

# **National Health Sector Support Program Capacity Assessment for Nutrition**

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## 1. Introduction

As part of the National Health System Strengthening Project (NHSSP) inception period team, Helen Keller International led an assessment over the first two week of November to identify key bottlenecks, needs, and recommendations for technical support to assist the Ministry of Health and Population in achieving the nutrition-specific goals and concepts presented in the National Health Sector Plan -2 (NHSP-2). While the NHSSP is a sector wide support program this assessment concerns itself only with nutrition and the nutrition components of the NHSP-2 and will contribute to the wider NHSSP capacity assessment. This assessment used two main methods for drawing recommendations and conclusions. The first method employed was an extensive document and literature review of Nepali specific policy, planning and analysis documents pertaining to nutrition and the health sector. The second method utilized interviews guided by a common questionnaire of key stakeholders in government, EDPs, and academia. The assessment reviewed over 30 relevant documents and interviewed 20 stakeholders during the course of this assessment.

Key recommendations of this assessment are:

- Development of Health Sector Nutrition Plan of Action to guide the MoHP and support the wider multi-sectoral National Nutrition Steering Committee. This plan should address the technical gaps discussed below.
- Align the NHSP-2 Result Framework with the current nutrition initiatives of the MoHP and the text of the NHSP-2
- Expand the number of MoHP staff and improve their capacity to design, plan, implement and monitor nutrition programming on the central, regional and district levels.
- Improve inter departmental coordination within DoHS and improve EDP coordination with regards to nutrition
- Improve planning, program designing and budgeting coordination between central, regional and district levels
- Form a long-term part-time non embedded TA team to support these processes in collaboration with the other components of the NHSSP.

## 2. Background

Stunting, underweight and wasting affects 49%, 39% and 13% of preschool children respectively and nearly one in every two of such children (48.4%) are anemic<sup>1</sup>. A recent assessment by the Government of Nepal<sup>2</sup> to identify gaps in addressing

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<sup>1</sup> DHS (2006). Nepal Demographic and Health Survey. Ministry of Health and Population, Government of Nepal, Kathmandu, Nepal.

<sup>2</sup> Department of Health Services, Ministry of Health and Population, Government of Nepal. Nepal Nutrition Assessment and Gap Analysis. 2010

childhood malnutrition found sub-optimal infant and young child feeding practices as a significant contributor to the poor nutritional status of young children in the country, particularly in rural areas. Whereas breastfeeding is close to universal in Nepal (98%), only 1 in 3 women (35%) initiates breastfeeding within one hour of delivery. Only 1 in every 2 children (53%) is exclusively breastfed until six months of age. The median duration of exclusive breastfeeding is only 3 months. Timely introduction of appropriate complementary food when a child is 6 months old was only 63%. Furthermore, a widening of the gap in nutritional status across wealth quintiles is also observed with children from lowest wealth quintile facing the highest burden of malnutrition<sup>2</sup>.

Though Nepal has made good progress in achieving the health-related MDGs and progress is on track for MDGs 4, 5 and 6, it will not achieve MDG 1 for reduction in hunger without substantial improvements in the overall growth of young children. The lack of sufficient progress in improving the nutritional status of women and young children is also highlighted in the NHSP-2, and has led the MOHP to identify nutrition as a high priority area for investment. The NHSP-2 establishes the activities that government will undertake to improve nutrition in the country. Within these activities are a range of food utilization and nutrition related services, including child growth monitoring and promotion, micronutrient supplementation, food supplementation and interventions to improve child survival. However, it is essential that health sector work closely with other sectors to reduce the prevalence of stunting. This also highlighted as one of the key lessons learned in the recent SWAp document<sup>3</sup>.

### **3. Institutional / Technical Assessment Situational Analysis**

As discussed above progress towards improved nutrition has yielded important results specifically in the areas of micro-nutrient deficiencies. However, the problem of malnutrition in Nepal has not been adequately addressed. In order for malnutrition to be appropriately addressed numerous institutional and technical challenges must be tackled. This is complicated by the cross-cutting and multi-sectoral nature of nutrition and the varying determinants that play a role in ensuring nutrition security. The current government policy environment, GoN and donor commitments make this an ideal time to begin strategically addressing the remaining challenges for health related nutrition interventions. This will require that the MOHP refine its approaches across multiple areas including policy, planning, human resources and coordination among other. Below is a more detailed analysis.

