district to district based on need. For example in Dang District, UNICEF mobilised three technical advisors who are currently working with the District Health Office focal persons for Nutrition, Child Health, Immunisation and MNCH to collect data to support a new monitoring system. At the same time, the GoN Health Management Information System is being strengthened, and when complete the new supervision and monitoring system will be merged with the HMIS system and UNICEF technical advisor positions supported will be phased out. In Darchula, a technical advisor has been employed to support training, building the capacity of the district level supervisors and help recruit and support new staff; once sanctioned posts have been filled this position will be phased out.

### **Policy support**

UNICEF has been supporting government in piloting new interventions and brings the field experience for reformulation of the policy and guidelines during scale-up. These include CB-NCP, Misoprostol, and micro nutrient powders. In addition, UNICEF has been supporting government for the protocol review of CB-IMCI, development of the long-term action plan for immunisation and the Immunisation Act, which is in the process of being endorsed by the government.

UNICEF have also assisted in revisiting the road map for development of SBAs, including an update of the national SBA training package; implementation guidelines for Misoprostol; and the Remote Area Guidelines for equitable access to services for remote districts. They have also been active members in various technical committees, subcommittees and coordination bodies to focus and align interventions to the GoN Health Strategy.

The review section of this report concentrates on the achievements of the field level TA. A listing of TA provided by UNICEF to MNCH policy, programming and

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<sup>44</sup> See UNICEF project reports - Fund Utilization Report sections.

implementation is provided in Annex 5, with a listing of UNICEF district coverage at Annex 6.

#### **4.5. Cost effectiveness**

It is similarly not possible to make a judgement on the cost-effectiveness of the AusAID contribution without being able to view the totality of UNICEF program costs and the breakdown for the various activities, including management and overhead costs. Anecdotally both senior government officials and some EDP representatives indicated that UNICEF was a high-cost option. The only contribution to UNICEF management costs that is easily identified is the standard 7 per cent HQ overhead cost<sup>45</sup>. However, the projects do seem to be supporting UNICEF regional consultants, and part of their role is program implementation and financial management. Without further breakdown it is not possible to determine to what extent AusAID is contributing to UNICEF Nepal core costs, or what these are. Even with such a breakdown this may be very difficult.

However, this support through UNICEF may well have been the most cost effective means to deliver this support available at the time, as, at the time of project start-up, UNICEF was somewhat in a monopoly supplier position, given that the AusAID strategy was to implement through an agency with high technical credibility and with both access at policy, and at district and community levels. This AusAID strategy seems to have been successful in both facilitating roll-out on CB-IMCI and particularly in raising the profile of nutrition as a key issue in Nepal.

#### **4.6. Fiduciary considerations and risks**

UNICEF passes funds directly from UNICEF Kathmandu to district government held accounts, either the local government (District Development Committee) or to the DHO. There is a signed agreement with the GoN that allows funds to be administered this way. While there is general support at district level and within divisions for this funding approach, as this is seen as providing much needed additional funding for key activities, this approach is not supported at the highest levels within the DoHS and seems to run contrary to the general thrust of NHSP-IP 2, which lauds the reduction in separate district level accounts and the reduced transaction and reporting costs.

Funds are disbursed against a district workplan, with release approved by the appropriate UNICEF regional team. Disbursement is in advance, and expenditure must be acquitted before further advances are made. Acquittals are monitored by the Regional team and at district level audited by the district government finance teams with intermittent audits from the GoN central level. UNICEF also has in place an audit and 'spot check system' which helps minimise fiduciary risk.

While this is a developmentally sound disbursement approach – and to some extent mirrors the mode of disbursement of pool funds – there must be the possibility of increased risk in the disbursement of AusAID project funds through this methodology, if there is the expectation that an AusAID audit would be able to fully account for all expenditure (as for example would be required if a managing contractor were being used).

Given the expenditure is third hand (AusAID to UNICEF to districts) and given the size and complexity of the UNICEF program, it does not seem possible for AusAID country staff to monitor expenditure in any reasonable fashion, except by accepting UNICEF's reports. In other words, AusAID is relying on the robustness of the UNICEF internal program financial systems while UNICEF at least to an extent is relying on district government systems. The UNICEF disbursement and accounting process may not be best appropriate for AusAID project funds.

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<sup>45</sup> While this was particularly identified as a problem by one senior DoHS official, this per centage is actually low by commercial or other UN agency standards.

## 4.7. Other relevant TA

### NHSSP

The Nepal Health Sector Support Programme is a three-year (September 2010-August 2013) TA program contracted by DFID on behalf of the pool partners. The concept of NHSSP is a TA facility to support NHSP, but with one of the pool partners agreeing to handle the contracting of the TA (rather than the TA being funded from within the pooled monies). This is a standard model. Furthermore, the concept was while DFID would act as the lead contractor, that other EDPs would be able to contribute funding to and support the TA facility. Various similar models exist in other countries (cf Pakistan). At an early stage in planning AusAID discussed co-funding NHSSP, but due to procedural and timing issues this did not go forward.

The focus of NHSSP is to strengthen Nepal's health system by building sustainable local capacity to deliver essential health services and leadership. It also includes improving the effectiveness of aid to the health sector. One of the core areas of support is essential health care service, including maternal, neonatal and child health. Nutrition is not a specific focus. Support is being provided through a national and regional structure. This technical support facility is reasonably new to Nepal and there is still some confusion as to how it operates.

As part of the inception period capacity review facilitated by NHSSP TA, the regional teams were identified as in need of critical strengthening<sup>46</sup> and long-term TA was agreed. Three specialists, in EHCS, GESI and health systems strengthening were appointed to the Regional Offices in consultation with the Regional Directors. All of the NHSSP regional teams were in place by early August 2012. It is then the role of the Regional teams to lead on capacity building for the districts under their area supported by the NHSSP TA.

## 5. Summary of findings and analysis

### 5.1. Summary of findings

- The interventions selected for support were agreed by all as of the highest priority and remain so in NHSP-IP 2.
- In the post-conflict era, it was accepted that at least a degree of support to direct service provision was required at district level and design of support was coordinated with other EDPs.
- UNICEF was selected as implementing agent due to its strong comparative advantage in combining unrivalled technical capacity in the target interventions, ability to provide TA at the central level, along with access and influence at the policy level in the preparation period for NHSP-IP 2.
- The evidence base for NHSP-IP 2 was further strengthened by AusAID work in the Investment Case and the SUNITA with the World Bank.
- The projects as designed have been implemented in a satisfactory manner, and the expected results achieved.
  - The Child Survival and Nutrition Initiatives have contributed to the scaling-up of CB-IMCI interventions at a time when districts were struggling to implement these critical initiatives.

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<sup>46</sup> Regional Support. Capacity Assessment for Health Systems Strengthening. An assessment of capacity building for health systems strengthening and the delivery of the NHSP 2 results framework. NHSSP. 2011.

- The nutrition support has resulted in a scalable model, and more importantly the increased focus on nutrition has raised the profile of this issue such that it has become substantially better addressed in the NHSP-IP 2 period, not just within the MoHP, but with significant new multi-sectoral commitment and financial support.
- The Maternal Health support allowed the extension of SBA training and placement and strengthened maternal health care during a transition period from project support.
- While designed as separate projects the inputs have been delivered as part of the UNICEF country program. This has tended to imply a program approach, rather than a capacity building approach, and while support is harmonised, it is not aligned. Furthermore, this approach is not ideally suited to a 'funding the parts of the national health plan that are unfunded' approach, rather than a 'here is what we are working on, and it fits the national plan' approach. This approach by EDPs is identified as an ongoing issue in NHSP-IP 2.
- While support has been given to district teams, the main capacity building has tended to equate to skills training.
- The projects as such do not address the sustainability of the support, and the UNICEF program approach is not ideally suited to long-term capacity building across all sectors of essential health service delivery at the district and below levels in the health sector<sup>47</sup>. Nor is the UNICEF program approach ideally suited to address the HR, financial management and other constraints which form significant blockages to further progress, although has considerable additional strengths at the community level. An example of the lack of ability to address service issues more generally is seen most acutely in the Maternal Health support where, even though capacity was built in some areas and SBAs were trained and supported, other parts of the system remained non-functional. A summary of these is shown in Annex 4.
- While efficiency – particularly cost efficiency – has been questioned, given the strategies, which seem valid at that time, the only choice was UNICEF. And therefore, the only implementation methodology was through a section of the UNICEF country program, identified through AusAID project support. This has consequences for AusAID management of projects.
- The methodology of fund disbursement used by UNICEF, while developmentally sound, relies on the financial capacity of district management, which has been questioned by some.
- The MoHP has now in place substantial TA funded as part of pool funding, along with plans to build capacity from centre to region, and then to district and below. However, the nature of Federal Nepal is still in the balance, and little has been done to strengthen the districts per se as yet. Planning and financial management remain problematic.
- AusAID is a valued member of the pool fund.

