



# Nepal Family Health Program II

Final Project Report

December 2007-November 2012



**USAID**  
FROM THE AMERICAN PEOPLE



**Nepal Family Health Program II**  
**Final Project Report**  
**December 2007 - November 2012**

© 2012 JSI Research & Training Institute, Inc./Nepal Family Health Program II NFHP II is funded by the United States Agency for International Development and implemented by JSI Research & Training Institute, Inc., with EngenderHealth, Jhpiego, Save the Children, World Education Inc., Nepali Technical Assistance Group, Nepal Fertility Care Center, Management Support Services Private Ltd., Nepal Red Cross Society , United Mission to Nepal, BBC Media Action, Digital Broadcast Initiative Equal Access, Family Planning Association of Nepal, and Center for Population and Development Activities.

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*Vitamin A dosing in Surkhet district, 2009.*

## LETTER FROM THE PROJECT DIRECTOR

As with many Asian countries, Nepal is undergoing a period of rapid change. Some of the changes reflect Nepal's emergence from a period of conflict and the birthing pains of its new democratic system. Some reflect dramatic changes in the exposure of rural populations to the urban environment of Kathmandu and to the lifestyles of other populations by outmigration for labor. Many demographic changes have been accompanied by social changes in the status and empowerment of women, improvements in education, and improved status of disadvantaged groups due to increasing attention provided to them by government policy. Structural changes have accompanied social changes, including increasing access to roads and the now nearly universal access to mobile phone communication. During this same period, Nepal has demonstrated marked improvement in health indicators, with dramatic declines in fertility as well as in maternal and child mortality.

The Nepal Family Health Program II (NFHP II) has supported the Nepal government in policy and strategy development, and implementation of their primary health programs, with a focus on peripheral health facilities and community-based activities. The approach has been in effect since 1981, when JSI began working in Nepal. The successive project implemented have also shared a consistent group of partners, which has strengthened the approach. While the value of this sustained support is difficult to measure, it certainly created an atmosphere of mutual respect and understanding between the projects, the Government of Nepal (GoN), USAID, and collaborating partners.

NFHP II benefited from this continuity by incorporating lessons learned, adapting to programmatic and demographic changes, and responding to new approaches identified in the global community. Recognizing that districts were becoming more and more diverse, the Government devolved authority to the district level. NFHP II assisted through an in-depth exploration of local governance, including community participation in health

facility management. The project renewed its attention to maternal and neonatal health after noting how neonatal mortality reduction was not improving as rapidly as the reduction in child mortality.

NFHP II helped the government to pilot and scale up innovations to reduce maternal and neonatal mortality, such as misoprostol for postpartum hemorrhage and chlorhexidine for cord care. NFHP II also helped the Government to understand the changing needs for family planning and the influence of spousal separation in the context of demographic changes and out-migration. In these ways, NFHP II has been both a *responsive* and a *proactive* partner with the Government, contributing to the health gains made through this collective effort.

NFHP II held an end-of-project dissemination event that was well attended by Government officials and stakeholders. A complete set of project materials and reports were distributed to all participants.

This report provides an overview of NFHP II's work in concert with the government and its partners. It presents on-the-ground innovations, and summarizes some of the results documented throughout the project. The report is by no means exhaustive. Rather, it is designed to give project-relevant information in an accessible format.

Nepal is globally recognized as a country with many successful elements in its health program, with a significant contribution from the strong cadre of Female Community Health Volunteers (FCHVs) established in 1988. These dedicated health workers have laid the foundation for much of the success achieved through NFHP II and previous projects. Their work will continue USAID's legacy of support in Nepal. We thank these volunteers, as well as our partners and the Government of Nepal, for collaborating with us during the life of the project. We certainly could not have succeeded without them.

*Ashoke Shrestha*  
NFHP II Project Director



*NFHP II end-of-project dissemination event held on August 16, 2012.*



*The end-of-project dissemination event on August 16, 2012 was attended by key stakeholders from the Government, development partners and the media.*

### ***NFHP II End of Project Dissemination Event***

On August 16, 2012, an end-of-project dissemination event was held to commemorate the closure of NFHP II. The event was attended by key stakeholders from the Government of Nepal, other development partners, and the media.

USAID, Mission Director, David C. Atteberry's remark at the event acknowledged "the many accomplishments of USAID's flagship health program since 2002 – the Nepal Family Health Program. It has been such a pleasure to hear about all the achievements that have happened over the years, work that continued throughout the insurgency and political unrest, without faltering. We are proud that these achievements played a role in the significant improvements we saw in the 2011 Demographic and Health Survey – clearly because of the hard work, investments and dedication of the NFHP team. The NFHP represents 10 years of close partnership with our Ministry of Health and Department of Health Services colleagues, as well as with the health development partners and all the others who helped make the program such a success."

Dr. Padam Bahadur Chand, Chief, Policy Planning and International Cooperation Division, Ministry of Health and Population, added, "Over the past 5 years, NFHP II has assisted the Ministry of Health and Population in a range of national and district level efforts from health policy development to working with district health offices to strengthen the quality of maternal and neonatal services, ensure quality for family planning services and management of childhood illness. The program also assisted the government with entrusting responsibility for service delivery to the districts and VDCs through support for the Local Governance Strengthening Program, and strengthening the health facility operations management committees. In these activities, with strong USAID support, NFHP II has been a good partner in addressing Nepal's important health issues."



*Health Exhibition in Bayalbaas Ishworpur,  
Sarlahi district*



## Key Achievements

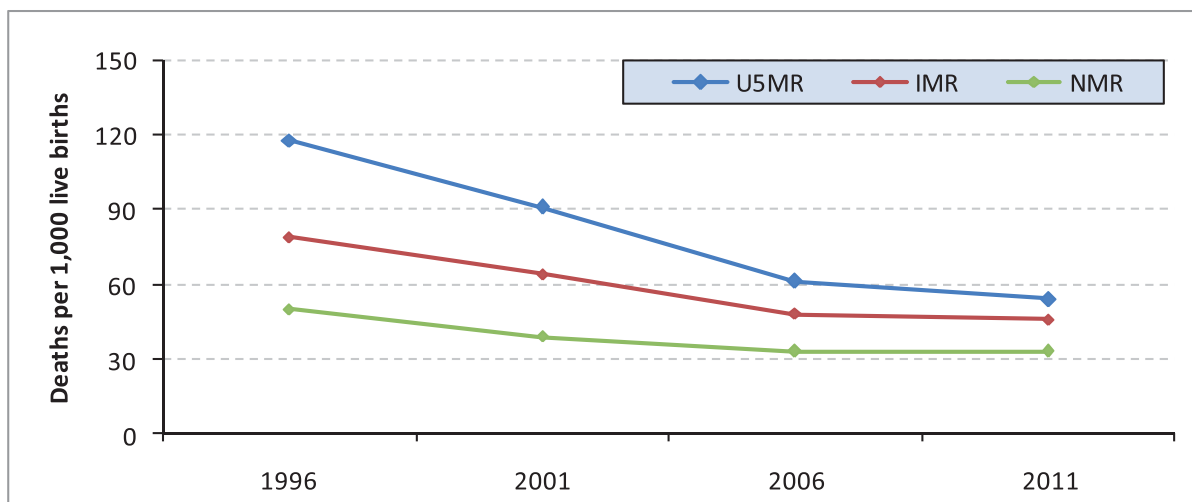
Earlier	Now
Stock-outs were common in health facilities	Fewer than 25% of health facilities experienced stock outs for essential drugs; less than 2% for family planning commodities
The Government of Nepal contributed to less than 5% of total costs for family planning commodities	The Government of Nepal now contributes to 74% of total costs for family planning commodities
Limited voice for dalits (a group of people traditionally regarded as untouchables)	Dalit members participated actively in 60% of Health Family Operation and Management Committee meetings in 11 districts
Inconsistent and unhealthy newborn cord care led to high infection rates among neonates	Use of chlorhexidine for cord care on newborns in the majority of 27 districts, resulting in lower infection rates
Less than half of health facilities offered delivery services	72% of MoHP health facilities in 18 core program districts offer delivery services, and among them, 90% offer 24-hour services
Few women were protected from postpartum hemorrhage	A majority of women are protected through health facility deliveries and use of misoprostol at home in 28 districts
Female Community Health Volunteers had limited access to financial resources	A majority of Female Community Health Volunteer (FCHV) are accessing the FCHV Fund in all 75 districts

# INTRODUCTION

The United States Agency for International Development (USAID) support in the health sector reflects one of the most longstanding and successful development assistance programs in Nepal. Despite a 10-year civil insurgency, Nepal has experienced two decades of steady improvement in health outcomes and has emerged as one of the few countries on track to meet the Millennium Development Goals (MDGs) to reduce child mortality and improve maternal health. Nepal is also making progress toward several other MDGs, including the eradication of extreme poverty and hunger, and combating HIV, malaria, and other diseases.

Nepal Demographic Health Survey (DHS) data shows that from 1996 to 2011, there was a continual decline in child mortality rates in Nepal. Between 2006 and 2011, under-five mortality declined from 61 per 1,000 live births to 54 per 1,000 live births, although neonatal mortality rate remained constant at 33 per 1,000 live births during this period. (1-4)

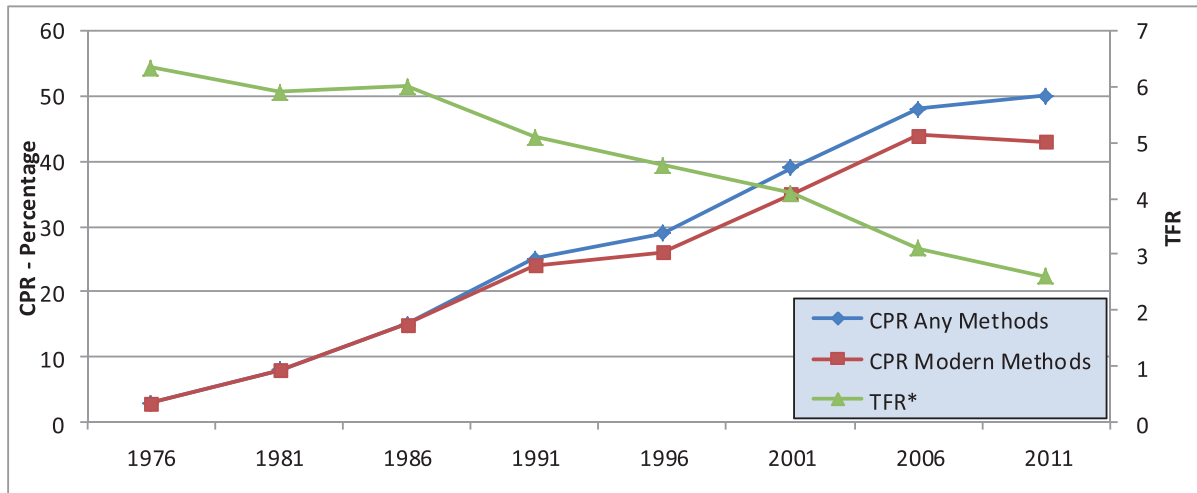
**Figure 1: Trends in Childhood Mortality Rates**



Nepal Family Health Program II (NFHP II), a five-year bilateral project, funded by the United States Agency for International Development (USAID) was awarded to JSI Research & Training Institute, Inc. (JSI) in December 2007. This bilateral project was implemented by JSI with other partners under the leadership of Ministry of Health and Population. The partners included Save the Children, EngenderHealth, Jhpiego, World Education Inc., Nepali Technical Assistance Group, Nepal Fertility Care Center, Management Support Services, Nepal Red Cross Society, United Mission to Nepal, BBC Media Action, Digital Broadcast Initiative Equal Access, Family Planning Association of Nepal and Center for Development and Population Activities.

From 1996 to 2011, the total fertility rate (TFR) in Nepal declined by 2 children, and between 2006 and 2011, the TFR declined from 3.1 to 2.6 children. In the last 15 years, the modern contraceptive prevalence rate increased remarkably from 26% in 1996 to 44% in 2006 but remained constant between 2006 and 2011. Challenges remain despite these advances, with significant disparities in access to health care. For example, infant mortality is nearly twice as high among children born to mothers with no schooling and among those born to the poorest households, compared to those born to mothers with some secondary education and to those from the richest households. There are also marked differences in infant mortality based on geographic regions and by rural urban areas.