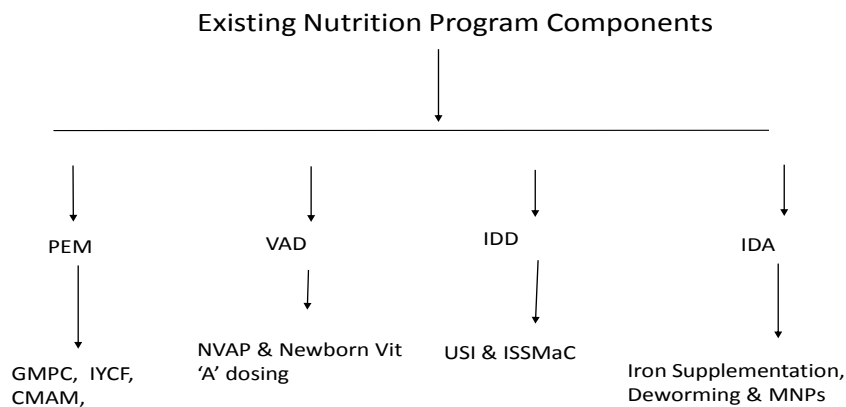
#### 3.1 Institutional and Technical Assessment Status and Analysis

##### a) Assessment of Technical Areas and Implementation Strategies

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<sup>3</sup> RTI International (May 2010): *The Sector-Wide Approach in the Health Sector, Achievements and Lessons Learned*. Research Triangle Park, NC, USA.

The priority groups for nutrition interventions from MoHP have historically been women of reproductive age and children under five. However, to address the problem of low birth weight and childhood under nutrition in a holistic manner, a comprehensive and sustainable community-based package needs to be envisioned. The diagram below illustrates the current programs under the Department of Health Services, Child Health Division (DOHS-CHD):



## Policy Gaps

- Life Cycle Approach:** As nutrition is a cross cutting issue it is imperative to utilize a model that links the varying but critically related stages of life and the impact and interaction of nutritional status and knowledge between them. The findings of this assessment found strong support and discussion for developing a nutrition strategy that is life cycle and continuum of care based. However, there is little mention in the NHSP-2 about how infant, child, adolescent and maternal nutrition will be linked under one paradigm. Linking technical interventions under the rubric of life cycle approach is well accepted framework for understanding, planning and implementing nutrition interventions within the health sector. No evidence or linkage to life cycle approach which leads to inclusion of adolescent and maternal nutrition is evident in the NHSP-2 documents or the results framework.
- Maternal nutrition:** Maternal nutrition is a critical need in Nepal. Low birth weight, weight gain during pregnancy, intra-household work and food distribution during pregnancy and after birth, and maternal anemia are essential issues that must be addressed. Our findings suggest that government, non-government and donor partners are equally concerned about improving maternal nutrition but have little idea of what

interventions could be introduced at scale to adequately address this challenge. This finding also alludes to the need of a specific policy on maternal nutrition. Discussions for a Maternal Nutrition Working Group led by the Family Health Division and other key stakeholders is an idea that is supported by this assessment but to this point has not been formed. Finally, the NHSP-2 document states that the nutrition programming “will also focus on maternal nutrition” but there is little direction on what strategies should be undertaken to address this.

- **Urban nutrition:** The NHSP 2 document and current government programming have little or no focus on nutrition issues that face growing urban populations. The NHSP-2 document does discuss strengthening partnerships with the Ministry of Local Development to test the feasibility of FCHVs in urban areas of Nepal which could have a direct impact on nutrition programming available to urban communities. However, technically, the only mention of urban programming in Child Health relates to IMCI in Table 1: “Cost-effectiveness of health interventions within the EHCS”. Considering the recent and continued growth of urban areas, the lack of an urban nutrition strategy, targets and programming is a major gap in the NHSP-2.
- **Gender and Social Inclusion:** Programs like the recently developed cash transfer program that deliver cash to remote and socially excluded families is a positive step to increase utilization of health and specifically nutrition services amongst these populations. By advocating a more community based approach for nutrition, NHSP-2, allows for the opportunity for improving access to nutrition interventions by socially excluded women and families. However, challenges remain in designing strategies to address the needs of such communities in an equitable manner. As stated in the supporting documents of this assessment, GESI training modules must be strengthened for FCHVs and other CHWs that are delivering nutrition and other community based health interventions. Improving the inclusion of GESI into nutrition programming is an important finding of this assessment and nutrition interventions will greatly benefit from the system wide focus on integration of GESI strategies into existing and future interventions.