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<sup>47</sup> Nor is it designed to do.

## 5.2. Analysis and value added

### CB-IMCI

The piloting of the CB-IMCI program had been completed by the time that AusAID support started, with AusAID support supporting 'roll-out'. It would seem that the value added of this component has been primarily in supporting service provision at district level, given that the capacity of the MoHP to take on these roles was limited at the time of project design. This support has been focused on 'UNICEF' districts.

What is less clear is the degree to which AusAID country support to CB-IMCI was able to leverage, along with the Investment Case work, the actual content of the interventions in this area in NHSP-IP 2, as the Investment Case data for Nepal was incomplete. While the initial plan was to complete the work in 2009 to enable the findings to inform the development of NHSP-IP 2, delays in the refinement of the methodology prevented direct influence in national planning<sup>48</sup>. However, the bottleneck discussions highlighted the potential of the analysis and highlighted nuances and constraints in the planning process. The initiatives planned in NHSP-IP 2 and those highlighted in the Investment Case work bear mainly congruencies, and it may well be that, even if not formally contributing to the NHSP-IP 2 planning process, that the involvement of UNICEF enabled the interim findings to be fed into the planning process.

Further district level support in this area seems likely to continue to be maintaining the current program rather than supporting any radical new initiatives as NHSP-IP 2 is implemented.

### Nutrition

What seems clearer is that the strategic focus on nutrition has been successful, in that over the period of the funding the GoN and EDPs have significantly increased the focus on nutrition interventions, and the multi-sectoral nature of the interventions needed has been recognised. The profile has been raised with EDPs and it is likely that appropriate future funding will be available. Within health, plans have been formalised for the strengthening of MoHP central capacity, with the MoHP gradually assuming full responsibility for the NVAP.

While it is difficult to quantify the contribution of AusAID to this, it would seem that being linked as a) a member of the pool fund, b) additionally to World Bank through SUNITA, and c) to UNICEF through its long-standing support for the Vitamin A program and the support of the district level nutrition interventions has positioned AusAID to be influential in the raised awareness of nutrition as a key issue.

### Maternal health

It is less easy to see the value added of the support to maternal health, as it seems that the interventions supported were only part of what is recognised as a much greater whole that must be in place to adequately address maternal health issues. While the support focused on the training of SBA, this was while considerable other constraints continued to be in play. These are described in some detail in Annex 4. While the project is described as 'gap filling', the gap filled seems to have been limited.

### UNICEF TA

The skill set of the TA is selected to provide technical support, not necessarily support in general or financial management and budget systems (see box in paragraph 3.6, Sustainability). While the TA is portrayed as being capacity building to the DHOs, the reality is that this is not its only function. While the TA supports the DHOs in work

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<sup>48</sup> Investment Case for Financing Equitable Progress towards MDGs 4 and 5. Scale-Up Report Executive Summary. August 2011.

planning and budgeting, this is centred on the UNICEF inputs. The TA has at least a part function of managing the UNICEF program.

The management of the UNICEF inputs also imposes some additional management costs on the government staff, in that separate work planning and financial reporting is required to satisfy UNICEF requirements.

### **Mode of support**

As has been detailed above, while the AusAID support has been two projects, UNICEF has implemented these as earmarked parts of their more general programs and projects. While this has had the benefit for AusAID of synergistic support from the other program activities, there are disadvantages to this:

- a) If the strategic intent was to leverage the support through UNICEF, then the project approach does not give maximal leverage as it restricts the AusAID engagement with UNICEF to a small number of outputs within the UNICEF program.
- b) Being restricted to only being legitimately interested in the project activities and not the rest of the program has meant difficulties in assessing the degree to which the AusAID projects are contributing to outputs, and also to core costs, or supporting other elements of the program, and makes formal review of the projects problematic.
- c) There is no easy or agreed way for AusAID staff to monitor the projects other than through the UNICEF reports and financial statements. There is no easy way to validate or cross check the reports. AusAID representatives do not seem to have been part of regular UNICEF program reviews, although it is envisioned in the UNICEF documents that EDPs will be part of reviews<sup>49</sup>. This may be as AusAID is only funding a part of the health program.

### **Fiduciary risk**

Given the way in which UNICEF accounts for expenditure AusAID may wish to consider if the methodology used is appropriate for AusAID project funding.

### **Cost effectiveness**

Given the information supplied by UNICEF it is not possible to make comments on the cost effectiveness of the support.

### **Sustainability**

While both project reports identify significant sustainability constraints, no attempt is made to address these within the project documentation.

### **Harmonisation and alignment**

While transferring funding from NTAG to UNICEF did achieve an element of increased harmonisation, it did not address the issue that is increasingly becoming a concern of Government of the coordination of TA, nor does it resolve the issue of AusAID being required to monitor its support to UNICEF outside the harmonised EDP/MoHP mechanisms which have been set up around the SWAp.

### **Value added**

The main value added by the AusAID projects seems to have been in the areas of nutrition, where AusAID's unique positioning as a pool funder, providing support at the district level, leverage with UNICEF and partnering in building the evidence base with UNICEF and World Bank through the Investment Case work and SUNITA is likely to

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<sup>49</sup> See: Country Programme Action Plan

have been effective. Nutrition has been afforded a much higher priority and funding in the next plan period.

## 6. Summary

The original strategic thinking behind the support was in essence:

- a) To provide support at district level in areas where AusAID had a historic association and which were critical to the attainment of MDGs 4 and 5 and during a period when government capacity at district level was weak in the post conflict period.
- b) To progressively move towards more harmonised support by implementing through UNICEF.
- c) To leverage support through UNICEF to support the development of NHSP-IP 2 to ensure that critical areas were addressed (this also included the SUNITA and there is now a MoHP plan in place to address this Investment Case support).
- d) To help bridge gaps and smooth the transition as other EDPs transferred support from district level to the pool fund.

These goals seem to have been essentially achieved and the strategy successful.

### a) Ongoing support to service provision

While this support was judged justified in the post-conflict period, the main trade-off was in the cost-effectiveness of the approach taken, but more so in the area of sustainability. Without inferring the approach of the UNICEF program the issue of sustainability of the inputs is ignored. Even inferring the UNICEF approach there have to be questions around the program approach implemented through UNICEF workplans. Support through UNICEF is not likely (given experience in countries with more long-standing SWAs) to ever be aligned with the MoHP systems, even if harmonisation is attempted.

Now that the issues around the NVAP and nutrition generally are being resolved and addressed, it seem less likely that AusAID funding to the UNICEF program will be critical to its success. Additional support has been built in the MoHP (with support from UNICEF) to manage nutrition initiatives in health.

### b) District level capacity building

There continues to be significant capacity weakness at the district level and below. The major issues are around creating a functioning health system rather than weaknesses in any one technical area. The review of the support in Maternal Health highlights this. There is now a rational MoHP plan in place to address this capacity issue through a phased approach in NHSP-IP 2, supported by significant TA through NHSSP.

This seems to be a more appropriate and sustainable approach to capacity building at district level.

### c) Leveraging support through UNICEF

While this seems to have been effective in the field of nutrition, there is limited evidence of its success elsewhere. Nutrition now seems to be adequately addressed for the next plan period.