**Figure 2: Nepal Contraceptive Prevalence Rate and Total Fertility Rate Trends**



The Nepal Family Health Program II (NFHP II) was designed to increase access to health services, particularly in rural areas, by strengthening public sector family planning and maternal, newborn, and child health services, in accordance with the Government of Nepal (GoN) plans(5-8). JSI planned to achieve this objective by continuing and building on a similar bilateral project implemented between 2001 and 2007—also by JSI Research & Training Institute, Inc.—with a focus on:

- Strengthening Ministry of Health and Population systems, policy, and leadership
- Enhancing public health service delivery for family planning, maternal, newborn, and child health
- Increasing access to and utilization of health services, especially by marginalized populations
- Increasing community participation in health service management
- Advancing global best practices in family planning, maternal, new born and child health services through policies and pilot initiatives

NFHP II approached these goals through work at multiple levels. At the national level, NFHP II worked with the Government on policy, standards, guidelines, curricula, information systems, work planning, and program



monitoring. Nationwide support was provided for several programs including the National Vitamin A Program, the Female Community Health Volunteer (FCHV) program, and the Ministry of Health and Population's (MoHP) Logistics Management and Family Planning Divisions. NFHP II also worked more intensively in 20 core program districts—10 in the Central and Eastern Terai, and 10 in the Mid- and Far Western regions. In collaboration with its partners, NFHP II added two districts midway through the project. NFHP II's contributions to these districts included significant support to strengthen the entire MoHP district health system, including peripheral facilities and community-based services.

In 2010, the U.S. Government's Global Health Initiative (GHI) officially designated Nepal as a focus country. The GHI calls for renewed attention to family planning, nutrition, HIV, and maternal, newborn, and child health. The GHI is helping accelerate progress towards the MDGs, and heighten the impact of all U.S. assistance in the health sector. Aligned with the GON's health strategy, the GHI is building on existing efforts to address the needs of women, girls, and other vulnerable groups, promoting research for policymaking and engaging other donors and civil society in health. Many of these strategies have been well incorporated in the NFHP II approach.

This final project report provides an overview of NFHP II's activities, programs, and interventions during the life of the project. It sets forth program strategies, underscores the major achievements, and highlights lessons learned and challenges ahead.

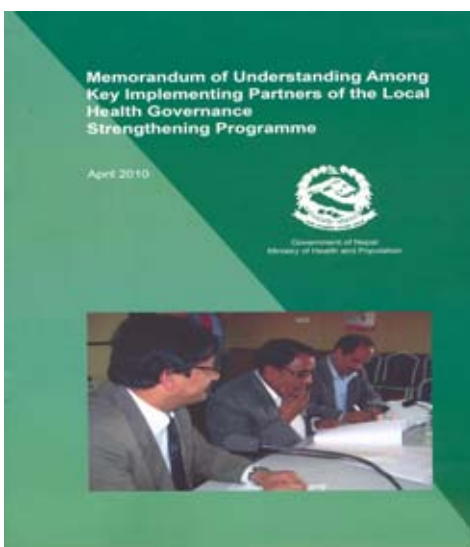


*An FCHV counseling community women at a Mothers' Group meeting in Banke district.*

# SUPPORTING POLICY AND LEADERSHIP DEVELOPMENT

## Results

- Assisted the GoN to draft national policies, strategies, and guidelines.
- Strengthened the decentralization process, enabling local committees to have greater control over resources through the Local Health Governance Strengthening Program, piloted in two districts.
- Increased Health Facility Operation and Management Committee (HFOMC) capacity through a simplified and more practical capacity enhancement package.
- Conducted pilot research that informed national policies and guidelines for misoprostol and chlorhexidine use.
- Contributed to a revised strategy for Female Community Health Volunteers (FCHVs) leading to innovative support systems such as the FCHV fund.
- Supported revision of central level electronic database containing FCHV profiles and training information that assists program managers, policy makers, and partners with strategic planning.
- Helped MoHP develop the National Family Planning Strategy, which provides clear guidelines and options for future family planning (FP) programming to meet FP needs.
- Helped revise the *National Medical Standard for Reproductive Health Services Volume I: Contraceptive Services in 2010* and included latest global standards to guide FP training and implementation.
- Supported the National Health Education, Information, and Communication Center (NHEICC) to develop the Maternal, Neonatal and Child Health and Family Planning Communication Strategies 2012-2016.



*Memorandum of Understanding among key implementing partners of the Local Health Governance Strengthening Program, 2010.*

NFHP II provided support on policy and leadership at the central level to ensure that FP/maternal neonatal and child (MNCH) service delivery yielded the greatest possible results. In addition to providing practical assistance with on-the-ground implementation, NFHP II was also involved in advocacy and policy development for activities such as health sector decentralization, family planning, local governance, and use of misoprostol and chlorhexidine.

## POLICY SUPPORT

NFHP II contributed by carrying out advocacy efforts, drafting policy documents, and implementing and evaluating activities. Most notably, the project implemented and evaluated programs such as use of misoprostol to address postpartum hemorrhage (PPH), chlorhexidine (CHX) to address neonatal sepsis, local health governance to increase community engagement, the community-based neonatal care package, strategies to increase access to family planning and maternal health services, and strengthening the female community health volunteer program. These programs are discussed in detail in the respective chapters of this report.

NFHP II's significant involvement at the implementation level also enabled the project to generate a large amount of evidence, lessons learned, and evaluation of policies, activities, and programs that were used to revise, formulate, and set policies and strategies (see *Policy Support Matrix* in Annex 1). For example, findings from the *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal: A Midterm Survey for NFHP II* were used extensively during the development of the Nepal Health Sector Program 2 (NHSP 2).

### DECENTRALIZATION AND LOCAL GOVERNANCE

NFHP II's local health governance and decentralization efforts included the implementation of the pilot on Local Health Governance Strengthening Program (LHGSP) in two districts, Dang and Surkhet, along with similar support from German Technical Cooperation for another two districts.

The LHGSP is in compliance with the Local Self Governance Act, 1999, and provides District Development Committees and local Health Facility Operations and Management Committees (HFOMCs) with authority for financial and human resource management for local health services.

NFHP II provided significant technical and financial assistance for the pilot, including:

- Designing the pilot
- Developing implementation guidelines
- Facilitating District Technical Team meetings
- Preparing Village Development Committee (VDC) profiles and using these to develop local level plans to improve health services
- Providing continuous monitoring and support

The MoHP provides earmarked grants to the pilot districts through the Ministry of Local Development and these funds are allocated through the District Development Committees to health facilities based on the merit of the plans prepared and submitted by local HFOMCs. In addition to the earmarked grants allocated by the MoHP, the HFOMCs also received additional matching funds from the District Development Committees, their own VDCs, and other sources.

Both districts have used the funds primarily for activities related to improving physical infrastructure and drug procurement. Surkhet allocated more money for capacity building than Dang, although in Dang too, it represented the area with the second-highest grant allocation. See *Technical Brief #28* for more details (9).

**NFHP II's significant involvement at the implementation level enabled the project to generate meaningful evidence and lessons learned, as well as to evaluate policies, activities, and programs.**



*Minister of Health and Population and the US Ambassador launch NFHP II in December 2008 as a high-profile project designed to strengthen health services for the Nepalese people.*

This activity is linked to the NFHP II intervention Health Facility Management Strengthening Program (HFMSM) discussed later in this report under community participation and engagement.

### FCHV POLICY STRENGTHENING

While the FCHV program has been globally recognized for its success in community-based service delivery, the Government has been attentive to ensuring that related policies and guidelines keep pace with demographic changes and shifts in FCHV activities. NFHP II supported the Government to strengthen its policies and develop guidelines to ensure adequate support for FCHVs as they took on new responsibilities.

Policy development included supporting the Government to revise the national FCHV strategy and develop program review guidelines and strengthening financial support to FCHVs without compromising their volunteer status. This included strengthening the funds available to them by assisting the Government to develop fund guidelines and training materials.

### Other Program Policy Support

NFHP II also supported the Government with policy development in a number of ways for multiple program areas. In logistics and information management, various NFHP II efforts supported contributed to policy evolution and establishing new approaches. NFHP II assisted the Government with revising existing policies, as in the case of family planning and maternal health. In service delivery, the experience with new approaches and with new interventions resulted in policy improvements as evidenced by the expanded use of partograph and the introduction of chlorhexidine.

*FCHVs posing with the Minister of Health and Population and other government officials during the Sixth National FCHV Day, December 2009.*





### LESSONS LEARNED AND CHALLENGES AHEAD

- The GoN has historically taken thoughtful steps prior to full-scale implementation of health interventions, from careful consideration of evidence generated through research, both globally and nationally, to piloting interventions to test their efficacy, and finally to nationwide scale-up. NFHP II helped the GoN translate research into policy, explore implementation through pilot activities, and when successful, bring interventions to scale. This process has ensured that interventions bring about the greatest possible results, impact, and reach.
- While communities and health facilities have fully asserted their ownership of the LHGSP, similar ownership is lacking at the district and central levels.
- The revised FCHV Strategy gives guidance regarding retirement of FCHVs who turn 60 years of age (with recommendation from their mother's group) or who are inactive or unable to work due to personal or physical reasons (voluntary retirement). However, FCHV withdrawal does not always take place in practice, as some FCHVs have been reluctant to retire.
- Policy change is complex, particularly during periods of political change. The Government is committed to improving services based on evidence of public health impact at scale, with modest cost. NFHP II's experience suggests that policy change is facilitated by active leadership at MoHP, personal relations, mutual respect, and an established international reputation.



*An FCHV returning home after an NFHP II training.*

# STRENGTHENING THE HEALTH SYSTEM WITH IMPROVED LOGISTICS MANAGEMENT

## Results

- Helped develop effective management of overall supply chain system and improved availability of FP and maternal and child health commodities and essential drugs at service delivery sites.
- Together with the GoN, launched web-based logistics management information system and inventory management system at the district level.
- Facilitated construction and equipping of 12 new district storerooms.
- Supported scale-up of inventory management pull system to all 75 districts under the leadership of Logistics Management Division, MoHP.
- Revised guidelines for auctioning, disposal, and write-off of expired supplies, making them generic, more accessible, and easier to use.

## HEALTH LOGISTICS SYSTEM

The Logistics Management System is a critical component of the overall health system. NFHP II's technical support to the MoHP's Logistics Management Division (LMD) has been consistent and effective in all functional areas of logistics management, including:

- Commodities security: forecasting, budgeting, procurement, and quality
- Using data from the Logistics Management Information System (LMIS) and strengthening web-based LMIS
- Strengthening storage capacity and distribution of essential health care commodities
- Implementing the pull system (inventory management) throughout the country
- Training on logistics management at all levels (discussed in detail in *Training* section, page 15).

All of these interventions have ensured availability of health commodities at service delivery sites and reduced stock outs leading to increased program coverage. NFHP II worked closely with the USAID| DELIVER PROJECT to strengthen the MoHP overall logistics system.

The logistics system underwent significant changes during NFHP II. The GON has taken ownership of a majority of logistics activities including distribution and transportation of commodities, construction of district warehouses, and logistics training. Effective coordination and technical assistance on consensus forecasting<sup>1</sup> of health commodities has also been a tremendous success, and the GON has committed to funding and timely procurement of FP and other health commodities. The GON

<sup>1</sup> The process in which the MoHP divisions, and donor partners together come to a consensus on quantity and funding requirements of commodities, based on forecasts provided by the LMD



Over 2,000 people have been trained through NFHP II in logistics management, leading to better-managed logistics systems overall.

has also taken the lead in planning district storeroom construction in 27 districts.

**Commodity Security**

The share of MoHP funding for procurement of family planning commodities has increased from 5% in 2001/2002 to 74% in 2011/2012, indicating a positive shift in commodity security and less dependence on external donor funds for procurement.

Every year, NFHP II with DELIVER supported the LMD in forecasting for reproductive health and child health commodities. Consensus forecasting, which began with family planning commodity security in 1998 under the leadership of the LMD, today includes quantification of essential drugs, maternal, neonatal and child health commodities, vaccines/syringes, and HIV and AIDS commodities.

**Logistics Management Information Systems (LMIS)**

The LMIS for district and regional stores was upgraded to a faster, more reliable and innovative web-based technology in 2008. NFHP II provided software programs, computers, related accessories, and network devices to all districts and assisted the LMD to operate the web-based LMIS. To enhance district storekeepers' capacity to operate the web-based LMIS, NFHP II, with the LMD, provided nationwide training. The GoN has approved a fund to support web-based LMIS in 75 districts for FY 2012/13.