### **Status of implementation of policies**

- **Micronutrients:** While micronutrient supplementation programs are the hallmark of Nepal’s nutrition interventions and have been very successful in reducing key micronutrient deficiencies, specifically Vitamin A, de-worming<sup>4</sup>, Iron and iodine, there is a need for the government to continue to gain ownership over these initiatives in the coming years, and

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<sup>4</sup> Though technically not a micronutrient de-worming is included in as part of child nutrition programming in the NHSP-2 document and in practice under the Nutrition Section of the Child Health Division.

relinquishing donor support for these well run programs. Additionally, there remain areas where additional coverage of micronutrient programming should be expanded:

- Iron distribution for pregnant and lactating women
  - Deworming for pregnant and school aged children
  - Micronutrient powder distribution for under-twos
  - Zinc for under-fives
- Infant Young Child Feeding (IYCF): Infant Young Child feeding behaviours in Nepal are critical to improving nutrition status of children under-two. The national policy for Infant and Young Child Feeding is adequate and promotes expansion of behaviours and practices shown to have impact on nutritional status. However, Nepal still faces a major gap in addressing this issue. Our findings suggest that exclusive breastfeeding and timely, appropriate and adequate use of complimentary foods for children 6-24 months needs more focused attention on how to deliver behaviour change communications, specifically counselling, to pregnant and new mothers at scale, using multiple contact points. The NHSP-2 document does discuss IYCF needs as part of the community based approach advocated by the document. However, this is not reflected in the results framework, which includes only one IYCF indicator – exclusive breastfeeding.

#### Current Nutrition Implementation Initiatives and NHSP-2:

Discussions on a multi-sectoral nutrition strategy have begun between the National Planning Commission (NPC), EDPs and the line ministries. This is being guided by the National Nutrition Steering Committee directed by the NPC. This is a positive development and recognition by all stakeholders of the importance of multi-sectoral coordination for combating malnutrition. The MOHP took a lead role with EDPs to develop the Nutrition Assessment and Gap Analysis (NAGA). The NAGA is leading document but does not preclude the need for a MOHP designed health sector specific nutrition plan of action. In developing a Nutrition Plan of Action this assessment found two major themes in the need for and approach of a Health Sector Nutrition Plan of Action that would directly feed into and take into account a Multi-sectoral framework to be developed by the National Nutrition Steering Committee.

Furthermore, the focus on community based implementation in the NHSP-2 was widely regarded as a positive step to designing programs that will be better able to reach those in need and address locally specific behaviours, practices, and challenges that impact nutritional status of mothers, children and adolescents. Indeed, the GON and donors, specifically USAID, are planning to implement a large scale community based nutrition program in 25 districts that will focus on mothers and children under two.

#### b) Specific Institutional Environment and Structure

- Management of Nutrition Programming: The management of nutrition programming has been challenging. Micronutrient supplementation, school nutrition, IYCF and growth monitoring are all managed by Nutrition Section under the Child Health Division while maternal nutrition is under the purview of the Family Health Division within the DOHS. However, FCHV's are and will be critical to the roll out of nutrition programming at the community level. The NHSP-2 clearly states that overall management and expansion of nutrition interventions "will continue to come under the child health division". Coordination between FHD and CHD would be crucial to address the continuum of care for nutrition.

One finding of this assessment is that serious discussions are being held within the MOHP about long term plans for developing a National Nutrition Center to allow greater autonomy. However, this poses both potential challenges and opportunities and deserves further policy dialogue.

- Coordination: Coordination within the MOHP will play a critical role in the effectiveness of the development and roll-out of community based nutrition programming. Our findings on the need for improved coordination were mixed but decidedly in favour of better coordinated nutrition planning and implementation, specifically amongst, FHD, CHD, the National Health Education Information and Communication Centre (NHEICC), the National Health Training Centre (NHTC) and the EDPs. The need for better coordination and interaction amongst them is vital for program effectiveness in terms of human resource development, avoidance of duplication, optimal use of resources and standardization of training, and communication activities.

Both FHD and CHD reside under the DOHS and are supervised by the Director General of Department of Health Services. However, the NHEICC/NHTC is a separate independent body formed under the Ministry of Health. Barriers to coordination lie in:

- Limited formal coordination mechanism between FHD, CHD and other DOHS divisions and centers
- Limited formal operating procedures, understanding of roles and responsibilities between the DOHS and NHEICC/NHTC

In addition to the intra MOHP coordination mentioned above, multi-sectoral coordination, as suggested in the NHSP-2, was also frequently cited in our findings. The findings of this assessment clearly suggest that that the MOHP understands the need for multi-sectoral coordination under the auspices of the National Nutrition Steering Committee.