By funding through a project approach AusAID have not taken advantage of its funding for UNICEF to attempt to influence the wider UNICEF program – in fact it seems to have been only involved in the discrete program areas of AusAID funding. There has possibly been a missed opportunity to engage in greater involvement with UNICEF over the wider country health program.

That being said, the management costs of that approach are substantial and it is accepted that AusAID post is not appropriately staffed to have undertaken this role.

#### **d) Bridging gaps – maternal health**

While of value, there is less evidence that AusAID support in this area has given significant added value, or that in the absence of AusAID support that these activities would not have taken place, albeit at a slower pace. The main problem in the maternal health support has been the unaddressed systems constraints.

## **7. The way forward**

AusAID is in the position of being committed both to the support of quality critical service provision and to progressively supporting this through program approaches. It is a member of the pool fund, and at present a direct funder of district activities (through UNICEF). Whilst purists might say that there is some conflict in this position, this is actually a natural situation for AusAID to find itself in, given that its support is placed in an evolving country situation. The analysis is that AusAID support is not defined by a set of absolutes, but a question of timing and phasing, with trade-off between the various approaches.

### **AusAID value added and comparative advantage**

1. AusAID is a valued member of the pool fund and its technical support is respected.
2. AusAID's value added at the moment is that it is both a pool donor, and has access and experience of the practical problems at district level – albeit in a limited way. This informs the policy debate within the pool donors. There is some value in retaining this.
3. The value added of the UNICEF relationship has been strengthened at the HQ level as Australia has more actively engaged with UNICEF on the international level. Similarly, it has been strengthened at regional level by the work through the investment case. However, of late this has weakened at the country level as AusAID staff have had conflicting demands on their time, as the pool funding has increasingly become the major method of support. If this is to be revitalised significant additional management and technical time and resources will need to be allocated to this.

## **8. Recommendations**

1. The district level and below is going to remain the key area for service delivery and access, especially for those most inaccessible and disadvantaged areas.

**It is recommended that AusAID continue to focus at least some of its support on capacity building at the district level and below.**

2. The main focus of effort in NHSP-IP 2 is going to be around capacity building at this level, and the efforts are going to be in building overall capacity. To properly take forward the successes to date in achieving MDG 4 and 5, and particularly MDG 5, requires more holistic support to the health sector.

**It is recommended that in future AusAID focus on broader support to the health sector at district level rather than on focused support as in the past.**

3. The primary route to achieve this is the planned capacity building support being implemented through NHSSP. This has a sustainable basis.

**It is recommended that AusAID reopen negotiations with MoHP and pool partners to explore options for contributing funding to the support of NHSSP.**

**All these three recommendations should contribute to the longer term sustainability of AusAID's support and address the concerns raised in the report.**

4. While there are arguments against 'putting all ones eggs in one basket' given the continuing fragile nature of political development in Nepal it is likely that pool funding and sectoral support will, increasingly over time and in the long term, become the primary method of support. AusAID should strategically consider if its knowledge of district level problems is of significant value to its role in supporting the pool funders and consider the value of continuing support through UNICEF. AusAID will also need to review its managerial and technical capacity in this decision.

**It is recommended that if AusAID decides to continue support through UNICEF that it take a 'whole of health program' funding approach. This means supporting UNICEF's Nepal program as a whole, and not individual components. In effect this would be providing general budgetary support to UNICEF in Nepal. This will increase leverage with UNICEF, but will have significant resource implications for AusAID to ensure value added engagement.**

**However, if this approach is taken it could be provided to UNICEF on the basis that UNICEF contributes this money to the pool funding. This would bring in UNICEF as a full partner and ensure its engagement at a strategic level.**

DFID have developed program funding instruments based on their HQ level agreements with UNICEF for funding country programs from the bilateral program, and if such instruments are not presently available within AusAID, would be likely to share examples with AusAID. This would also address some of the fiduciary concerns, which might be raised by a project funding methodology.

## Annex 1: Terms of Reference

### **Terms of Reference for an Independent Review of two AusAID funded UNICEF Projects on Child Survival and Nutrition, and Maternal Health in Nepal**

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#### **1. Introduction**

AusAID is seeking to appoint an international and a local consultant to conduct an Independent Review of two AusAID funded UNICEF projects in Nepal specifically:-

- Child Survival and Nutrition Initiatives, phase I and II; and
- Communities as Change Agents: Providing Maternal Health Services to the Disadvantaged; and

The review will also look at the contribution of this UNICEF technical assistance to MNCH policy and programming in Nepal.

It will be a short term (28 days) contract for the specified scope of work outlined in section 4 of this document. The review will help inform the development of a four year delivery strategy for the AusAID health portfolio in Nepal, including the future positioning of the Nepal Program vis-a-vis MNCH Technical Assistance to the health sector in Nepal. It will also broadly inform a future joint development partner technical assistance component to the Nepal Health Sector Program (NHSP) Phase 2.

#### **2. Background on the AusAID funded UNICEF projects**

##### 1. Child Survival and Nutrition Initiatives, phase I and II

AusAID has provided AUD 1.6 million to UNICEF for implementation of two phases of Child Survival and Nutrition Initiatives in Nepal. Phase I activity commenced in May 2009 and Phase II ended in June 2011. The overall objective was to contribute to provide children increased access and opportunities to utilise high-quality, high-impact child and newborn health and nutrition interventions and practices contributing to improved child survival and development.

The project sub-objectives were as follows:

##### Health:

- Support the maintenance of quality CB-IMCI program at district and national level
- Continue the pilot of CB-NCP in three districts, and achieve a sustainable increase in the adoption of healthy newborn care practices and a reduction in prevailing harmful practices.
- Strengthen the quality of promotive, preventive and curative newborn health services from the community level to health facility level.
- Provide technical support on planning, monitoring and analysis of the CB-IMCI program as well as the CB-NCP.

##### Nutrition:

- Support promotional and social mobilisation activities for the biannual vitamin A distribution, with special emphasis on increasing coverage of children aged 6–11 months and in municipal areas

- Expand community-based promotion of IYCF package linked with Sprinkles supplementation
- Expand national communication initiative to promote key breastfeeding practices.
- Provide technical and coordination support to the government to conduct national advocacy and system-building activities.

## 2. Communities as Change Agents: Providing Maternal Health Services to Disadvantaged'

AusAID has provided AUD 1 million to UNICEF for implementation of 'Communities as Change Agents: Providing Maternal Health Services to the Disadvantaged'. The project commenced in June 2010 and will conclude in December 2011. The overall objective is to contribute toward further reduction of maternal mortality by expanding coverage of high evidence based maternal health services and initiating new innovative approaches in 5 districts.

The sub-objectives of the project are as follows:

- Reduction of maternal mortality through increased access to skilled birth attendant at birth, increased uterotonic coverage for prevention of post partum haemorrhage at birth and increased access to quality maternal health services.
- Strengthening the continuum of care from community to the service site, through increasing knowledge and awareness of the pregnant women and her family and creating demand at the community.
- Strengthening of referral system for emergency obstetric care service in the district
- Capacity building of service providers and strengthening of the government health system.

In addition, the project's technical assistance focuses on capacity building of the District Health Officers (DHOs) and their teams, especially in the planning, supervision monitoring and reporting of the government's maternal and newborn health (MNH) program.

### ***3. Background on other components of the AusAID health portfolio***

#### Nepal Health Sector Program (NHSP) Phase I and II

The Government of Nepal and donors commenced a health sector wide approach in 2004 to support implementation of the NHSP. Since 2009 AusAID has channelled its funding for the NHSP through the pooled funding mechanism. The World Bank has fiduciary management responsibility on behalf of the pooling donors. AusAID is an active partner in the government and development partner coordination processes. This assistance through the government system is in accordance with Australia's commitment to the International Health Partnership (IHP), and with Nepal being an IHP country. The IHP is aimed at accelerating progress towards achievement of health MDGs through improved donor coordination and country activities, and a robust national health plan. Australia has provided AUD 6 million to NHSP Phase I and has committed AUD 26 million for the phase II program (2010-2015) with AUD 5.2 million disbursed to date.