Regular paper-based LMIS reporting from the 4,187 public sector health facilities and district stores has consistently been over 90% since 2005 indicating that this reporting system is well institutionalized. Information generated from the LMIS was extensively used for logistics decision-making. Refer to *Technical Brief: Nepal: Transforming Decision-Making with Web-based LMIS* (10).

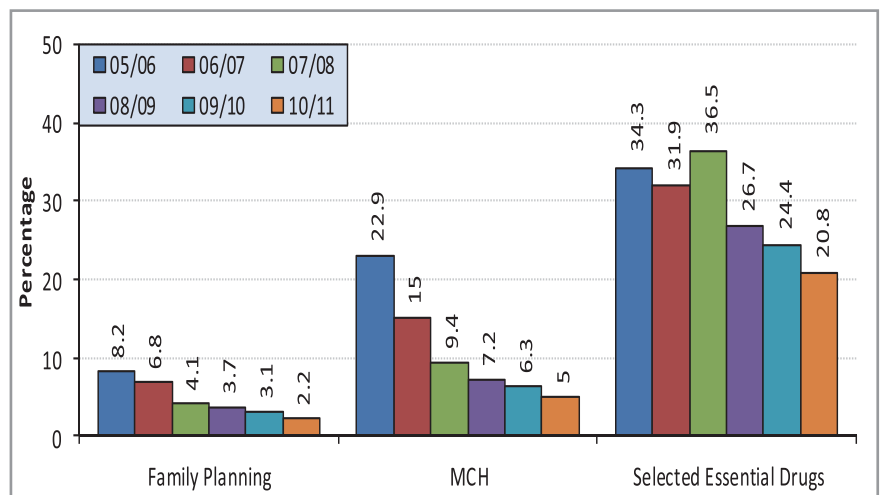
**Strengthened Storage Capacity at All Levels**

During the program period, 12 district storerooms<sup>ii</sup> were constructed with German Development Bank and MoHP funds, while NFHP II provided equipment to the newly constructed

<sup>ii</sup> Rolpa, Ramechhap, Pyuthan, Surkhet, Dailekh, Achham, Morang, Banke and Khotang, Lamjung, Sindhupalchowk, Jajarkot

**The district and regional warehouse logistics management information system has been upgraded to a web-based technology.**

**Figure 3: National Quarterly Stockout % of Health Commodities at Health Facilities**



**Unused supplies have been auctioned and district store rooms and health facilities cleaned, opening up 15,438 sq. feet of space and generating NRs. 2,219,744**

stores. The district storerooms are now well equipped, with a well-functioning first expiry, first out system and have adequate space for safe storage of health commodities. Refer to Technical Brief: Increased Storage Capacity Improves Nepal's Public Health Supply Chain for further information (11).

#### ***Inventory Management***

In 2010, the LMD decided to scale up the logistics pull system to all 75 districts and included budget for training in 41 districts. NFHP II continually supported the LMD in the scale-up and maintained the pull system through a range of activities including training of trainers, refresher trainings, printing curriculums, and regular monitoring and supervision.

Government institutions are required to auction and dispose of unusable commodities every year. Because of the cumbersome processes and complexity of coordinating with other government departments, however, these tasks are often neglected. In 2010, NFHP II helped the LMD and other government departments revise the guidelines for auctioning, disposal, and write-off, making them generic and accessible by any public sector division or department and also easier to use, thus ensuring minimal external support.

Since then, significant progress has been made in auctioning and cleaning district storerooms and health facilities throughout the country. These efforts helped vacate 15,438 sq. feet of space and generated Nepalese Rupees (NRs.) 2,219,744 to the national treasury.

NFHP II supported LMD to plan and carry out the Annual Commodity Distribution Program, one of the LMD's key approaches to ensure availability of FP commodities in the districts and health facilities. The program delivers commodities to district stores and ensures an adequate buffer stock to the Regional Medical Store, based on LMIS consumption data.

#### **LESSONS LEARNED AND CHALLENGES AHEAD**

District storekeepers often come from sectors other than health and may have difficulties understanding health logistics. NFHP II worked with the LMD to recommend a new policy that district storekeepers come from a health background. If endorsed, this policy will benefit the country's supply chain management system.

The implementation of the web-based LMIS and Inventory Management System at the central, regional, and district levels has become a positive example



*Supply truck delivers NFHP II-provided equipment to one of 12 new district store rooms.*

for other divisions of the MoHP and can influence the development of web-based human resource management, health management information system (HMIS), and financial management systems. With a web-based LMIS, the center, regions, and districts are empowered to make evidence-based logistics decisions, ultimately ensuring year-round availability of key health commodities and essential drugs to the end users. The GoN plans to fund and own the web-based LMIS in all 75 districts.

Although the LMIS is sustainable at the district level and below and health personnel have the necessary skills to use it, sustainability is yet to be achieved at the central level.

Quality issues, procurement and budget delays, shortage of iron tablets, cotrimoxazole tablets, and implants were common during the program period, resulting in their limited availability at service sites. An alternative method of local district procurement of essential drugs and program commodities was enforced, but the GoN and stakeholders need to increase efforts on efficiency, transparency, and capacity of local-level procurement.

Timely procurement and supply from district centers to peripheral health facilities remains a challenge because of difficult geography, poor transport infrastructure, and inefficient budget management. With the growing demands for health commodities, the storage facilities at center and regional levels pose new challenges, and at the moment, storage is inadequate. NFHP II worked closely with GoN and developed detailed architectural designs for modern central and regional warehouses. The GoN is in the process of allocating funds for the construction of these warehouses.



*Cleaning out expired supplies, such as at this storage facility in Jumla district, has been a key aspect of inventory management.*



*Finding supplies stored neatly on shelves is now the norm throughout most of the country.*

# TRAINING AND QUALITY IMPROVEMENT

## Results

- Trained 93,489 health volunteers, service providers, and community leaders.
- Trained 1,941 service providers in clinical family planning methods and comprehensive family planning services.
- Established district-level quality assurance working groups that are functioning well in 20 core program districts.
- Helped Management Division develop and disseminate Health Facility Level QA Guidelines and the Integrated Supervision Guidelines to ensure quality services.
- Initiated alternative training approaches including on-site coaching for IUCD and self-paced learning for no-scalpel vasectomy and logistics.
- Increased use of sterile equipment at health facilities from 17% in 2008 to 62% in 2012; similarly, proper disposal of other medical wastes increased from 51% in 2008 to 80 % in 2012 and maintenance of a clean environment increased from 55% to 86% during the same period.

NFHP II assisted the National Health Training Center (NHTC) to strengthen training capacity particularly in the areas of family planning and health logistics. NFHP II provided support to establish the Training Working Group (TWG) in May 2009 and ensure it functioned optimally. Prior to the TWG's establishment, there was poor coordination among stakeholders and training data were not properly kept, creating difficulties maintaining a cadre of appropriate trainers. Establishing the TWG helped to develop integrated training plans, proper reporting and recording of training data, and better coordination among stakeholders. Similarly, NFHP II supported the NHTC and district health offices (DHOs) to form District Training Coordination Group in the Siraha and Rolpa districts.

## STRENGTHENING THE TRAINING SYSTEM

NFHP II also helped to improve quality and proper function of six training sites<sup>III</sup>. NFHP II staff conducted regular technical support visits to these sites to ensure that the quality of service and trainings met national standards and guidelines. To fulfill the need for training, especially on long acting family planning methods, NFHP II helped re-establish the Paropakar Maternity Hospital and Koshi Zonal Hospitals as training sites. NFHP II also provided support to hand over full ownership of the Chhetrapati Family Welfare Center to the MoHP, Department of Health Services, moving away from dependency on USAID funds.



*Conducting comprehensive family planning counseling training in Rolpa district.*

III Chhetrapati Family Welfare Center (CFWC), Institutionalized Clinic and Training Center (ICTC) Nepalgunj, Koshi Zonal Hospital, Tribhuvan University Teaching Hospital (Family Planning and Fertility Care Center), Paropakar Maternity and Women's Hospital, and Family Planning Association of Nepal

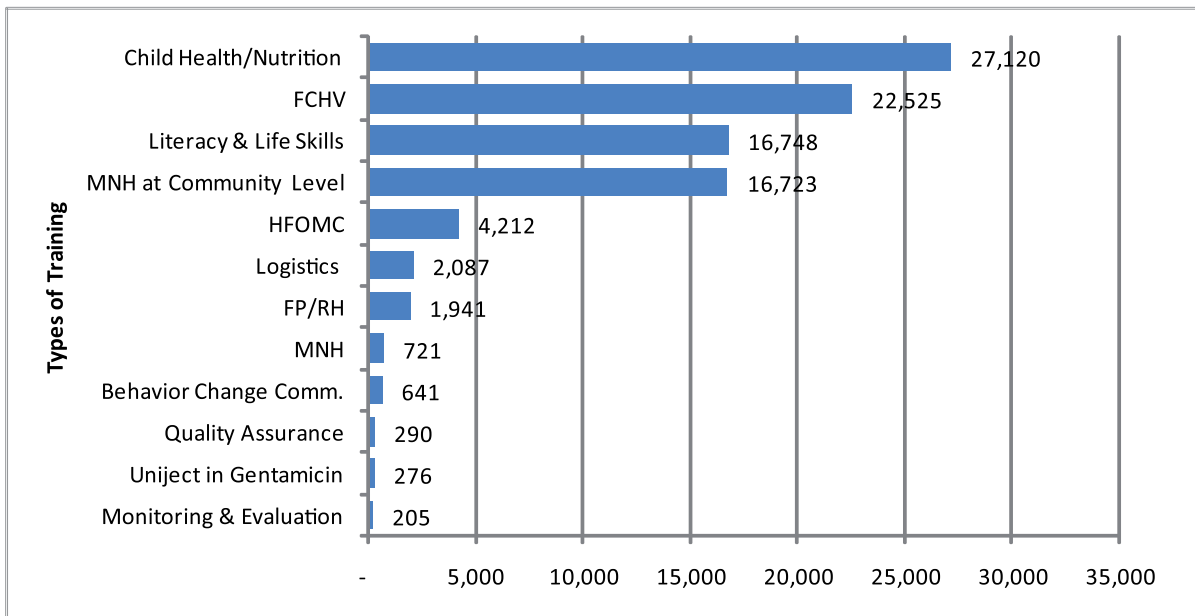
NFHP II assisted NHTC to revise, print, and use Quality Improvement tools, standard training packages, materials, and guidelines for infection prevention (IP), comprehensive family planning and counseling (COFP/C), implants, IUCD, and health logistics. Overall, NFHP II helped to train a total of 93,489 health volunteers, service providers, and community leaders (see chart below) during the project period, contributing to strengthened quality health care services at the community level.

NFHP II explored new training approaches and used alternative learning approaches for intrauterine contraceptive device (IUCD) coaching for skilled birth attendants (SBAs). The project used distance-learning and self-paced learning to train physicians in no-scalpel vasectomy. NFHP II also carried out clinical training skill sessions for 99 district supervisors and service providers to conduct training for village health workers (VHWs) and maternal and child health workers (MCHWs), and FP refresher and COFP/C trainings. Strengthening the training system and clinical training skills enhances access to FP services. Please refer to the following chapter for more details about the FP program.

NFHP II supported the LMD and NHTC to conduct training in broad areas of health logistics in order to build the capacity of logistics staff in district level procurement, LMIS, and inventory management. A pool of trainers was formed at the LMD, NHTC, and RHTCs to institutionalize the training within the GON system.

**Provider training has contributed to an increase in the number of service delivery sites; for example, implant sites in NFHP II’s districts increased from 15 in 2007 to 96 in 2011.**

**Figure 4: Numbers of Persons Trained by Types of Training (2008-2012)**





NFHP II's interactive training CD for self-paced learning, Basic Health Logistics, developed with NHTC.

**In exit interviews more than 95% of clients said that they received the contraceptive method of their choice. More than 89% of caretakers knew about oral rehydration therapy (ORT) for diarrhea, and 87% knew how to prepare it correctly.**

Over NFHP II's five-year period, the project trained 2,087 health personnel in logistics-related areas. The trainings have resulted in increased LMIS reporting and improvements in year-round availability of health commodities at service delivery sites. NFHP II has also successfully transferred ownership of logistics trainings to the NHTC and LMD. Today, NHTC has a pool of trainers who are capable of conducting logistics-related trainings with limited technical assistance from NFHP II. Moreover, the LMD and NHTC have been allocating funds for logistics training.