Finally, this assessment found dissatisfaction amongst both government and EDP stakeholders in EDP-government coordination. Specifically, findings showed that government counterparts were spending significant time managing donor partnerships and issues. There was also a sense among government counterparts that EDPs should be more transparent and accountable to the government. While these are broader findings they are important and will be considered below in our recommendations for coordination in the nutrition sector.

EDP partners did suggest that the NHSSP could play an important role in aid effectiveness and that pool funded and non-pool funded coordination would be vital to maximizing resources and supporting government counterparts. Key donors in nutrition are UNICEF, USAID, World Bank, DFID, AUSAID and the WFP. All of these donors collaborate and support embedded staff with in the MOHP.

- Human Resources: Current leadership in the DOHS, the Nutrition Section of CHD and in the FHD are well positioned to develop needed systems to achieve the goals of the NHSP-2. While staff movement for key positions in this area can be frequent, some key positions, particularly the Chief of the Nutrition Section have achieved relative stability in recent years. It should be noted that current staff should be commended for accomplishments and efforts over the past few years to focus nutrition programming and provide direction for NHSP-2. The NAGA document is a solid example of these efforts. However, challenges remain.

It was a clear finding of this assessment that lack of human resources for nutrition is a critical barrier for implementation of existing nutrition interventions and to effective design, expansion and roll out of nutrition programming nationwide. Human Resource issues focused on two main issues. The first barrier identified is the number of staff allocated to serve in nutrition functions within DOHS at the national, regional and district level. The second barrier concerns knowledge and capacity of staff to design, plan, implement, monitor and refine nutrition programming across the country.

- Staffing: It was evident throughout this assessment that the number of staff currently assigned to nutrition programming in Nepal cannot meet the planning, implementation and monitoring needs of the nation's nutrition targets as they relate to the MDGs, the NAGA document and the NHSP2. With only two permanent staff nationwide focused on nutrition, the current capacity of the Child Health Division, Nutrition Section is greatly taxed. There is no regional level staff assigned to deal solely with nutrition. Currently Regional MCH staff also deal with nutrition programming. A similar structure exists on the district level where a nutrition focal person is designated but not fully assigned to monitor, assess, plan and implement nutrition



programming nor are they given the resources or mandate to better understand nutrition determinants in their areas and propose locally specific interventions. New staff have been requested by DOHS in their annual planning processes but these new positions have not been approved. Most recently DOHS-CHD budget submission did request five regional nutrition focal persons to help realize the current nutrition commitments and future plans but these positions were not approved in the final budget.

- Staff Capacity: As already mentioned above, a core finding of this assessment is that the technical capacity of MOHP-DOHS staff in the areas of nutrition is not sufficient to meet the nation's needs nor the goals set out in the NHSP2 and NAGA documents. Within CHD there is no personnel with an advanced degree focusing on nutrition. The need for key staff members who have the capacity to assist the DOHS and CHD in developing, planning and implementing programs based on evidence is essential. Additionally, these staffs are needed to provide assistance to regional and district level staff for program implementation, coordination and monitoring of nutrition interventions that address local realities.

c) Finance:

This assessment did not look deeply into finance issues. However, it was a finding of this assessment that increased funding must be allocated to maintain and expand current nutrition programs. It was also mentioned that periodic orientation to Ministry of Finance staff should be held so that resources allocated will be in line with the national nutrition priorities. Current government financing is not enough to reach the goals envisioned by the NHSP-2. Nutrition funding currently is allocated partially to the Nutrition Section at the Child Health Division but some components are allocated to the Family Health Division

However, significant funding for nutrition is planned by donors beginning in 2011. USAID has released a \$46 million request for assistance to work with the MOHP on designing a community based nutrition program to support the aims of the NHSP-2. In addition, pool funders, such as the World Bank and some other donors have expressed their support for the development and expansion of nutrition interventions in line with NHSP-2 as a more clear strategy develops.

d) **Monitoring & Tools**

Currently, monitoring for nutrition across Nepal is weak. HMIS does provide data on Vitamin A and deworming and some other micro-nutrient related indicators such as maternal iron supplementation but is limited in its ability to catch broader nutrition issues related to maternal and child nutritional status. Furthermore, HMIS also does not collect indicators related to infant and young

child feeding which are critical for the government to monitor factors that contribute to the prevalence of underweight.