#### Scaling up Nutrition in Nepal (SUNITA)

AusAID has recently partnered with the World Bank in a 3 year project (2011-2013) to enable the Government of Nepal to design targeted and integrated action to address

malnutrition. The project is providing support in the form of analytical work and evaluations of nutrition interventions. The AusAID contribution of AUD 2.788 million is channelled through a multi-donor trust fund.

### Investment Case

AusAID has partnered with the Bill and Melinda Gates Foundation to finance the work on Investment case (IC), a research-for-policy initiative looking at financing equitable progress in achieving the Millennium Development Goals (MDGs) 4 & 5. Nepal is a beneficiary of this initiative which aims to provide policymakers and development partners with the best available evidence for an equitable scaling-up of priority interventions that addresses the burden of Maternal, Newborn, and Child mortality.

In its current phase the IC initiative will support the strengthening of district level planning in 10 districts of Nepal with particular reference to MNCH cost analysis and budgeting. In its previous two phases, phase 1 included the mapping of policy documents, analytical work, and datasets relevant to MNCH, as well as the identification of gaps in information or data availability for analysis. Phase 2 activities involved the equity analysis, which examined the equitable distribution of MNCH indicators; and the scaling-up analysis, which examined the scaling-up strategies, associated costs and impact. The Nossal Institute for Global Health and the University of Queensland are responsible for the implementation of the Investment Case in close collaboration with UNICEF and the Department of Health Services (DoHS) of the Government of Nepal.

## **4. Objective of the independent review**

The objective of the independent review is to:

- Assess if the two AusAID funded UNICEF projects achieved (or are on track for achieving) their objectives and to assess their value add (of their project technical assistance) towards achievement of key results in Maternal Newborn and Child Health (MNCH) in Nepal.
- Assess the contribution of UNICEF technical assistance to MNCH programming and policy in Nepal.

The review will look at the suggested criterion of **relevance, effectiveness, efficiency, analysis, learning** and **sustainability** of the projects. A list of possible evaluation (review) questions and criterion can be referred to in Annex II of this TOR.

The review will also analyse the UNICEF technical assistance to maternal and child health policy, programming and implementation considering the same criterion and in line with the Paris and Accra frameworks for its harmonisation and alignment with other existing MNCH technical assistance and the Government of Nepal's Health Sector Program (NHSP).

The review will assess the sustainability and value add of the two UNICEF projects, as parallel assistance to the NHSP, in assisting the GoN to deliver its MNCH and nutrition programs and services, and if any policy uptake has occurred. The review will assess if stakeholders have sufficient ownership of the project's benefits, and sufficient capacity and resources to continue the work after the AusAID assistance ceases. The review would note if any technical assistance gaps (not being addressed by other development partners) remain and the nature of these. For example if these are health system issues that can only be resolved by government and/or if they would benefit from further targeted assistance, for what period, and if a particular agency or existing technical assistance mechanism is best placed to assist and the donor funding.

## **5. Scope of Work**

The consultants will undertake a desk based and in-country independent review of the 2 UNICEF projects for AusAID.

Sharing of the consultants preliminary findings will take place with AusAID and UNICEF. At the end of the in-country work, the consultants will separately debrief AusAID on any sensitive findings and recommendations that may be important for a future AusAID health strategy.

Specifically the consultants will:

- Review with reference to NHSP II the key project documents including the original proposals, reports from UNICEF and the annual AusAID Quality at Implementation reports.
- Review with reference to NHSP II related technical assistance reports and assessments on MNCH in Nepal.
- Undertake an in-country visit including interviews with stakeholders and a field visit to assess the project achievements and its value addition.
- Meet with key stakeholders [UNICEF, Child Health Division, FHD, District Health Office (DHO) section, the Nepal Health Sector Support Program (NHSSP), the Nepal Family Health Program (NFHP)], and other partners and donors. The field visit may be at district and facility level and would meet with beneficiaries including DHO staff, Female Community Health Volunteers, and community people (women groups).
- Present preliminary findings to AusAID and UNICEF, and a separate debriefing session with AusAID team in Kathmandu at the conclusion of the in-country work.
- Produce a final report of about 15 pages with recommendations for AusAID and UNICEF.

### **Deliverables**

1. An inception report detailing the review methodology, data collection instruments, work plan and division of work between the two consultants to be presented and finalised prior to commencing the review work.
2. A brief presentation on the preliminary findings to be done in-country upon completion of the field visits. This would outline UNICEF's role in providing project technical assistance, the achievements and value addition, and remaining technical assistance gaps (which are not being covered by other development partners).
3. A 15 page (approximately) report with clear analysis of the project achievements against the objectives and their value addition, and recommendations for AusAID to inform its delivery strategy especially for future technical assistance in MNCH to the health sector in Nepal. The report should address the suggested criterion of relevance, effectiveness, efficiency, analysis, learning and sustainability. The report may include sections on sensitive findings for internal use only, and modified section for public sharing.

## ***Duration and Phasing***

<b>Milestones</b>	<b>Details</b>	<b>Maximum no. of days</b>		<b>Dates</b>
		<b>Team Leader</b>	<b>Team Member</b>	
Review of the key documents	- Review of key documents -Preparation of in-country mission	3 days	3 days	26 –28 <sup>th</sup> Oct
Preparation of an inception report	Detailing evaluation (review) methodology and data collection instruments such as interview schedules, challenges/limitation and measures to address the limitation. Division of work between two consultants.	2 days	1 day	2 <sup>nd</sup> Nov
In country mission	- Field visit to 2-3 districts - Interviews with key stakeholders at national and district (field) level. - Preliminary findings sharing with AusAID and UNICEF (may include the NHSSP and NFHP) -Debriefing to AusAID only team	14 days (including Travel)	12 days	7-18 <sup>th</sup> Nov
Report writing	Consolidation of findings and submission of draft report	7 days	5 days	2 <sup>nd</sup> Dec
Finalisation of report	Feedback and revision as required	2 days	1 days (if required)	23 <sup>rd</sup> Dec
<b>Total</b>		<b>28</b>	<b>22</b>	

### ***1. Conduct of Consultancy***

There will be two consultants (one international and one national), who will work as a team. AusAID representatives will be involved during planning of evaluation and preparations. The consultants will be primarily responsible for the review and production of the final review report. The division of work between two consultants can be negotiated and outlined in the evaluation plan by consultants.

### ***2. Reporting and Liaison***

The consultant will report to Latika Pradhan, Program Manager, Kathmandu who will be responsible to manage the review work and coordinate the in-country mission. Joanne Greenfield (Health Adviser, AusAID) will provide technical oversight in review process.

### ***3. Specifications of the consultants***

- The consultants should have relevant experience on MNCH and nutrition programs and services with exposure to working in this field in developing country settings.
- Knowledge in the delivery of health services and programs with a mixture of expertise in monitoring and evaluation, health systems, human resources for health and capacity development in a developing country context.

- Familiarity with the current agenda of aid effectiveness, development modalities and issues including sector wide approaches, Millennium Development Goals, Accra and Paris declarations, donor harmonisation and the 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 I

Key documents that will be made available for the Review:

1. UNICEF projects proposals on “Child Survival and Nutrition Initiative” phases I and II and ‘Communities as Change Agents: Providing Maternal Health Services to the Disadvantaged.
2. UNICEF submitted donor reports.
3. Nepal Health Sector Program - Implementation Plan II (2010-2015).
4. National Safe Motherhood and Newborn Health Long Term Plan (2006-2017).
5. Remote Area Guideline (2009).
6. Reproductive Health technical assistance matrix (development partners mapping).
7. DFID’s paper on the MNH effort.
8. Evaluation of DFID support to NHSP 1 (the Support to Safe Motherhood Program), 2010.
9. Capacity Assessment of Health Systems by NHSSP (Essential Health Care Services), 2010.
10. Relevant policy and program documents on community based IMCI and the community based newborn care program.
11. Family Health Division, and Child Health Division Annual Work Plan and Budget.