Furthermore, NFHP II assisted NHTC to develop an interactive training CD on "Basic Health Logistics" for self-paced learning. To date, 16 district staff have successfully completed the "Basic Health Logistics" course and have received certification from NHTC.

### **Strengthening Overall Quality Improvement**

NFHP II is one of the key members of the Quality Assurance Technical Working Group (QA TWG) formed by the Management Division (MD). NFHP II collaborated with the MD to formulate the quality monitoring system and developed the Health Facility Level QA Guidelines (2009) and the Integrated Supervision Guidelines (2009). This national effort helped establish ongoing attention to quality assurance in service delivery. These guidelines were used in districts by QATWG in 20 CPDs.

### **Quality Improvement at the District and Facility Levels**

At the district level, NFHP II worked with D/PHO in CPDs to strengthen quality assurance and supervision systems. NFHP II helped to conduct workshops for 314 D/PHO supervisors from 17 CPDs to enhance their knowledge and skills of systematic monitoring and supervision based on a performance improvement (PI) approach (Refer to the NFHP II *Technical Brief # 18*). As per the PI approach (use of self-assessment tools), NFHP II helped supervisors to identify key performance gaps and explore root causes of problems and help to implement appropriate interventions for improvement of service quality. NFHP II supported training/workshops on infection prevention based on the PI approach for 356 staff from 10 hospitals and 2,152 health workers from 277 peripheral health facilities. NFHP II also helped construct 128 placenta pits and 497 waste burning/disposal pits. Similarly, NFHP II supported 402 HFs to improve their water supply systems and also repaired toilets in 146 health facilities. Please refer to *Technical Brief #31* for further details(12).

Data from 3,330 clients and client caretakers collected through exit interviews in NFHP II program districts show that more than 95% of clients responded that they received the contraceptive method of their choice. More than 89% of caretakers of children with diarrhea knew about oral rehydration therapy (ORT), and 87% knew how to prepare it correctly.





More than 22,000 Female Community Health Volunteers were trained through NFHP II, thus improving services in even the most remote areas of Nepal.

### District Quality Assurance Working Groups

As per the National Policy on Quality Health Services (2007), NFHP II supported the MD to establish and ensure the Quality Assurance Working Group (QAWG) functioned properly in core program districts. Managers and supervisors of D/PHOs appreciated the value of the QAWG as a forum to discuss overall performance and quality-related issues, ways to address these issues, and how to make better use of available resources. The QAWG was also linked with the district supervision system, which helped to develop a system of sharing findings of supervision and addressing the gaps for improvement of services. NFHP II supported D/PHOs to establish a Quality Assurance District fund, which helped them to implement important activities to address identified gaps in health facilities and communities. Although the fund was relatively small in amount, it helped each district address gaps immediately and increased credibility of the supervision system. During life of the project, NFHP II provided approximately NRs 28.5 million for the Quality Assurance District fund. Refer to *Technical Brief# 25* for details (13).

### LESSONS LEARNED AND CHALLENGES AHEAD

The QAWGs are functioning well in most of the districts despite discontinuation of NFHP II's technical and financial support from December 2011. The GoN has started allocating funds to the districts to strengthen the quality assurance system using the QAWG mechanism, per the Quality Assurance Guideline. D/PHO supervisors are properly trained to use quality improvement principles and approaches. However, the supervision mechanism from the center and districts needs to be strengthened, to ensure better identification of gaps, explore root causes, and implement activities to improve the quality of services.

All six family planning training sites are functioning well and providing training, including voluntary surgical contraception (VSC), intrauterine contraceptive devices (IUCDs), and implants. The current challenge, however, is lack of interest from medical doctors to work as trainers on clinical family planning methods (in particular VSC). Training offers no career advancement and as such, there is frequent disruption of clinical training on VSC.

**NFHP II helped construct 128 placenta pits and 497 waste burning/disposal pits. Similarly, NFHP II supported 402 HF's to improve their water supply systems and also repaired toilets in 146 health facilities.**



Placenta pit at the Sarlahi District hospital.

# IMPROVING SERVICE DELIVERY AT THE FACILITY LEVEL

In order to increase access and utilization of family planning, maternal, neonatal, and child health services, it is important to strengthen services at both health facilities and the community level. In this regard, NFHP II has provided support to Nepal's public health facilities, such as the sub health posts (SHPs), health posts (HPs), primary health care centers (PHCCs), as well as to hospitals. Although NFHP II facility-level work most directly addressed the technical areas of family planning, maternal, neonatal, and child health, their interventions helped improve the overall services offered by these health facilities. NFHP II support to strengthen community-based services is discussed in the next section.

## Results

- Increased Contraceptive Prevalence Rate in 20 core program districts from 48% in 2007/08 to 53% in 2010/11.
- Total new acceptors of IUCD and Implant in 20 core program districts increased from 2,274 and 3,115 in 2007/2008 to 8,943 and 9,409 respectively in 2010/2011 (MoHP, HMIS).
- Piloted and helped MoHP to expand postpartum family planning in 10 hospitals.
- Helped MoHP to increase service sites for regular availability of long-acting FP methods such as IUCDs and implants.
- Strengthened family planning services in 23 safe abortion clinics of the Family Planning Association of Nepal and 9 community mobile clinics.

## FAMILY PLANNING

Family planning (FP) services are available from the public and private sectors and through social marketing. However, the public sector remains the major source of modern contraceptives in Nepal (69%) (4). NFHP II was highly involved in the national FP program and helped Nepal's Family Health Division (FHD) to develop strategies, standards, guidelines, to design and implement new FP approaches, and to expand FP services—with a particular focus on rural and marginalized communities in all CPDs.

According to NFHP II's mid-term survey in 2009 (14), there has been a slowdown from the steady increase in contraceptive use rates seen in Nepal between 1976 and 2006, although fertility has continued to decline in 2011. As a result, NFHP II worked closely with FHD to address the possible stagnation of contraceptive use by introducing innovative approaches. The approaches included district level planning to support the D/PHOs in developing a more strategic FP program, increasing information on FP in rural areas, improving counseling



*Postpartum mothers now receive family planning counseling after birth so they can space their children as wanted.*

through introduction of the Reproductive Health (RH) Counseling Kits, strengthening family planning in safe abortion service sites, updating family planning to periphery level health workers and volunteers, and introducing postpartum FP services. At the same time, NFHP II analyzed the mid-term survey data to examine the possible association between the stagnation of the contraceptive prevalence rate and the increase in out-migration of people seeking employment (15). This analysis suggested the need to examine both the conventional measurement of the contraceptive prevalence rate and the unmet need in populations with high out-migration. Nepal must also adapt strategies to meet the contraceptive needs of migrant couples.

#### ***Increasing Access to Family Planning Services***

One of the MoHP's key priority is to increase access to family planning services, especially in rural and marginalized communities. Temporary family planning methods—notably condoms, pills, and injectable contraception—are widely available in Nepal. Long-acting family planning methods, such as IUCDs, implants, and sterilization services are more limited. Hence, NFHP II assisted D/PHOs to increase access to long acting family planning methods in the district clinics, PHCCs, and HPs in 20 CPDs by providing trainings to appropriate health workers, repairing physical facilities, supplying essential equipment/instruments, and providing on-site coaching to service providers. The study on *Changes in Health Systems and Services* (HSSA) conducted by NFHP II in 2011 showed that the availability of IUCDs in PHCCs increased from 43% to 77% and in HPs from 7% to 33%. Similarly, for implant it increased from 25% to 63% in PHCCs and from 3% to 29% in HPs. Moreover, these services are now offered on a regular basis. NFHP II also supported D/PHOs to provide quality VSC services regularly in district clinics/hospitals and through mobile services by providing training, equipment, supplies, through pre-VSC meetings, and through TSVs. In addition, NFHP II supported the Family Planning Association of Nepal (FPAN) to regularize comprehensive family planning services in three district clinics and nine community static clinics. These clinics now provide regular family planning services.

Counseling and informed choice are key components of quality family planning services. To strengthen counseling and informed choice, NFHP II designed, developed, and distributed RH Counseling Kits to all district clinics, PHCCs, HPs, and selected SHPs in 22 CPDs. Service providers and managers said that this kit helped them provide proper counseling.

**NFHP II was heavily involved in the national family planning program, and helped the FHD develop policies, standards, and guidelines in order to design and implement new FP approaches.**



*Client receiving family planning services in Rolpa district.*

NFHP II also worked together with FHD to implement a “satellite clinic” approach in all CPDs. In this approach, trained service providers from a nearby health facility or hospital regularly visit peripheral health facilities and provide long-acting family planning methods to interested clients. After some time, these facilities are upgraded and service providers are trained to provide long acting FP methods regularly. This approach again helped increase options for family planning services in rural communities and has been scaled up in other districts by the MoHP through the regular government budget.

#### ***Integration of FP into Maternal Health Services***

NFHP II worked with FHD and D/PHO to integrate FP with maternal health services. The postpartum family planning program was initially piloted in two hospitals and scaled-up in 10 hospitals. This resulted in an increase in the number of postpartum and post-abortion women receiving FP counseling and using FP. In these health facilities, mothers receiving FP counseling after delivery increased markedly from 4% to 43%, and clients receiving FP services in post-abortion care and comprehensive abortion care sites increased from 60% to 73% and 72% to 80%, respectively. Refer to *Technical Brief #30* (16).



*NFHP II developed a reproductive health counseling kit and helped train providers to effectively counsel women with up-to-date information.*

NFHP II supported FPAN to strengthen family planning services in 23 safe abortion service sites. NFHP II also helped conduct initial and follow-up workshops for medical doctors, nurses, counselors, and branch managers to update their knowledge and emphasize the importance of family planning. These workshops improved counseling approaches, enhanced the use of family planning methods after abortion, and contributed to improved method mix in the utilization of contraceptives following this intervention. Monitoring data of FPAN show that post-abortion family planning use increased from 74 % to 78 % during the last six-month period in 23 safe abortion service sites. The FHD also adapted this approach for government safe abortion service sites through their regular budget.

#### ***Increasing Demand and Service in Hard to Reach Areas***

NFHP II piloted an approach to provide FP information and services in rural areas and to marginalized communities by mobilizing FCHVs and health facility operation and management committee (HFOMC) members in their local communities. NFHP II implemented this approach in 117 VDCs across 10 CPDs of NFHP II. The project succeeded in increasing the use of long-acting family planning methods—mostly by adolescents, postpartum mothers, and women in rural and marginalized communities.

This approach also helped 1,115 FCHVs enhance their knowledge of FP, as well as improved their interpersonal communications skills.

NFHP II subcontracted with the Centre for Development and Population Activities (CEDPA) to target a family planning program for marginalized communities in the Bara and Rautahat districts. Locally hired Community Facilitators (most of whom were women from marginalized communities) conducted house-to-house visits and provided health education about the importance of family planning. They also supported mothers' health group meetings and PHC outreach clinics. The program also informed Muslim religious leaders from 17 VDCs on FP and MNCH and sought their support to disseminate health messages and refer clients for services in local health facilities.

#### **Lessons Learned and Challenges Ahead**

- After implementing various approaches focusing on rural and marginalized communities, it became clear that use of family planning services among these populations can be increased. However, intensively focused efforts are needed and community engagement is critical to improve FP service use.
- The stagnation of the contraceptive prevalence rate and the unmet need for FP has drawn the attention of all stakeholders. There remain significant differences in the utilization of FP services between urban and rural populations and between the rich and the poor, while certain population groups continue to have a high, unmet need. More work is needed to determine how best to increase awareness and use of modern FP services.

#### **MATERNAL HEALTH**

NFHP II activities to strengthen public sector maternal health services have included support to the FHD in initiating new approaches to enhance the knowledge and key skills of SBAs working in rural health facilities. NFHP II also supported the FHD to strengthen annual work planning, develop training materials, and improve quality of services in NFHP II core program districts.

The FHD was also provided support in conducting regular Safe Motherhood Neonatal Sub-Committee meetings and various Technical Advisory Group meetings, in which stakeholders agreed to pilot and initiate new approaches. NFHP II also helped FHD formulate policy and guidelines related to maternal health.