An important finding of this assessment was that while all stakeholders agreed on the need for improved nutrition monitoring and availability of data, there was broad consensus that this should take shape through HMIS and improvements to monitoring capacity in the field. Furthermore, the stakeholders also agreed that the need for utilization of HMIS data for local level planning should be a priority.

At this point in time the most widely used M&E tool is the Demographic Health Survey (DHS) that is implemented every five years. Our findings indicate that the DHS is a widely used and accepted tool that provides excellent data on key nutrition outcomes. Its limitations lie in the time between surveys. The government currently has no common mechanism to assess nutritional status or trends in between DHS surveys.

- e) History of Technical Assistance and Current and Future TA
  - a. Formal TA / Informal TA

The assessment revealed that very limited TA was provided to the nutrition section in the past years. Also, the TA was more projects specific such as the Vitamin A and iron supplementation project and was non-embedded part-time technical assistance team and volunteers. Currently, nutrition section is mostly receiving informal TA from EDPs such as UNICEF, MI etc.

#### **4. Capacity Development Strategy**

The recommended capacity development strategy is to have a non-embedded part-time technical assistance team that can work with key stakeholders in both the DOHS and with EDPs to help direct key capacity building interventions. It is a clear recommendation of this assessment not to embed a long term technical assistance position into the DOHS. It is recommended that a capacity building initiative take the form of a constant but part-time TA support team augmented by specific short term-TA consultants as needed. Capacity Development strategies would focus on facilitating the following processes:

- Development of Health Sector Nutrition Plan of Action with linkages to the NNSC National Nutrition Framework. This Nutrition Plan of Action would provide needed direction in regards to NHSP 2 goals, NAGA recommendations and critical implementation gaps listed above.
- Advocacy and assistance in identifying solutions to staffing challenges
- Development of in-country medium-term training modules for key nutrition personnel with in-country pre-service resources to build technical capacity of nutrition personnel on the national and district levels
- Collaborate with DOHS to identify possible areas where short-term technical TA may be needed for key activities and/or to assist in

implementing operations research in order to identify achievable interventions in key areas of need

- Collaborate with NHSSP staff, DOHS staff and HMIS staff to improve system wide monitoring, collection and analysis and use of key nutrition indicators that are needed.

By employing a team of individuals with close ties to the DOHS who commit a certain percentage of their “level-of-effort” this assessment aims to reduce cost and increase ownership within the DOHS.

## **5. Justification for chosen methodology**

The above methodology and objectives serve multiple needs. First, one of the findings of this assessment was the broad consensus among stakeholders that long-term embedded TA will not be effective given the current circumstances within CHD and FHD. A part-time team of approximately three members, all with considerable experience in Nepal and strong relationships with key personnel in DOHS will have greater impact in developing a productive relationship with rapid-start-up capacity.

Second, another key finding of this assessment is the need to increase the number of staff available to support the nutrition goals of the NHSP-2. It was also broadly agreed upon by stakeholders that support to new and current staff is needed but that to ensure ownership and decrease chances of dependency, that a part-time TA team would better fit the needs of the current situation

Finally by employing this type strategy the project acquires a broader set of skills from experienced consultants at similar or reduced costs to embedded TA. However, it should be noted that additional costs will be incurred if short-term STTA is brought in as needed.

## **6. Risk Assessment and risk mitigation strategy**

Multisectoral and cross cutting nature of nutrition makes involvement and response of other sectors imperative to achieve outcome. However there is lack of multisectoral policy and mechanism to address the root causes of malnutrition. Nutrition capacity must therefore be strengthened or established at the national level among various ministries for a coordinated multi-sectoral attention to nutrition through integration and alignment of policies as well as indicators.

Sustainability of interventions- the gains from micronutrient supplementation have historically not been complemented by food based approaches to ensure sustainability.

The increasing interest and funding from EDPs for nutrition activities must be matched by the capacity and leadership of Nutrition Section, as well as the regional and district offices. Capacity of the community level health workers and volunteers need careful exploration with regard to CHW workload and effectiveness for nutrition interventions.

There is also a need to improve food and care related behaviors with GESI perspective.

## 7. Recommendations

Below are the detailed recommendation from this assessment:.