## Annex II

### ***List of specific evaluation/questions along set indicators for consideration***

#### Relevance:

- Are the objectives relevant to Australian Government and partner government priorities?
- Were the objectives relevant to the context/needs of beneficiaries?
- If not, what changes should have been made to the activity??
- Was the implementation approach suitable to a highly harmonised aid environment? To what extent were the projects harmonised and aligned with government priorities and systems?

#### Effectiveness:

- Were the objectives set out in the proposal achieved? If not, why?
- To what extent did the activity contribute to achievement of objectives?
- Are the interventions evidenced based?
- Are the TA activities aligned with Government's MNCH program and harmonised or compliments other existing Technical Assistance on MNCH?? Or is it duplicating efforts?

#### Efficiency:

- Did the implementation of the activity make effective use of time and resources to achieve the outcomes?
- Are there any risks associated with the project- fiduciary or development risks?

#### Sub-questions:

- Has management of the activity been responsive to changing needs?
- Did the activity suffer from delays in implementation? If so, why and what was done about it?
- Did the activity have sufficient and appropriate staffing resources?
- What were the risks to achievement of objectives? Were the risks managed appropriately?

#### Impact (if feasible)

- Did the activity produce intended or unintended changes in the lives of beneficiaries and their environment, directly or indirectly? Did the activity /lessons learnt from the activity feed into government / partner policy?

#### Sustainability:

- Do beneficiaries and/or partner country stakeholders have sufficient ownership, capacity and resources to maintain the activity outcomes after Australian Government funding has ceased?
- Has the TA helped build sufficient government capacity to take on the work??
- Has the TA been helpful in strengthening the government system – especially in delivery of services at below district level.

- Are there any areas of the activity that are clearly not sustainable? What lessons can be learned from this?
- Are there are other Donor partners who are willing and rightly placed to fill in the gap should AusAID withdraw??

Gender Equality:

- What were the outcomes of the activity for women and men, boys and girls?

Sub-questions:

- Did the activity promote more equal access by women and men to the benefits of the activity, and more broadly to resources, services and skills?
- Did the activity promote equality of decision-making between women and men?( specially on demand creation bit)
- Did the initiative help to develop capacity (donors, partner government, civil society, and so on) to understand and promote gender equality?

Monitoring and Evaluation:

- Does evidence exist to show that objectives have been achieved?

Lessons:

- What lessons from the activity can be applied to future technical assistance in Health Sector?? (Delivery strategy, program/designing future activities).

## Annex 2: Meeting schedule and people met

Time	Meetings	Location	Notes and People Met
<b>Phase 1</b>			
<b>7 November 2011</b>			
1255hrs	Jennifer arrives from TG 320		
1430-1530	Brief AusAID team meeting with the consultants to discuss Independent review	AusAID office, Australian Embassy, Bansbari	Country Manager, 2 Program Managers, First Secretary
1630-1730	Meet with World Bank (Dr Bert)	World Bank office, Yak and Yeti	Albertus (Bert) Voetberg – Lead Health specialist
<b>8 November 2011</b>			
0830 - 1230	Meeting with UNICEF team to discuss the Independent Review	UNICEF office	Dr Asha Thapa Pun (MNH) Chahana Singh (Rana) Health and Nutrition Dr Sudhir Khanal Child Health and Survival
1400-1500	Meeting with NHSSP and DFID	DFID Office, Ekantakuna	Dr Amit Bhandari and three NHSSP local health advisors
1500hrs	Depart for Airport and fly 1630 Buddha Air flight to Nepalgunj		
<b>9 November 2011</b>			
800 hrs	Drove to Dang (3 hours)	Gadawa Health Post in Gadawa VDC	Local facilitator Rajesh Magar
1400 hrs	Drove to Gangaparaspur VDC	Tharu village	Brief by health in-charge, Observed the demonstration FCHV) on their learning from CBNCP/IMCI program Interacted with the FCHV, mother and children who benefited from the CBNCP, EOC (Emergency Obstetric Care fund)
1700 hours	Dang DPHO	District Public Health Hospital, Dang	Mr Keshav Pandit, chief, and team at the DPHO
<b>10 November 2011</b>			
0800	Day spent driving from Dang towards Darchula, overnight at Doti district, Hotel Pipal Chautarii in Budar	On highway towards Darchula	Met with Dr Asha Pun who joined at Dhangadhi

Time	Meetings	Location	Notes and People Met
<b>11 November 2011</b>			
0700	Primary Health Care Centre of Gokuleshwor VDC to	Left Budar for Gokuleshwor VDC, Darchula	PHCC In-charge: Ganesh Singh Bohara, Chairperson and members of health facility management committee of the PHCC Observed health facilities and MNH services of PHCC /BEOC centre <ul style="list-style-type: none"> <li>ANC/PNC service</li> <li>FP service</li> <li>Immunisation/subcentre</li> </ul> Brief by PHCC in charge in about the change made for women and children health Interaction with MNH service provider, health management committee members Observe/Monitor IMCI/EPI/MNH activities
	Gokuleshwor VDC	Primary Health Care Centre of	Met Dr Amrit Pokharel, District Public Health Officer, DPHN (Mrs Gomati Mahara) and IMCI focal person Mr Narendra Raj Joshi
<b>12 November 2011</b>			
	Meeting at the health facility	Dethala Health Post	HP In-charge (Mr Lokendra B Chand), the birth attendant (ANM) Mrs Urmila Humli at the birthing centre, members of the health facility management committee, and the community, women who had used the birthing centre
	Overnight at Dadeldhura		
<b>13 November 2011</b>			
0700	Travel from Dadeldhura to Dhangadi		
1400h	Depart from Dhangadi to Ktm		Arrived Kathmandu 4.30pm
<b>14 November 2011</b>			
	Working at Hotel	Worked on report	Trying to get appointments with MoHP
<b>15 November 2011</b>			
1000	Meeting with AusAID team on (update and discuss any key issues)	AusAID office	Country Manager, 2 Program Managers, First Secretary
	Preparation		

Time	Meetings	Location	Notes and People Met
<b>16 November 2011</b>			
	Meeting with Family Health Division (Dr Naresh KC)	Department of Health Services (DoHS) Teku	Not available
	Meeting with Child Health Division (CHD)	Department of Health Services (DoHS) Teku	Not available
18.00-20.00	Meeting with IMCI Chief	WHO Conference	Dr Parashu Ram Shrestha
<b>17 November 2011</b>			
0900-1030	Meeting with USAID and NFHP team	USAID office, Maharajgunj	Ms Anne M Peniston (USAID) and team members from Office of Health and family planning
1100-1130	Meeting with UNFPA (cancelled)	UNFPA office, Sanepa	
1140-1230	Meeting with WHO team	WHO office, Pulchowk UN house	Dr Kishori Mahat; National Program Officers
	Meeting with Family Health Division (Dr Naresh KC)	Department of Health Services (DoHS) Teku	Not Available
<b>18 November 2011</b>			
0830-0900	Debriefing with AusAID	AusAID office	Country Manager, 2 Program Managers, First Secretary
0900-1030	Consultants to de-brief AusAID and UNICEF team on the findings of the IR	AusAID office	5 UNICEF Staff
1130-12.30	Meeting with UNFPA	UNFPA office, Sanepa	UNICEF Rep and Geeta
13.00-14.00	Meeting with Family Health Division	Department of Health Services (DoHS) Teku	Dr Shilu Aryal
<b>19 November 2011</b>			
	Working at Hotel	AusAID office	Latika
<b>20 November 2011</b>			
12.00-13.00	Meeting with Child Health Division	Department of Health Services (DoHS) Teku	Dr Shyam Raj Upreti Director
13.00-14.00	Meeting with Family Health Division	Department of Health Services (DoHS) Teku	Dr Naresh Pratap KC Director