*An FCHV visits a recently delivered woman in Jhapa for FP/MNCH services*

**Use of maternal and child health services has dramatically increased in NFHP II core program districts.**

### Results for Maternal Health

- Helped ensure proper functioning and improved quality of maternal health services at birthing centers.
- “Maternal and Neonatal Health Services in Rural Nepal,” a new intervention introduced by NFHP II, strengthened active management of third stage of labor in 12 CPDs.
- Increased the proportion of pregnant women who received at least one antenatal and postnatal care contact with health services from 74% in 2008 to 93% in 2011, and 41% to 55%, respectively (compared to the national figures of 85% and 51%, respectively).
- Increased the number of SHPs providing delivery services from 4% in 2008 to 22% in 2011, and at health posts from 52% to 82% during the same period.

Guided by the objective to improve quality and increase demand for maternal and neonatal health services, NFHP II supported FHD to conduct the first ever National Public Health Nurse (PHN) Conference in 2011, attended by 132 PHNs from 62 districts.

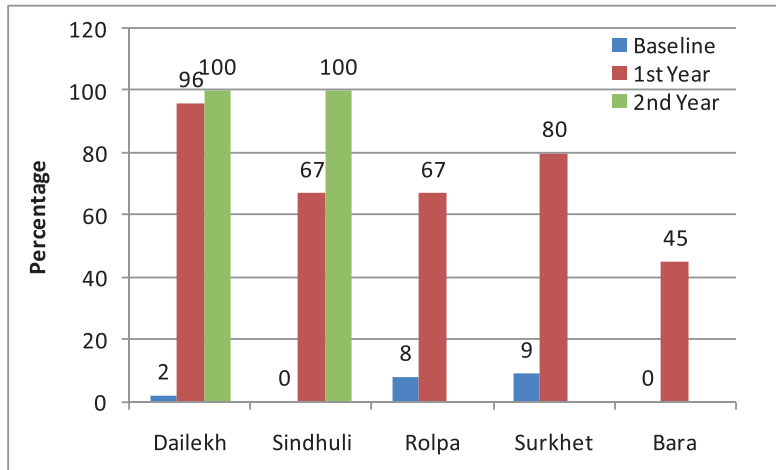
### *Enhancing Knowledge and Skills of Rural Service Providers*

With assistance from NFHP II, FHD introduced a new intervention, *Strengthening Maternal and Neonatal Health Services in Rural Health Facilities*, in 12 CPDs<sup>IV</sup>. This was a set of interventions aimed at improving the overall quality of MNH services in rural health facilities. It included training service providers about selected SBA skills, including support to create an enabling environment and promotion of community participation. NFHP II monitoring reports showed a significant increase in the number of functional basic emergency obstetric care (BEOC) sites and birthing centers, as well as improvement in the quality of care. Significant increases in the number of health facilities routinely using partographs to monitor progress of labor and performing active management of the third stage of labor for prevention of PPH were noted in all districts. In Dailekh and Sindhuli districts, use of partographs—once negligible—is now routine in 100% of health facilities. The number of health facilities that can effectively manage pre/eclampsia with magnesium sulphate and perform neonatal resuscitation also improved. Several service sites have also shown a significant improvement in infection prevention and waste management, including preparation and use of chlorine solution, sterilization techniques, and construction and usage of placenta pits. Based on lessons learned, FHD scaled up this intervention nationwide in partnership with other donors. See *Technical Brief #26* (17).

**NFHP II monitoring reports showed significant increases in the number of functional BEOC sites and birthing centers as well as improvements in the quality of care**

IV Kanchanpur, Dailekh, Kalikot, Surkhet, Jumla, Banke, Salyan, Rolpa, Dang, Bara, Sindhuli, Morang

**Figure 5: Percentage of health facilities in intervention districts where partographs are in use by district**



**Improving the Quality of Maternal Health Services**

Technical support visits (TSVs) and on-site coaching were conducted at BEOC service sites and birthing centers to ensure that services were available on a regular basis and in compliance with national standards. NFHP II also provided orientations to community stakeholders on maternal and neonatal health issues, including the *Aama Surkchhya* Program<sup>V</sup>, at selected sites. These orientations promoted institutional delivery and community involvement in establishing and continuing 24-hour birthing facilities.

NFHP II's efforts have contributed to increased access to MNH services in the CPDs. The percentage of women who had institutional deliveries increased from 13% to 36% in NFHP core program districts during the life of the project. The 2012 HSSA report showed that the percentage of facilities providing delivery services increased from 4% in 2008 to 22% in 2011 for SHPs and from 52 % to 82% for HPs. Of those who provided delivery services, 96% of HPs and 86% of SHPs provided 24 hours service.

**Lessons Learned and Challenges Ahead**

- Training alone is not enough to improve the quality of care. Once trained, providers need ongoing efforts that ensure an enabling environment. Regular TSVs, on-site coaching, and regular follow-up of progress and challenges must complement training intervention to ensure lasting change. Community engagement can also play a vital role in increasing demand for services, mobilization of resources, creating a more supportive environment for health workers, and regularizing service provision at health facilities.



*The Strengthening Maternal and Neonatal Health Services intervention improved the overall quality of MNH services and was scaled-up nationwide by the FHD in 2011.*

**There has been noticeable improvement in MNH service use in core program districts.**

<sup>V</sup> Free delivery care with incentives for women who deliver at qualified health institutions.



Expecting mother receives services in Rolpa district.

- There has been a rapid expansion in the number of birthing centers in most districts. Ensuring quality of care in these sites has been a challenge because of rapid expansion in the absence of adequate physical facilities, instruments/equipment, essential supplies, and lack of availability of skilled service providers. Notably, there are frequent disruptions in 24-hour birthing services, especially in rural areas, due to the frequent transfer of health workers. Retention of skilled health workers in remote facilities continues to remain a challenge.

### **Saving Women by Using the Knowledge Gained from Maternal and Neonatal Health Update**

*Prior to the maternal and neonatal health update, none of the health facilities in Sindhuli, a hilly district in Nepal, had magnesium sulphate (MgSO<sub>4</sub>). Each time a woman with eclampsia came to a health facility, they would refer the convulsing woman to Janakpur Zonal Hospital, approximately 3 hours away from the district headquarter. This journey often resulted in women dying on the way.*

*During the NFHP II MNH update, providers learned about the importance of having MgSO<sub>4</sub> ready for use at health facilities, and one year later, all health facilities in this district had MgSO<sub>4</sub> in stock. Manju Neupane, an auxiliary nurse midwife in Sirthauli Primary Health Care Center (PHCC) said "Even after a two-month-long training on managing obstetric complications, I was not confident and was scared to use MgSO<sub>4</sub>. The MNH update however, gave me a clear understanding on the correct and safe way to use it. Last month, a woman came to us convulsing a day after delivery. I was as scared, but I gave her a loading dose of MgSO<sub>4</sub> before sending her to Janakpur. When she returned to the village she thanked me for saving her. Her attendants told me that she did not have fits on the way to the hospital or after reaching there."*





*Teaching safe delivery during an MNH Update training in Rolpa district*

# SUPPORTING COMMUNITY-BASED SERVICE DELIVERY

## Results

- NFHP II helped introduce innovative intensive monitoring for CB-IMCI that brought attention to gaps in service delivery while improving performance.
- Support for expansion of CB-NCP contributed to improved knowledge and behaviors for maternal and newborn care and increased institutional deliveries.
- NFHP II helped introduce new interventions including chlorhexidine and misoprostol, demonstrating ability to achieve good coverage. These are now being scaled up nationally.
- NFHP II supported the Government in developing training materials on the FCHV fund and trained 1225 fund management committee members. Today, three-quarters of the VDCs/communities in NFHP II districts have supported FCHVs, largely through cash contributions.
- Improved FCHV visibility and awareness of the importance of their role through targeted media, including a television drama and radio spots aired nationally.

While NFHP II recognizes the critical role that health facilities play in Nepal's health system, the project also focused on ensuring that services are available at the community level, especially in rural areas. NFHP II's key areas of interest at the community level included integrated management of childhood illness and maternal, neonatal, and child health. At the center of these community-based services are the VHWs, MCHWs, and Nepal's unique female community health volunteers (FCHVs).

## FEMALE COMMUNITY HEALTH VOLUNTEERS

There are currently approximately 49,000 FCHVs in rural Nepal. They serve as a local health resource and a bridge between health facilities and the community. FCHVs have been globally recognized for their early success in vitamin A supplement distribution and in providing community-based treatment of pneumonia and diarrhea, referring severe cases to health facilities. FCHVs have expanded on these successes and become more involved with mothers and newborns, and now counsel pregnant women using the Birth Preparedness Package and provide counseling on FP and other MNCH activities. FCHVs also now provide iron folate to pregnant women nationwide and distribute chlorhexidine to pregnant mothers for improved neonatal cord care, and misoprostol to prevent PPH in selected districts.

Overall, NFHP II support to strengthen the FCHV program can be classified into three broad areas. NFHP II helped improve FCHV performance through better policies and strategies, enhanced in-service training systems, gave regular technical updates during monthly and



*Helping FCHVs learn how to better monitor and track activities, such as CB-IMCI, is leading to better data quality, better planning, and ultimately better health care in communities*

bi-annual review meetings, strengthened Mothers' Groups for Health, and provided supportive supervision and monitoring. NFHP II supported the MoHP to economically empower FCHVs by establishing and properly operating the FCHV fund for income generation activities. NFHP II helped enhance FCHVs' image and credibility through the annual FCHV Day celebrations on December 5, and through national radio and television programs. FCHVs' enhanced credibility not only makes them more accepted by their communities as important health service providers, but also encourages and motivates the FCHVs in their work. This is evidenced by the ongoing support FCHVs receive from local communities, including contributions to the FCHV fund.

NFHP II focused on quality of care for community service delivery through FCHVs more intensively in program districts.

## CHILD HEALTH

### *Community-based Integrated Management of Childhood Illness (CB-IMCI)*

Nepal is one of only five countries that have reduced under-five mortality by 50% since 1990. The Community-based Integrated Management of Childhood Illness (CB-IMCI) initiative contributed to this achievement. CB-IMCI was started in three districts in 1999 and was gradually expanded to all 75 districts by the end of 2010.

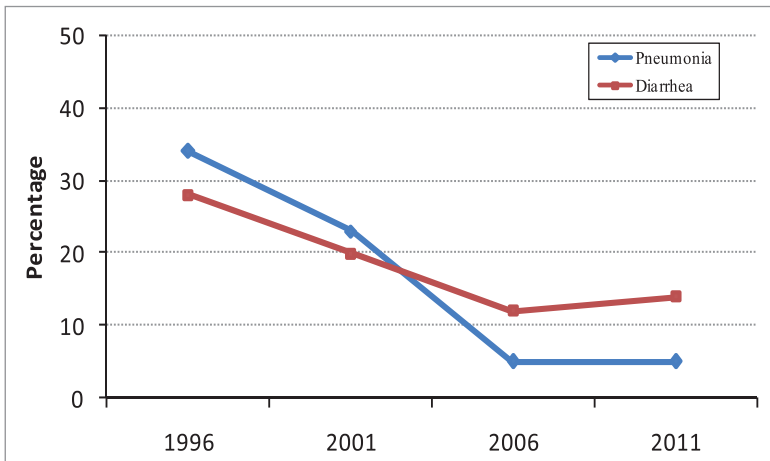
The main objective of the CB-IMCI program is to reduce morbidity and mortality among children under-five due to the five most common causes of death (pneumonia, diarrhea, malnutrition, malaria, and measles) and to promote healthy growth and development of children and neonates. The program package was revised in 2004 based on the WHO guidelines to include management of neonatal infection, hypothermia, and jaundice, and use of zinc for management of diarrhea. Zinc to treat diarrhea was piloted in 2006 in two districts and expanded to all districts by 2010. Over the last decade, both the prevalence and severity of pneumonia and diarrhea in under-five children has declined dramatically, and currently, less than 1% of cases seen at HFs are severe (18).