GAP	Recommendation: Short-term (Up to 3 yrs)	
	Central	Regional
<b>Policy</b>	<ul style="list-style-type: none"> <li>• Alignment of key nutrition policies like IYCF and School Health Nutrition with the NHSP-2 results framework.</li> <li>• GAP/Policy analysis on evidence on impact of life cycle approach including GESI</li> <li>• Urban nutrition issue to be covered</li> <li>• Maternal nutrition (calorie intake, Low birth weight, weight gain during pregnancy)</li> </ul>	
<b>HR</b>	<ul style="list-style-type: none"> <li>• No long term Embedded TA</li> <li>• Develop part-time TA umbrella Team (1 FT)</li> <li>• <b>Technical training</b> <ul style="list-style-type: none"> <li>-Pilot in service training for public health nutrition using NHTC/IOM)</li> <li>- Program management &amp; M&amp;E</li> </ul> </li> <li>• <b>Positions</b> <ul style="list-style-type: none"> <li>-Sanctioned (5)</li> <li>-Additional Service PH officer <ul style="list-style-type: none"> <li>○ M&amp;E public health officer</li> <li>○ Logistics and Admin Assistant</li> </ul> </li> </ul> </li> <li>• Facilitate discussion and decision on National Nutrition Center</li> </ul>	<ul style="list-style-type: none"> <li>• No long term Embedded TA</li> <li>• Training on nutrition program management related aspect planning, monitoring, supervision</li> <li>• Positions <ul style="list-style-type: none"> <li>-Sanctioned (5)</li> </ul> </li> <li>Regional/Nutrition coordinator</li> </ul>
<b>EDP Co-ordination and Aid effectiveness</b>	<ul style="list-style-type: none"> <li>• Annual Government and EDP review and planning meetings to prepare work plan</li> <li>• WWW/Approval partnership data</li> <li>• Development of common indicators system for all nutrition programs-w/a threshold at # of HHs</li> <li>• Multi-sectoral co-ordination by NPC</li> <li>• Assist the government in coordinating with EDPs and monitoring key nutrition interventions.</li> <li>• Assess EDP and donor support for TA and embedded positions to improve coordinated TA to the MOHP.</li> </ul>	

<b>Intra MoHP co-ordination</b>	<ul style="list-style-type: none"> <li>• Form nutrition committee led by the DG with participation from EDPs, CHD, FHD, NHTC, NHIECC</li> <li>• Assign a Nutrition focal person in each division and report to respective director and co-ordinate with CHD/nutrition section (DG and department head driven)</li> <li>• DoHS level nutrition co-ordination meetings under DG four times a yr with NFOs</li> <li>• Central level nutrition review meeting under DG twice a yr</li> </ul>	
<b>Multi – Sectoral (Inter-Ministry)</b>	<ul style="list-style-type: none"> <li>• Nutrition working group co-ordination meetings four times a yr to discuss about technical issues</li> <li>• Development of multisectoral common nutrition indicators</li> <li>• Establish a stronger nutrition link with poverty alleviation / social equity programs/agriculture programs</li> <li>• National Nutrition plan of Action <ul style="list-style-type: none"> <li>○ Link to ministry plan</li> <li>○ TA to NFOs at NNSC</li> </ul> </li> </ul>	
<b>Evidence Generation for policy making</b>	<ul style="list-style-type: none"> <li>• Conduct innovative operational research on nutrition such <ul style="list-style-type: none"> <li>○ Linking nutrition with social transfer programs/Agriculture programs</li> <li>○ Strategies to Improving maternal nutrition</li> </ul> </li> </ul>	

## 8. Conclusions

This assessment has clearly shown the technical gaps, coordination gaps and resource gaps facing the MoHP. The opportunity in Nepal to improve nutrition programming is promising. Increased donor support and government driven programming have created a positive environment for change. The NHSSP has the opportunity to support this trend through the provision of targeted TA that will improve the capacity of government systems to deliver effective nutrition programming and improve overall aid effectiveness in the nutrition sector.

In order to maximize the current national momentum in the nutrition sector, NHHSP is in a strong position to:

- Improve the alignment of current nutrition needs and policy into NHSP-2 results framework

- Develop a Health Sector Nutrition action plan that provides an integrated life-cycle approach to address malnutrition
- Assist the government to augment current policy in key gap areas like maternal and adolescent nutrition
- Assist the government to increase the number of technical as well as managerial staff allocated to nutrition functions
- Enhance the capacity of current and future staff on national, regional and local levels
- Improve coordination within the MoHP and between the MoHP and EDPs as well as with other key ministries