Time	Meetings	Location	Notes and People Met
14:00-15:00	Meeting with Nutrition Section, CHD	Department of Health Services (DoHS) Teku	Mr Raj Kumar Pokharel Chief
<b>21 November 2011</b>			
09:00-10:30	Meeting with AusAID	AusAID office	Country Manager, 2 Program Managers
<b>Phase 2</b>			
<b>16th January 2012.</b>			
12:45-14:30	Briefing AusAID	Solatee Hotel	Ben Reese, Tara Gurung, Latika Pradhan, Jill Bell
<b>20 January 2012</b>			
14:30-15:00	Meeting DG DoHS	DoHS Teku	Director General, Department of Health Services (Dr Y V Pradhan) .Briefing on key issues.
<b>23 January 2012</b>			
13:30-16:00	NHSSP	NHSSP Office MoHP	Nancy Gerein, Team Leader. Briefings on NHSSP and Nepal situation.
<b>27 January 2012</b>			
15:00	Follow-up and further briefing on projects AusAID	AusAID office	Tara Gurung Latika Pradhan,
<b>30 January 2012</b>			
11:00-12:30	UNICEF	UN House.	Discussions on the projects and UNICEF program. Dr Asha Pun. Dr Bahadur Buda. MNH Consultant (Regional Mid and Far West) Nepalgang
<b>31 January 2012</b>			
16:00	DFID		Matt Gordon Natasha Mesko

## Annex 3: Progress of Maternal Health project against logical framework Indicators

### Communities as Change Agents: Providing Maternal Services for the Disadvantaged Progress against Logical framework

Goal/Strategic result	Output	Target	Status and Progress	Budget Notes
<b>Creating an enabling environment for skilled birth attendance</b>				
Ensures increase in access to SBA and EOC service to reduce maternal and neonatal mortality due to complications	Enabling environment created at the Birthing centres/BEOC sites for the SBAs to efficiently provide EOC services	3 of PHCCs provide BEOC services and 7 of HPs and 25 SHPs function as birthing centres.  Micro planning of birthing centres using AI approach in 35 sites	<b>STATUS: ONGOING</b> <b>TARGETS: ON TRACK</b>  Support provided for establishing/strengthening new and old BEOC to 35 sites in 5 districts. Support included Needs assessment of service sites Upgrading facilities, monitoring and supervision Review & planning workshop through AI approach at the HF level and support for break through team Provide Technical support to 3 MNH Districts <b>Micro planning of birth centres 50 per cent complete</b>	Total Budget \$135,000 \$100,000 was on TA
<b>Increase access to skilled birth attendant at birth</b>				
Ensures increase in access to SBA and EOC service to reduce maternal and neonatal mortality due to complications	Pregnant women from the 5 districts have access to skilled birth attendant at birth.	10 SBA trained per district to ensure 60 per cent of the birthing centres have at least one SBA providing service. Increase of deliveries taking place at health facilities 90 per cent of ANMs, ( participant number 200 service providers) MCHWs and Nurses of birthing	<b>STATUS: COMPLETED</b> <b>TARGETS: ACHIEVED</b>  Support for SBA training (50 SBAs) MNH Update workshops for service providers as per target in 5 Districts	Total Budget \$55,000 \$35,000 on SBA Training \$20,000 MNH workshops

Goal/Strategic result	Output	Target	Status and Progress	Budget Notes
		centres receive the MH updates		
<b>Increase access to quality EOC services</b>				
Increase access to quality EOC service	Pregnant women of the 5 districts have access to quality 24 hour delivery services	About 35 health facilities (BEOC and birthing sites) will receive basic equipment and instruments for conducting normal deliveries.  Whole site IP training in 35 sites	<b>STATUS: COMPLETED</b> <b>TARGETS: ACHIEVED</b>  Supply equipments and instruments, minor renovation for CEOC, BEOC and birthing sites. Total number of facilities that have benefited = 40 Sites across 5 districts  Whole site infection prevention training for newly established birthing centres in 35 sites	Total Expenditure \$60,000 \$40,000 equipment and instruments Infection Prevention Training \$20,000
<b>Create community awareness and increase demand for quality EOC services</b>				
Strengthening the continuum of care from community to the service site, through increasing knowledge and awareness of the pregnant women and her family and creating demand at the community	Community are encouraging pregnant women for institutional delivery and are accessing the free delivery services and utilising the transport incentives.	35 birthing centres benefit (Achham and Humla districts) (1250 FCHVs+village facilitators, HW 150) 50 participants attend workshop 315 watch group formed, 315 EOC fund established	<b>STATUS: ONGOING</b> <b>TARGETS: ON TRACK</b>  Orientation on AAMA Program and social auditing Update FCHVs on Health issues using adult learning approach and capacitate them to successfully conduct health education and knowledge transfer <b>is ongoing – have requested at 5 month no cost extension to cover this</b>  Workshop with key stakeholders to discuss the major issues concerning FCHVs and way forward <b>will be complete at the end of the month</b>	Total Expenditure \$280,000 35,000 Orientation AAMA Program \$190,000 update of FCHVs \$10,000 Workshop for key stakeholders \$30,000 scaling up watch groups \$15,000 inter/intra district observational visits

Goal/Strategic result	Output	Target	Status and Progress	Budget Notes
			Establishment of watch groups, establish EOC funds	
<b>Strengthen functional referral system</b>				
Strengthening of referral system for emergency obstetric care service in the district and increase access to quality care	Pregnant women with complications are timely referred for proper management of the complication	Functional referral system in 5 districts  100 sets of CDMA used effectively	<b>STATUS: ONGOING</b> <b>TARGETS: ON TRACK</b>  Coordination workshop between peripheral sites and referral sites to <b>be completed at end of month</b>  Supply of CDMA SIM card and mobiles to every birthing centres as a means to communicate and coordinate with the referral site	Total Expenditure 25,000 \$5,000 on coordination workshop \$20,000 on CDMA SIM card and mobile
<b>Implementation of Remote Area Guidelines</b>				
Reduction of maternal mortality through increased access to uterotonic coverage for prevention of post partum haemorrhage at birth.	Community will understand the importance of using SBA at birth, birth preparedness and identification of danger signs and able to timely refer. More women will have uterotonic coverage.	2436 FCHVs, 174 MCHWs, 231 VHWs and 400 HWs	<b>STATUS: COMPLETED</b> <b>TARGETS: ACHIEVED</b>  All level of health workers and FCHVs trained in revised BPP, Prevention of post partum haemorrhage at home birth with Misoprostol as part of the national program	Total Expenditure 235,500
				\$790,000.00 (Program Total) \$139,500 (technical Support) \$HQ Recovery 7 per cent of costs Grand Total \$1,000.00

## **Annex 4: Challenges and gaps for the delivery of MNCH services in Nepal**

### ***Quality of services***

Many projects activities are scaled up without being adequately reviewed or assessed to see how they integrate with other programs and into the health system. Rapid scale-up and lack of supportive monitoring and supervision of project activities at the community level have resulted in decreased program quality, this is a big challenge for the government and partners, and requires the continued combined efforts of the Government and partners to work more vigorously on supporting poor performing districts.

### ***Lack of skilled human resources***

Although there has been some improvement in human resources, it still continues to be a challenge for the scaling up of MNCH services at all levels of service delivery. Reasons behind the shortage of human resources include the inadequate number of sanctioned posts given the caseload, a large number of unfilled positions, and the lack of transparency in deployment and transfer decisions. Recent efforts for creating demand as well as conditional cash transfer for service utilisation has increased access to services while strengthening of services to address the demands has seriously lagged behind. There is lack of specialist positions at district hospitals to provide appropriate care to the patients with obstetric complications who are referred from the peripheral birthing centres. Lack of skilled human resources (doctors and nurses) in the government system is a severe constraint to the fulfilment of MNCH needs. Even when the VDC is ready to finance Auxiliary Nurse-Midwives (ANM) with its own funds, it is difficult to find skilled local SBAs for hiring.