NFHP II assisted the government with strengthening this mature program. Monitoring data shows that correct case management of pneumonia by FCHVs has been consistently over 95%, as measured by correct antibiotic dose for age and appropriate follow-up visits. Data from NFHP II core districts also show that FCHVs have good knowledge of

**Monitoring data shows increases in FCHVs contacting pregnant and postpartum women to promote service utilization.**



*An FCHV counting the breath of a sick child using the ARI timer.*

**Figure 6: Symptoms of Pneumonia and Diarrhea (1996 - 2011)**

**Over the last decade, the percentage of children under five with pneumonia and diarrhea symptoms has declined dramatically.**

#### **NFHP II supplied:**

- 24,000 ARI timers
- 2,487 clinical thermometers
- 1,618 weighing scales
- 8,154 Delee suction tubes
- 3,119 bag and masks
- 6,350 Clean Delivery kits
- 483 safety boxes
- 43,000 insulin syringes
- 9,700 pairs of gloves
- 44 resuscitation dolls
- 20 ordinary dolls and 100 baby wrappers
- 287 ORT corner sets
- 55,000 posters

the four home rules to treat diarrhea. FCHV contributions are also reflected in the HMIS Annual Report 2009/2010 which showed that of the 70% of children who received treatment for pneumonia at the community level, 52% were treated by FCHVs. Similar figures were seen in the treatment of diarrhea: 53% of children were treated by FCHVs.

Intensive monitoring is a new and innovative activity to bring improvements in low-performing HFs and communities within a short period of time. NFHP II, along with DHO/DPHO supervisors, carried out this

intensive monitoring approach in 118 HFs and built the capacity of 221 health workers in six districts (Jhapa, Morang, Rautahat, Parsa, Dang, and Banke) leading to improved under-five case management in health facilities. This approach was successful enough that the GoN is planning to introduce the approach in other districts.

NFHP II provided technical and logistics support to expand the use of zinc in conjunction with ORS to treat diarrhea among children. HMIS data from 2009/10 shows that 48% of under-five diarrheal cases were treated with zinc and ORS and the majority of such cases were treated by FCHVs at the community level. However DHS-2011 data suggest far lower coverage for zinc with ORS.

#### **National Vitamin A Program**

The National Vitamin A Program (NVAP) began in 1993 in eight districts. By the end of 1997, the program covered 32 districts, and by 2002 it covered all 75. The NVAP consists primarily of distributing high-dose vitamin A capsules to all children 6-59 months old and de-worming tablets to all children 12-59 months of age during twice-yearly campaigns through FCHVs, on fixed Nepali calendar dates.

NFHP II and its partner NGO, Nepali Technical Assistance Group (NTAG), provided ongoing support to the Child Health Division (CHD) to ensure smooth implementation and that high coverage of this important program was maintained. This included emergency logistics backstopping, community mobilization, and monitoring, as well as intensification of efforts in urban areas where coverage was lower. The program has sustained consistently high coverage in all districts.

## MATERNAL AND NEONATAL HEALTH

The GoN, with support from NFHP II, designed an interim strategy of MNH activities at community level that focused on high-impact interventions through a continuum of care from pregnancy through the postpartum period and from the community to health facilities. Please see *Technical Briefs #10 and #11* (19, 20). The interim strategy was designed to be implemented at scale by the MoHP. The interventions were built on existing government programs, structures, and activities such as the birth preparedness package (BPP) and iron intensification.

This set of activities was implemented in 11 districts<sup>VI</sup> with slight variation by district, but antenatal and postnatal contacts by FCHVs and iron intensification were core activities in each district. For this, FCHVs were mobilized to identify pregnant women living in their catchment areas, visit them in their homes to provide counseling on birth preparedness (money, transport, and service providers), identify danger signs, strengthen referrals, promote hygiene, nutrition and self-care, and promote essential newborn care. They provided iron to all mothers, and misoprostol to prevent post-partum hemorrhage to those living in districts where misoprostol activities were implemented. They also carried out post delivery visits to reinforce counseling messages, screen for danger signs in mothers and newborns, treat or refer as appropriate, and provided vitamin A to all mothers.

Significant improvements were observed in pregnant women receiving antenatal (ANC) counseling and the full course of iron tablets (except when national iron stock-outs occurred), institutional deliveries, and the use of misoprostol in home deliveries. Monitoring data also showed an increase in FCHVs contacting pregnant and postpartum women to promote service use.

NFHP II conducted follow-up surveys on maternal and newborn health in selected districts which confirmed that MNH activities at community level have been successful at achieving high coverage of services through the mobilization of FCHVs and health workers(21, 22). Promoting institutional delivery was the primary objective of the MNH interventions. The follow-up surveys showed that institutional deliveries were 29%, 34% and 50% in Bajhang, Jumla and Banke district respectively. Similarly, the coverage of misoprostol was 79%, 77% and 52% respectively in these districts, allowing the majority of pregnant women to be protected from PPH. NFHP II monitoring data in all 11 program districts shows that 49-80% of pregnant women were in contact with FCHVs during the pregnancy period, with the exception of four districts<sup>VII</sup>.

**The introduction of high-impact interventions through a continuum of care from pregnancy to postpartum periods was scaled up from 11 to all 75 districts through the revised birth preparedness package.**

VI Jhapa, Banke, Kanchanpur, Sindhuli, Jumla, Kalikot, Mugu, Bajhang, Dailekh, Rolpa and Salyan  
VII Rolpa, Salyan, Sindhuli and Kanchanpur



A trained FCHV weighs a new baby.

**NFHP II follow-up data showed that three months after training, 75% of FCHVs retained knowledge on essential newborn care, 90% on PSBI signs, and 80% on birth weight classification.**

### **Newborn Care Program**

To reduce the high neonatal mortality rate and achieve MDG 4, the MoHP and partners developed a community-based neonatal care package (CB-NCP) that expanded on the experience with early MNH activities in communities. This new neonatal care package added sepsis and birth asphyxia management to address the full spectrum of contributors to neonatal mortality.

The package focuses on seven major components: behavior change communication, promotion of institutional delivery, postnatal follow up, management of infections, low birth-weight, hypothermia, and birth asphyxia. The MoHP implemented this program in ten districts<sup>viii</sup> in 2008/2009 and has been gradually expanding it in other districts with support from partners, including financial and technical assistance from NFHP II in four districts. To reinforce the knowledge, skills, and motivation of health workers and FCHVs, follow-up after trainings were held after two to three months in these four districts in coordination with the DHO team, during which on-site coaching was provided along with re-supply of commodities.

After a year of program implementation, Mahottari and Salyan saw substantial progress in key indicators. Data from February 2011 to January 2012 shows that coverage of FCHV services (registration of pregnancy among expectant mothers) was 61% in Mahottari and 46% in Salyan. Likewise, of all the deliveries where FCHVs were present, more than 95% of neonates in both districts received appropriate immediate newborn care i.e., skin-to-skin contact and breastfeeding within one hour of birth. More than 90% of postpartum women and neonates were visited by FCHVs on the seventh day and almost all women were visited on the 29th day. Data also showed that of all possible severe bacterial infection (PSBI) cases, more than 90% in Salyan and 100% in Mahottari received the full dose of gentamicin.

NFHP II carried out a follow-up three months after training and the data shows that 75% of FCHVs across the four districts retained knowledge on essential newborn care, 90% on PSBI signs, and 80% on birth weight classification. Progress has also been made on increasing institutional delivery in these four districts.

NFHP II supported development of CB-NCP training materials, job aids, and reporting forms for HFs and communities. These materials were based on lessons learned from CB-IMCI and the Morang Innovative

VIII Doti, Bardiya, Dang, Palpa, Chitwan, Parsa, Kavre, Dhankuta, Sunsari, Morang

Neonatal Intervention (MINI) and other community-based maternal-newborn pilot activities conducted under NFHP and NFHP II. The overall CB-NCP is currently being evaluated. Based on the recommendations from the evaluation, the components of the CB-NCP program may be revised for implementation in the remaining districts.

## INNOVATIONS

### **Misoprostol for Prevention of Postpartum Hemorrhage at Home Birth**

With PPH a leading cause of maternal mortality, and with many women still delivering at home without skilled attendants, the GoN supported use of misoprostol for home deliveries based on positive results from clinical trials. An initial pilot to test feasibility, acceptability, and safety was done in 2005, which demonstrated successful coverage from community-based distribution—with results published in 2009 in the *Journal of Perinatology*. Based on these findings, misoprostol has been scaled up in 27 districts, with NFHP II support in eight. With promotion and improvement in institutional deliveries, NFHP II monitoring data showed that addition of misoprostol for home deliveries has markedly improved overall uterotonic coverage. See *Technical Brief #11* (20).

### **Introduction of Chlorhexidine to Reduce Neonatal Mortality**

Use of potentially harmful substances on freshly cut umbilical cords is prevalent in Nepal and can lead to neonatal sepsis and, ultimately, neonatal death. Encouraging results from several studies showed that use of chlorhexidine (CHX) on the umbilical cord immediately after the cord is cut reduces overall neonatal mortality by up to 23% (23, 24). These results encouraged the GoN to pilot a CHX intervention with NFHP II support in four districts in 2009.

Results from the pilot showed high rates of both coverage (receipt and use of CHX) and correct use (full tube used; application immediately after cord-cutting; application on cord tip and surrounding area). Coverage in Banke reached 75%, followed by Jumla (66%) and Bajhang (43%). In the more remote districts, like Bajhang, family members and recently



*An FCHV distributing misoprostol to a pregnant woman.*



*A health worker applying chlorhexidine on a newborn's umbilical cord. After conducting research that illustrated the effectiveness of the method, the use of chlorhexidine has been scaled up across Nepal.*

**Once chlorhexidine was shown to reduce umbilical cord infections and overall neonatal mortality it was piloted in 4 districts.**

**Results from the pilot showed high rates of both coverage and correct usage of chlorhexidine by FCHVs.**



NFHP II supported the National Vitamin A program, which distributes vitamin A capsules and de-worming tablets to all children through FCHVs.

delivered women predominantly applied CHX, whereas in Banke, a less remote district, health workers and FCHVs did the application (22).

Success of the pilot led to the formal endorsement of CHX as a national program by the GoN in 2011. Chlorhexidine has been included in essential newborn care practices and has been integrated with other government programs such as CB-NCP and misoprostol expansion. It has also been included in the SBA curriculum. The 4% CHX gel has been included in the Government's Essential Drug List. This intervention has now been introduced in 27 districts and is being rapidly scaled up. See *Technical Brief #27* (25). Based on this work, JSI submitted a proposal and was awarded a grant to implement a project on *Better cord care saves babies' lives: Reducing newborn deaths in Nepal through the use of chlorhexidine for preventing sepsis*, under the Saving Newborn Lives Challenge Grants.

#### **Vitamin A Supplementation for Newborns Pilot**

Promising results from several field trials in Indonesia, India, and Bangladesh on newborn vitamin A supplementation, encouraged the GoN to implement a vitamin A pilot in four districts between 2009 and 2011, with technical and financial support from NFHP II (Sindhuli and Banke), UNICEF (Tanahun and Nawalparasi), and the Micronutrient Initiative.

The primary objective of the pilot program was to test whether the mother/family member-dosing model (Sindhuli and Tanahun) or FCHV-dosing model (Banke and Nawalparasi) was the best approach to distribute vitamin A (50000 IU) to newborns within 48 hours of birth, and to ensure maximum coverage and safe dosing.

In addition to regular monitoring of the intervention to assess program coverage and possible adverse effects, endline household surveys were conducted. The results demonstrated that reasonable coverage can be obtained through both models, and that a combination is likely to achieve adequate coverage to impact mortality rates (21, 26).

Based on conflicting studies in Africa, the WHO published a statement saying that newborn vitamin A supplementation is not currently recommended. It recommends further field trials to document the efficacy of newborn vitamin A on mortality impact. Thus, MoHP has put this intervention on hold.

#### **Other Innovations**

NFHP II assisted the GoN in supporting several other new interventions designed to address program gaps. The gentamicin in Uniject design



stage trial was a study carried out by NFHP II and PATH USA, under the leadership of the CHD, to explore the feasibility and acceptability of gentamicin in Uniject in combination with oral cotrimoxazole to treat PSBI when administered by FCHVs in the community. The study was conducted in five VDCs in Morang district (27). During the study period, FCHVs recorded 422 live births. Of these, 94 were identified as having PSBI and 87% were seen by FCHVs. Among the 82 PSBI episodes first seen by FCHVs, 67 were treated with gentamicin in Uniject for the prescribed seven days under the supervision of a health worker. Although the results were positive, the MoHP has decided to keep this intervention on hold due to cost and other programmatic factors.