### ***Retention and recruitments of health workers***

Retention of health workers in the remote districts is a challenge for want of an enabling environment. This is particularly true for personnel who possess higher skills. This is possible related to the difficulty in attracting staff in remote locations. Maintaining skills on maternal care, essential newborn care practices and management of sick newborn babies is a challenge. Regular reviews and frequent monitoring and supervision are prerequisites for maintaining the quality of the program.

Similarly, retention of the knowledge and skills of FCHVs on essential newborn care practices and management of sick newborn babies is a challenge. Feedback from the field is that there is rapid dropout rate of FCHVs in remote location and there is an ongoing need to train and support newly recruited health volunteers

### ***Recruitment and retention of local staff***

Recruiting and retention of local staff is important, especially for 24-hour delivery services at health facilities where only one or no posts are sanctioned for SBAs. This is being done by locally contracting appropriately skilled personnel through funds made available either by the health facility management committee or funds made available for the purpose from the centre. In the Terai region, well performing birthing centres with high population coverage have generated enough revenue from the AAMA Program to easily cover salaries and investments for the service. In hill and mountain regions, however, revenue collected from normal deliveries, even for a well performing birthing centre, is not sufficient to cover salary expenses. There is a risk that the incentives scheme, meant to develop equity, will create inequity between regions, as incentives are given on case performance and large differences exist between targets according to geographic region.

### ***Placing and posting of SBAs at inappropriate service sites***

Placing and posting the SBAs at appropriate service sites is another challenge that needs to be addressed. Frequent transfer of SBAs to health facilities that are not birthing centres, and also to irrelevant units within hospitals, has been a challenge for ensuring 24-hour delivery services. Hiring appropriately skilled local staff for birthing centres may help in addressing this problem to some extent.

### ***Delay in equipment and supplies***

The MoHP has not been able to supply equipment according to needs identified during initial baseline assessments. Though UNICEF is helping to upgrade existing and some new birthing centres by supplying instruments, with more sites being established every month it is difficult to meet the continuously increasing demand. This delay in the supply of equipment to many peripheral facilities has slowed down the enormous achievements and efforts of communities in starting 24-hour delivery services.

### ***Low coverage of zinc treatment***

Low coverage of zinc treatment for diarrhoea is a concern. A recent survey conducted by the National Family Health Program in 40 districts revealed coverage of only 7 per cent. This situation demands a joint effort between partners as well as intensified social mobilisation and BCC campaigns to increase coverage and compliance of treatment with zinc during diarrhoea.

### ***Vitamin A procurement***

Though Government initiated the transfer of core responsibility including Vitamin A procurement to its regular programming, the major contribution in the National Vitamin A program is still from donors. The Government is aiming to fully transfer core responsibility by 2013. Until then external backstopping in supply logistics, media promotion and addressing inequities is essential to ensure the sustainability of the program.

### ***Buffer stocks of MNP***

Keeping adequate buffer stock of micronutrient powder in hand is a challenge since the global market, especially related to local brands, is uncertain because of increasing emergencies caused by floods and earthquakes. In order to mitigate this constraint, the LMD's capacity to maintain adequate buffer stocks needs to be strengthened which requires more technical and funding support.

### ***Raise awareness of exclusive breastfeeding***

Around 20 per cent of babies under six months are not exclusively breastfed and are introduced to water at this age. Increased awareness by mothers and families about the completeness of breast milk for their children for feeding purposes will help to increase exclusive breastfeeding practices. Communication tools supporting this message are already available but the challenge is to ensure information is effectively transmitted to hard-to-reach groups.

## **Annex 5: UNICEF's contribution to policy, planning and implementation**

### **Major Achievements in Policy Planning and Implementation in Collaboration with Government / MoHP and other Partners since 2009-2010<sup>50</sup>**

#### ***Work Undertaken since 2009-2010***

- In 2010, UNICEF enhanced its focus on upstream work carrying out successful advocacy with government, partners and donors especially in the under addressed nutrition and health equity sectors and in access and utilisation of services for the marginalised.
- UNICEF co-chaired with Government the cross cutting group in National Health Sector Planning process (NHSP II – 2010/11 – 2014/15) and ensured enhanced focus and funding for the marginalised and disadvantaged, nutrition sector and women.
- UNICEF continues to play an active role in strengthening the Government's EPI program. Data from the EPI coverage survey 2010 reported 88 per cent children were fully immunised. Only 75.9 per cent in the lowest quintile received all vaccines as compared to 96.4 per cent in the highest quintile. Further, HMIS data for 2009/2010 shows an increasing trend in coverage of all antigens compared to 2008/2009 with the highest gain of 9.7 per cent in measles coverage. With Rotary, SABIN and other partners, Countdown meetings for members of the Parliamentary sub-committee on health and social sectors were held on immunisation followed by maternal health and WASH. The immunisation Countdown meeting led to "The Kathmandu Declaration" with Parliamentarians committing to advocate and legislate for sustainable immunisations financing and mobilisation of local resources.
- To reach all children with quality vaccines, Periodic Intensification of Routine Immunisation (PIRI) in the form of Immunisation month, revision and updating of micro-plans in 22 poor performing districts, IEC activities, strengthening of cold chain and vaccine management were technically supported under the leadership of Child health Division. UNICEF supported the training of more than 100 lower level staff from various health facilities in vaccine and cold chain equipment management. UNICEF along with WHO and CHD supported the MLM training for more than 25 Program managers focusing on EPI.
- Staff of 10 districts were trained to collect and report on key 25 indicators on maternal and child health disaggregated by caste and ethnicity. Collation and analysis were done locally at VDC and district levels. Efforts are now ongoing for linking up districts with the central data reporting unit following which this system could be institutionalised.
- Nepal is at high risk of re-infection with polio virus because of its close proximity with the polio endemic districts of Bihar, India. Six cases were recorded this year with five from just one district - Rautahat. With excellent mop up activities (eight rounds between June and November) and intensification of routine immunisation activities, the epidemic was soon brought under control. UNICEF

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<sup>50</sup> Department of Health Services 2066/67 (2009/2010); Annual Report. Government of Nepal, MoHP, Kathmandu

support included the provision of vaccines and social mobilisation activities and logistics support.

- CB-IMCI including zinc use in diarrhoea is now operational in all 75 districts. UNICEF assisted in organisation of review meetings for program implementation evaluation and in dissemination of key child health messages to the most disadvantaged communities besides supporting training and arranging for supplies including zinc.
- In the area of newborn health, UNICEF together with the partners supported the Government in the development of a national BCC strategy for MNH, child health and nutrition. The community based newborn care pilot (CB-NCP) in ten districts (including three UNICEF districts) has now entered into implementation phase and based on the reported effective implementation by the FCHVs and at Government request, UNICEF and partners will expand these activities to five additional districts (UNICEF – two) in 2011.
- UNICEF played a role in the revision of the FCHV strategy and its dissemination and supported the Government in strengthening the FCHV Fund management committee and in celebrating the FCHV day.
- In 2010, UNICEF enhanced its programming in maternal health to Darchula and Bajura in addition to the eight earlier districts. UNICEF continued to provide technical assistance to the Family Health Division and helped develop “National guidelines for implementation of Misoprostol” and initiated preparatory work for piloting of “Prevention of Eclampsia with use of Calcium”.
- Under the leadership of the National Health Training Centre UNICEF supported the updating of the National Skilled Birth Attendant (SBA) training package. PMTCT was integrated into this package in close coordination with HIV/AIDs section, NASCC and NHTC,
- In UNICEF supported MNH districts, advocacy and technical and financial support led to twenty-four hour delivery services availability in an additional ten per cent of health posts [HP] (74 per cent – 2009) and basic emergency obstetric (BEOC) services in 90 per cent of Primary Health Care Centres [PHCC] (72 per cent – 2009). Two additional CEOC service sites were also made functional (total seven sites). The number of 24-hour birthing centres increased from 94 to 132 with 34 per cent being in 4 VDCs.
- UNICEF supported SBA training for 82 service providers from remote peripheral sites. Whole, site infection prevention training encouraged VDCs to contribute to the establishment of placenta and waste disposal pits, incinerators and toilets in most VDCs.
- Demand creation for increased utilisation of free delivery services (AAMA program) was carried out through VDC level orientations. Through MNH orientation, VDCs were motivated to invest VDC funds for enhancing quality of services through investments in additional human resources (70 ANMs), infrastructure, equipment, supplies and incentives for community.
- UNICEF led the recent revitalisation efforts in the nutrition sector and successfully advocated with Government and partners for enhanced financial allocation in NHSP II and the development of a multi-sectoral national nutrition action plan under the leadership of the National Planning Commission (NPC). UNICEF and partner supported Nutrition Assessment and Gap Analysis report was endorsed by the Ministry of Health and Population and provided the basis for nutrition sector planning in NHSP II. National Nutrition Coordination

Committee was revitalised and 19 focal officers from different sectors were capacitated on nutrition programming.

- The Government is keen to expand the successful UNICEF supported community management of acute malnutrition (CMAM) pilot [95 per cent estimated severely acute malnourished children (SAM) enrolled, 81.7 per cent recovery rate and only 0.9 per cent case fatality rate].
- Initial positive results of the ongoing infant and young child feeding (IYCF) and micronutrient supplementation promotion (three districts) led to greater partner interest to upscale these interventions especially in the disadvantaged mid and far West districts (WFP, HKI, USAID).
- Efforts to enhance Government involvement and ultimate takeover of Vitamin A and Iodised salt programs have led to Government increasing the financial allotment for both these activities. In 2011, UNICEF will promote greater involvement of partners and Government in strengthening these successful initiatives.
- The nutrition emergency cluster was given an independent identity and separated from health in June 2010 so as to focus better on nutrition aspects of the disaster Management cycle. Cluster policies, strategies, contingency plans and information management systems were developed together with partners. Sufficient Health and Nutrition supplies were prepositioned at central and regional levels.
- In the area of HIV and AIDS, out of 112,225 ANC attending pregnant mothers 66,606 (59 per cent) accessed the PMTCT services provided in 22 sites of 19 districts of Nepal. In an effort to reach out to the women who are not attending ANC, community based (CB) PMTCT program was established in 3 districts of Nepal. Out of 10,733 pregnant women 7,299 (68 per cent) availed PMTCT services through CB services. In terms of ARV access, 80 per cent identified HIV pregnant women and 98 per cent babies have received ARV prophylaxis and 60 per cent of identified HIV exposed and infected infants received CPT. Out of all the children identified as infected, 93 per cent received ART. UNICEF initiated the process of mainstreaming PMTCT in ANC services.
- Approximately, 42 per cent of the adolescents from the intervention area have increased knowledge on HIV prevention. Moreover, 4857 MARAs and EVAs were reached with HIV prevention activities in 4 districts. VCPC members and WDOs from the 4 districts were sensitised on the issues of HIV and CABA. Community based basic support package was implemented in 4 districts Sunsari, Achham, Syangja and Kailali. Through this support package 1765 children were retained in the school, cases of acute malnutrition were averted and during the period only 8 CABA were identified. Moreover, 173 family members of CABA received sustainable livelihood trainings and out of these over 35 CABA households are implementing these regular livelihood activities and are supporting the family. A national strategy and guidelines on CABA has been developed in line with the SAARC regional framework for CABA.

### ***Work Just Commenced***

- The Government is keen to introduce the measles-rubella vaccine, which will also provide a second opportunity for measles and further assist in moving towards measles elimination status. In 2010 out of the 23 reported measles outbreaks, only four were confirmed as measles and most measles like reported cases were actually rubella. UNICEF is strongly advocating for this

activity and will provide financial and technical support for carrying out this activity.

- UNICEF is supporting the Government of Nepal to develop strategies to conduct district level maintenance activities for the CB-IMCI program. UNICEF with Government and partners is working on developing the monitoring tools for monitoring the program performance at the VDC and district levels. UNICEF is also supporting the Government in developing child health integrated review guidelines to streamline all the vertical reviews on child health interventions that take place at the district and community levels.
- UNICEF is focusing on increasing coverage and compliance of the use of zinc for treatment of diarrhoea and to conduct an assessment of zinc coverage to determine the factors behind the low coverage of zinc intake. Based on the CB-IMCI BCC strategy, intensive social mobilisation and BCC activities will be conducted to raise community awareness. UNICEF will make special efforts to mobilise child clubs, mothers' groups and frontline workers to create awareness at the community level in UNICEF-supported DACAW districts, where the focus is on reaching the most disadvantaged communities. UNICEF will support the Government in expanding the CBNCP in 2 new districts in 2011-2012.
- Support has just begun on the implementation of maternal audits at facility and community level and strengthening of the existing surveillance mechanisms in the country to bring new disaggregated data by caste and ethnicity for maternal and newborn policy and program shifts. UNICEF will also assist in the establishment/strengthening of new/old birthing centres and BEOC sites in five districts through needs assessment, upgrading, monitoring and supervision, capacity-building and technical backstopping.
- Efforts are being directed towards increasing government ownership, funding and capacity building activities in existing nutrition interventions like Vitamin 'A' campaign and micronutrient supplementation. Support is also being provided for the scaling up of MNP supplementation linked with IYCF to the entire nation.
- Continued support is being provided to the Government to assist in MNP IYCF community promotion piloting in 6 districts and in scaling up to 15 districts by 2012. The IYCF approach will also be linked with the nutritious food distribution & child grant programs for improving nutrition status of children in the Karnali districts.
- Assistance will be extended for developing the multi sectoral nutrition action plan. National Nutrition Steering Committee's capacity building activities to coordinate with various sectors will be supported in order to expedite the development of the multi sectoral nutrition action plan. Technical and administrative support to the National Nutrition Steering Committee will also be provided. Advocacy, meetings, orientation programs and exposure visits aiming to improve capacity of nutrition focal officers will be supported.
- Breastfeeding & IYCF and Care promotion is being promoted to increase mothers and families awareness about the importance of exclusive breastfeeding and timely initiation of complementary feeding including adequate care for young children.

## **Annex 6: UNICEF geographical program coverage**

The following information has been adapted from the Department of Health Services (2009/2010); Annual Report. It demonstrates the broad coverage of UNICEF services. This can be an added value when working UNICEF because projects activities are usually integrated and coordinated with these activities.

- Immunisation Nationwide
- IMCI Maintenance activities 8 districts
- Community Based Newborn Care Package 3 districts
- Introduction of zinc for the treatment of diarrhoea 3 districts
- Safe Motherhood/MNH 9 districts
- FCHV Program 15 districts
- Vitamin A Deficiency Control /Deworming Nationwide
- Iron Supplementation Nationwide
- Universal Salt Iodisation Nationwide
- PMTCT/ ART 16/21 districts
- Emergency Health 13 districts
- Emergency Nutrition 5 districts
- Community based Management of Severe Malnutrition 5 districts
- Support to Nutrition Rehabilitation Centres 6 NRH
- Micronutrient Supplementation with Infant and Young
- Child Feeding Community promotion 3 districts
- Iodised Salt Social Marketing Campaign 3 districts
- Newborn Vitamin 'A' dosing piloting 2 districts

## **Annex 7: Documents reviewed and consulted**

### **General Documents**

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- Best Practices at Scale in Home, Communities and Facilities: Five Year Action Plan for Family Planning, Maternal, Neonatal and Child Health, and Nutrition, March 2011-September 2015.
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- Nepal Demographic and Health Survey (NDHS) 2006
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Post Training Follow-up for Skilled Birth Attendants: Review of Implementation Experiences: Nepal Ministry of Health and Population, September 2009

Relevant policy and program documents on community based IMCI and the community based newborn care program.

Remote Area Guideline (2009)

Reproductive Health technical assistance matrix (development partners mapping)

Supplemental Work Plan) USAID and MOHP, Fiscal Year 2010-2011

UNICEF projects proposals on “Child Survival and Nutrition Initiative” phases I and II and ‘Communities as Change Agents: Providing Maternal Health Services to the Disadvantaged.

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Work Plan for Safe Motherhood and Neonatal Health, (Combined Redbook and

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