To address pre-eclampsia as a leading cause of maternal mortality, the GoN is responding to positive results from clinical trials with the use of calcium. NFHP II, in collaboration with MCHIP, supported the Family Health Division in initiating a pilot study to explore coverage and compliance of the use of calcium during pregnancy for the prevention of pre-eclampsia and eclampsia. The intervention has been initiated in Dailekh district and the final evaluation will be conducted through a household survey after one year of program implementation.

#### LESSONS LEARNED AND CHALLENGES AHEAD

- NFHP support for the FCHV program has contributed to equity and access to health services among disadvantaged and marginalized rural, hard-to-reach populations. As FCHVs are trained and start to perform new services, expectations have increased which may have a detrimental effect on the voluntary nature of their services. The formation of a central-level committee is essential to ensure coordination between the various divisions, centers, and partners that support FCHVs. It is equally important that VDCs and communities recognize FCHV efforts and share the responsibility of supporting them.
- Review monitoring meetings were conducted among HWs for correct assessment, classification, treatment, and follow-up. The quality of review monitoring meetings at both HFs and the community level are not at the expected level. NFHP II's experience with the mature CB-IMCI program has significant implications for other newer programs which will need ongoing support for some time.
- The importance of the biannual review meetings has not been internalized by health workers, which means that conducting timely and effective meetings remains a major challenge to the program.

Without these meetings, FCHVs miss opportunities for updates and collegial interaction with other FCHVs.

- The CB-IMCI effort represents a mature program with some elements having been introduced over a decade ago. In spite of this, ongoing support is needed to ensure that the quality of service delivery is sustained, particularly in the face of introduction of additional interventions. Maintaining coverage, sustaining quality of review meetings, ensuring commodity availability, and meeting training needs remain challenging. New approaches to add energy to such programs are needed, and the NFHP II's strategy of intensive monitoring has proven to be helpful in improving the quality of services.
- Developing a focused approach to provide key services through the continuum from pregnancy through the neonatal period has been successful in Nepal. MNH activities at the community level, followed by the CB-NCP, have increased the demand, access, and utilization of services during antenatal, pregnancy, and postpartum periods. FCHVs have played an integral role in this and ensured that program goals were achieved. NFHP II helped the MoHP document feasibility and at the same time achieved substantial coverage and scalability for interventions shown in clinical trials to be effective in reducing mortality. Community level activities have been synergist with health facility strengthening and contributed to increased delivery in HFs.
- Several findings have emerged from the introduction of these maternal and newborn health activities at the community level. A community-based focus on maternal and newborn health has led to improved awareness, changed behaviors, and increased appreciation of health facility services and their importance. Pilot initiatives have demonstrated that it is possible to build on the existing platform to introduce new interventions, such as adding misoprostol and chlorhexidine to FCHV activities. Combining more interventions into a more comprehensive package with the introduction of the CB-NCP is in a very early stage of implementation. The CB-NCP was designed based on experiences for some components, while introducing new components such as birth asphyxia management. The ongoing program evaluation will provide a comprehensive review and new direction to the program, as early and rapid expansion has demonstrated challenges in the maintenance of quality in training and in data reporting at the district level.

- There is still a need for a more focused approach to target hard-to-reach populations and ensure equity in services provided. While FCHVs have demonstrated equity in their service delivery, it is critical to sustain their motivation and overall support at all levels. Over time, as more robust means of delivering services through professional health workers are developed, it can be anticipated that the role of the FCHV will evolve, likely at different rates in different districts. Recognizing the increasing differences between districts, and their different needs, particularly regarding community-based services, remains a challenge for the future.

**NFHP II helped test gentamicin in Uniject to explore the feasibility and acceptability of the antibiotic in Uniject in combination with oral Cotrimoxazole to treat possible severe bacterial infection (PSBI) when administered in the community by FCHVs.**

### **Meena's Experience with FCHV Support**

*Twenty-four year old Meena is one of many women in Sindhuli who have benefited from community-based interventions. She comes from a socially and economically disadvantaged community. Because it takes 3-4 hours to reach the district hospital, her first child was delivered at home, without any ANC visits prior to delivery.*

*Upon learning about Meena's second pregnancy, FCHV Dhani Maya Thapa visited her and discussed with Meena and her family birth preparedness, ANC care, use of tetanus toxoid (TT), iron and de-worming tablets. Meena was also informed about possible danger signs during pregnancy and the benefits of delivering at the health facility. Being well-informed and through the encouragement from her family, particularly her sister-in-law Nanda, Meena received 2 TT vaccines, 1 dose of de-worming tablets and iron tablets for 6 months, and accepted all care as suggested by health workers and FCHV including delivery at a health facility. During her eighth month, she also received misoprostol and vitamin A for her newborn.*

*On 9 February 2011, while waiting for the ambulance to take her to Sindhuli Hospital, Meena gave birth to a baby boy. As advised by Dhani Maya, Nanda gave Meena the misoprostol tablet and her newborn vitamin A. Meena has now expressed her wish for a permanent family planning method, but has yet to convince her husband. However, because of the excellent support demonstrated by both her family and Dhani Maya, both Meena and her baby boy are healthy and happy.*



# COMMUNITY AND HOUSEHOLD ENGAGEMENT AND PARTICIPATION

## Results

- Over 6,500 Health Facility Operation and Management Committee (HFOMC) members from 612 VDCs in 13 districts received orientation on their role and responsibilities related to management of local health services.
- NFHP II helped improve accountability of HFs by working to increase the display of citizen charters in health facilities, from 46% to 88% in NFHP II CPDs.
- Use of health services by Dalits—a disadvantaged group—increased. The ratio of Dalit proportion among health facility (HF) clients versus proportion among catchment population increased from 1.41 to 1.48.
- Women's participation at HFOMC meetings increased from 89% to 96%, and Dalit members' increased from 42% to 58%.
- A total of 10,024 women of reproductive age completed health education and literacy (HEAL) classes.
- Contraceptive use among HEAL participants increased from 43% to 74%.
- HEAL participants used the small grants funds to promote healthy behaviors, resulting in the construction of over 800 pit latrines in their communities.

## The Health Facility Management Strengthening Program (HFMSPP) worked on the premise that:

- **communities have a right to quality health care,**
- **a responsibility to support government efforts to provide community health services, and**
- **there is potential to foster local health governance provided they are well equipped with capacity, resources, and authority.**

Communities are not only recipients of health services, but also agents of change, and they have the responsibility to support government efforts in providing quality health care services. NFHP II implemented programs that acknowledged the importance of community empowerment, participation, and engagement, through health facility management strengthening and literacy and life skills programs, targeting those from marginalized communities to increase their participation.

### HEALTH FACILITY MANAGEMENT STRENGTHENING PROGRAM

Recognizing the immense potential role of local communities in fostering more meaningful local health governance at health facilities, and to support government efforts of health sector decentralization, NFHP II designed an innovative intervention to empower and build the capacity of the HFOMC called the Health Facility Management Strengthening Program (HFMSPP), which was implemented in 13 districts. The HFMSPP approach involves a two-year period of support to HFOMCs and its members (one year of intensive implementation and one year of limited technical support), starting with a three-day interactive training, review workshops every five months, regular follow-up, and promotional activities. Empowering HFOMC members from disadvantaged communities, i.e. *Dalits*, *janajatis* (indigenous people) and women through special coaching sessions to enhance their participation and role at

HFOMC meetings was a priority. Please see *Technical Brief #17* for further details (28).

In order to build capacity for implementing the HFMS approach, NFHP II worked with three NGOs— Nepali Technical Assistance Group (NTAG), Sustainable development in Nepal (SUDIN), and Nepal Red Cross Society (NRCS)—to scale up the HFMS in the 13 program districts. Materials and technical assistance have also been provided to other organizations to implement the HFMS elsewhere.

#### ***Increased Resource Mobilization and Community Engagement in HF Management***

The HFOMCs were very successful in mobilizing local resources that were used to hire HF staff locally, improve infrastructure, conduct awareness-raising activities, and increase staff motivation. NFHP II monitoring data showed that of all the HFOMCs that implemented HFMS visited by NFHP II, 84% mobilized resources in 2011, increasing to 90% in 2012, while resource mobilization from other local organizations increased from 52% to 59% during the same period.

Regularity of HFOMC meetings increased from 38% to 81%, whereas the number of effective meetings increased from 0% to 59% between 2008 and 2012. Similar improvements were noted in gathering issues from the community, prioritizing these issues, developing action plans based on local health needs, and sharing decisions with the community.

#### ***Increased Equity and Inclusion in Health Services***

The Local Self Governance Act 1999 ensured inclusiveness through representation of *Dalits* and female members in HFOMCs. The HSSA report showed an increase in the presence of *Dalits* in HFOMC meetings (42% to 58%) and women members (89% to 96%). Monitoring data showed that 73% of women/*Dalit* members raised issues during the meetings in 2011, a clear indication of participatory and inclusive decisionmaking. Similarly, the HFMS ensured increased access to and

**The Health Facility Management Strengthening Program supported health facilities by hiring staff, building maintenance, ordering supplies, etc. After the program was launched, new-staff hiring increased more than 2.5 fold, and more technical staff were hired.**

### ***Increased Voice of Dalits in HFOMC Meetings***

*Sushma BK, 40, a resident of Binauna-4, in Banke is an active HFOMC member representing the dalit community. Until recently, she did not regularly attend the HFOMC meetings—and even when she did, she did not suggest topics for the agenda. But today, the situation has changed.*

*“I was not regular in the meetings. Actually, I was not interested because I didn’t know the importance of the meeting and I rarely put any agenda items forward. But now I attend the meetings and even wait for the monthly meetings to come. This is because I have many issues/problem to raise during the meeting which I collect from my community. Regular inputs from the HFMS opened my eyes about the importance of such meetings and my participation, including techniques to collect issues from my community. Now I feel empowered because many people of my community know me as a representative of the HFOMC.”*

**The Literacy and Life Skills Program empowered girls and young women—primarily from marginalized and disadvantaged communities—through literacy materials integrated with health information, better enabling them to change health behaviors and access health services.**



*Women studying with a low-literacy curriculum that helps them learn basic health information while learning to read.*

service utilization by *Dalits*, demonstrated by a steady increase in the ratio of *Dalit* proportion among HF clients versus *Dalit* proportion among catchment population over time: from 1.41 in 2008 to 1.48 in 2012.

***Increased Transparency and Accountability***

There are many key governance issues confronting peripheral public health facilities, including understaffing and absenteeism at health facilities, poor supervision and monitoring, poor community participation, lack of transparency, ownership and accountability, and mismatches between plans and actual health needs, to name a few.

HFOMC members were involved in regular supervision and monitoring of HFs, conducting social audits, and displaying the citizen charter, which contributes to transparency in HFs. As a result, the number of HFs running on-schedule and staff availability increased over the program period. The HSSA report showed that the display of the citizen charter in HFs increased from 46% in 2008 to 88% in 2011. These activities have made health services more accessible, staff more accountable in providing services, and maintained transparency in HF activities.

**LITERACY AND LIFE SKILLS**

Based on the experience of the World Education *Swastha Chautari* Program, NFHP II developed and implemented the Literacy and Life Skills (LLS) program in eight districts, in collaboration with eight local NGOs. The program aimed to empower girls and young women, primarily from marginalized and disadvantaged communities, through literacy. LLS also aimed to help improve maternal and child health outcomes by bringing about favorable changes in knowledge, skills, and attitudes, better enabling young girls and women to change health behaviors and access health services.

Literacy and Life Skills was comprised of three separate components: Health Education and Adult Literacy (HEAL), Girls Access to Education (GATE), and Learning Circles/Mothers' Groups (LC/MG).

***HEAL and GATE***

HEAL and GATE were literacy programs targeting illiterate women, with HEAL covering rural adult women between the ages of 15 and 45, and GATE covering girls aged 10 to 14 who are out of school. Both curricula contain health content. GATE's primary objective was to encourage enrollment into formal schools after girls' completion of the GATE program, while HEAL's focus was to reduce infant, maternal, and child mortality and morbidity by improving women's health knowledge and simultaneously providing them with literacy skills.

A total of 4,393 adolescent girls participated in GATE during the program period and most were subsequently enrolled in formal schools. A total of 10,024 women of reproductive age completed HEAL classes. HEAL successfully attained the program’s objective in reaching disadvantaged (*Dalits* and *Janajatis*) and under-served populations. Data shows that a high percentage of participants coming from disadvantaged communities. Please refer to *Technical Briefs #22 and #23* (29, 30).

The pre-and post-HEAL test data shows that use of contraceptives among married participants increased from 38 % at the beginning of HEAL classes to 72 % at the end of HEAL classes. Similarly, spousal communication on family planning increased from 29% to 55%.

Pre- and post-test data also show that women’s health knowledge concerning pregnancy and delivery was enhanced. Recognition of danger signs during pregnancy as well as during delivery increased markedly.

There was a notable increase, from 48% to 91%, in women seeking ANC from health workers, as well as in receiving ANC from SBAs and FCHVs, with an increase from 18% to 42% and 18% to 31%, respectively.

Behavior pertaining to infant and child health practices also showed marked improvements: use of oral rehydration solution (ORS) during diarrhea increased from 75% to 90%, as did feeding more-than-usual-solids from 27% to 79% and more-than-usual-liquids from 40% to 89%.

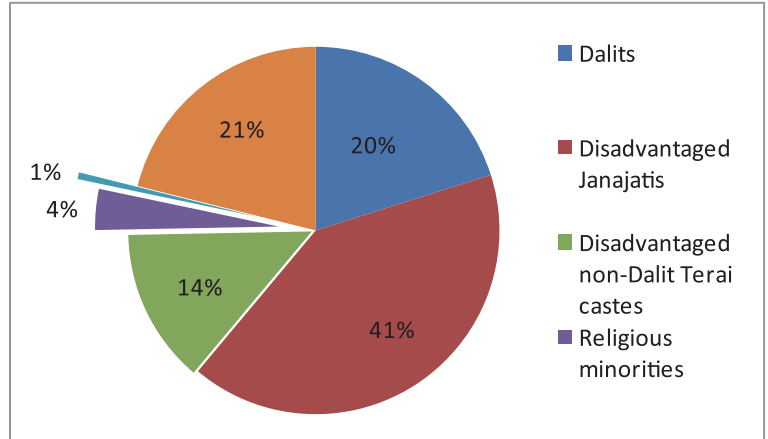
**Small Grant Support Program**

The small grant support program (SGSP) was an important sub-component of HEAL. The initiative targeted HEAL participants who completed the HEAL course and were interested in implementing maternal and child health promotional initiatives in their communities. Small grants were provided to around 190 HEAL groups to implement community-based activities to improve use of health services.

**Learning Circles/Mothers’ Groups (LC/MG)**

The MoHP has formed Mothers’ Groups (MG) in each of the nine wards (small geographic unit) in a VDC, which consist of all women 15-49 years residing in that ward. The role of the MGs is to support their local FCHV and to serve as change agents in their communities.

**Figure 7: Distribution of HEAL participants by caste/ethnicity**



**Use of contraceptives among married participants increased from 38% at the beginning of HEAL classes to 72% at the end of HEAL classes.**



*A mothers' group learning circle in Mahottari district.*

The MG program targets existing MG members and strengthens the capacity, effectiveness, and efficiency of FCHVs to fulfill their roles as community health educators and health promoters. The Learning Circle (LC) program trains young women using modules that combine health education with participation in peer support groups. The LC program strengthens the FCHV's skills and knowledge and provides her with training and support in facilitating the program and continuing her role as a health mobilizer in her community. The LC modules, which were divided into 12 separate modules, one for each monthly meeting, were found useful to conduct MG meetings. 1,619 FCHVs were trained through the LC approach, and 35,731 women of reproductive age participated in LCs.

MoHP has incorporated this structured modular approach for MG meetings into their national program.

**35,731 women of reproductive age participated in Learning Circles that combine health education with peer support.**

#### LESSONS LEARNED AND CHALLENGES AHEAD

- Capacity building of local bodies is a continuous process and should not be thought of as a one-time training event. It requires continuous engagement, periodic follow-up, coaching, and refresher training.
- It is essential that *Dalits* and women members receive regular coaching on their roles and responsibilities. Interventions on educational and livelihood empowerment would also enhance their skills and ensure optimal and meaningful participation in the committees.
- The selection process for committee members should occur at public gatherings to increase community accountability. The structure should be inclusive in nature and should ensure that the chosen individuals are motivated and competent (or have the potential to become competent), in order to maintain a spirit of active voluntarism and group empowerment.
- The integration of a health curriculum within a literacy program was effective in making HEAL participants both literate and empowering them to become change agents in their communities and in the field of public health.



- Because the program is intensive and lengthy, reaching women and girls who would benefit from HEAL and GATE takes time. Scale-up for optimal impact requires investment, commitment, and action by various partners from the central to the local/community level as well as implementing NGO partners. The latter required more supervision and guidance by NFHP II than anticipated to ensure they carried out the required monitoring and evaluation of HEAL and GATE. The resource- and time-intensive nature of the program also made recruiting qualified and committed facilitators from the community a challenge.



*A learning circle group attends class in Sarlahi district.*

# COMMUNICATIONS AND BEHAVIOR CHANGE

## Results

- Reached approximately 8 million people with health messages through Radio Nepal, a network of 74 FM stations, and 40 FM radio stations within NFHP II core districts.
- Trained 237 health workers on interpersonal communications and counseling skills, leading to improved skills as observed during monitoring visits.
- Organized more than 170 health exhibitions in rural areas.

**Informed Choice Posters and FP/RH counseling tool boxes were so effective that NHEICC and other partner organizations adapted and reprinted them for wider distribution.**

The communications and behaviour change (CBC) program at NFHP II worked to improve household health practices and care-seeking behaviour related to family planning, maternal, neonatal, and child health, nationally, and in NFHP II core program districts, especially among rural and marginalized community groups. NFHP II also worked to build the capacity of service providers to design and implement effective health education and promotional activities. NFHP II emphasize a mix of communication channels, community mobilization, and materials designed for the local context. Every NFHP II communications and behaviour change initiative was designed to address identified needs and gaps, and to consider target groups' socio-cultural environment, thus helping people internalize adjustments needed to modify deeply ingrained behaviours.

All CBC interventions were planned, designed, and implemented in close consultation with the National Health Education Information and Communication Centre (NHEICC), in accordance with the GoN's and NHSP-2 communication program strategies.

## **Documents, Curricula, and Materials**

NFHP II supported the NHEICC to develop the *Maternal and Neonatal Child Health and Family Planning Communication Strategies 2012-16*, mentioned in the policy section of this report. NFHP II also assisted NHEICC to develop the *Health Message Content Document*, which supplied and promoted health content information to journalists and health program producers who generally lack this knowledge.

NFHP II developed and distributed print materials, including posters, leaflets, and stickers on newborn danger signs and danger signs during pregnancy, on the benefits of FP, and on child health nationwide. In addition, the Informed Choice Posters and FP/RH counseling tool boxes were made available at all health facilities within the NFHP II program districts. These materials were found to be so effective that NHEICC and other partner organizations adapted and reprinted them for wider distribution. The Health System and Services Assessment illustrated that



Women go through a leaflet distributed during a health exhibition in Dailekh district.

presence of an Informed Choice Poster in a HF increased from 56% in 2008 to 94% in 2011.

### Radio and Television Programs

The project developed 16 radio spots and jingles on FP/MNCH, with the goal of providing health information and changing health behaviors. The spots were aired on a regular basis during prime time through Radio Nepal, a network of 74 FM radio stations and 40 local FM radio stations covering 20 NFHP II core districts, reaching a total target population of around eight million.

NFHP II also developed several mass media radio programs. The 104-episode radio health program, *Gyan Nai Sakti Ho*, produced during NFHP was also re-aired by NFHP II. This program was so popular and effective that Radio Audio FM station in Kathmandu packaged it under the radio program *Khulduli.com* and aired it on 40 FM radio stations in 28 districts.

NFHP II supported Equal Access to air 80 episodes of *Jeewan Jyoti*. The program was very popular as it was aired in four local languages and also contributed to changes in health-seeking behavior. A few radio stations, such as Radio Mithila and Radio Siraha, plan to continue running the program with potential funding support from local NGOs.

BBC Media Action and NFHP II aired 104 episodes of the *Ghar Agan* radio program on MNCH topics through 48 FM radio stations throughout the country. The 30-minute radio program magazine format included interviews, reports, testimonies, case studies, success stories, and short dramas.

The FHD, NHEICC, and NFHP II also developed an 84-minute entertainment-educational television show, *Mitho Satya*, which focused on delaying marriage, FP, and maternal health. A small-scale telephone survey showed that of 250 respondents, 20% had heard about the drama, and 10% had watched it—a high figure for a mass media effort. *Mitho Satya* has been distributed to DPHOs in all 75 districts and other organizations for future airings.

### Health Exhibitions and Social Mobilization

During the program period, more than 170 health exhibitions were held under the leadership of the DPHOs with support from NFHP II in remote sites of the 20 core districts. Combining popular community media with an entertainment-educational approach, health exhibitions proved to be very effective at generating

**Health messages delivered through radio programs improved health-seeking behavior.**



Radio listeners sit with promotional posters as they tune in to the weekly radio program *Jeewan Jyoti*.



A cultural show performance engages the community during a health exhibition in Dailekh district.

awareness, particularly if activities were carried out in local languages and addressed socio-cultural issues. The exhibitions attracted between 150 to 7,000 community members per event, depending on the effectiveness of pre-event promotions. Rapid assessments showed that people were able to grasp the health messages and had the intention to use health services, some of which were provided at the site as part of mobile camps (e.g., for long-term temporary FP contraceptive methods). Please see *Technical Brief #29* (31).

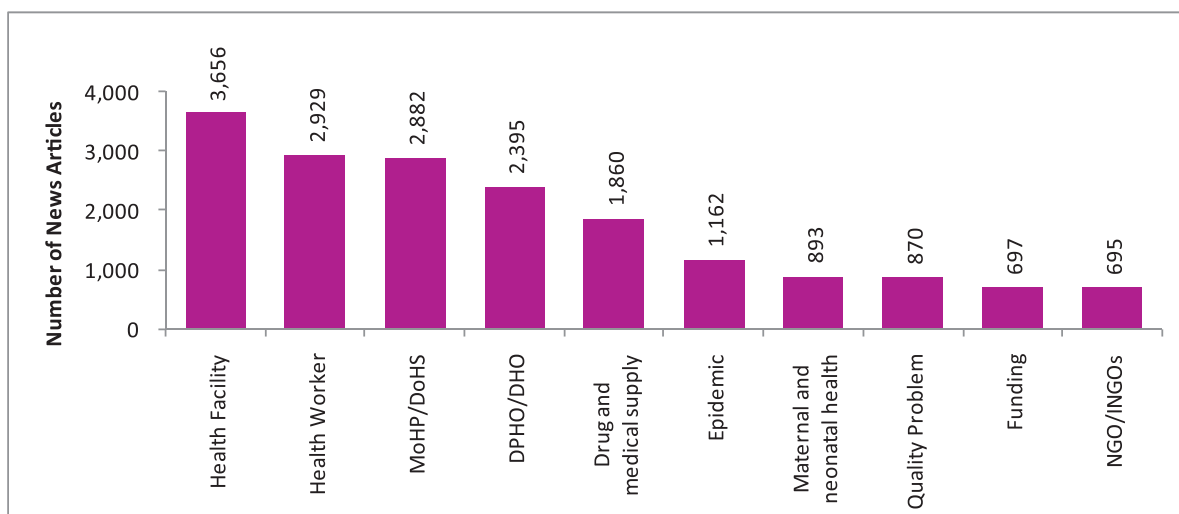
The NRCS played an important role in mobilizing communities while conducting health exhibitions in almost all NFHP II districts to provide health education and promotion activities. They mobilized Youth Volunteers during diarrhea outbreaks in Jajarkot and Banke districts and carried out advocacy activities for establishing blood transfusion services and maintaining service quality in eight of the NFHP II program districts.

#### Monitoring Health News in Print Media

NFHP II monitored health news in print media between 2009 and 2011 to analyze the state of public health reporting in Nepal, as well as to understand media coverage of health issues.

A total of 5,968 health news articles from eleven popular dailies and seven weeklies were recorded. Of the 42 keywords monitored, the most frequently used keywords included health facility, health worker, MoHP/DoHS, and DPHO/DHO. The NFHP II study found that the majority (83%)

Figure 8: Coverage of Top 10 Health Issues in Print Media



of health news captured by the project was published in the middle pages of the newspapers, whereas only 10% of health news articles were published on front pages. The articles were more frequently presented on national-level issues (35%), followed by central region issues (18%). The issues of other regions received less than 10% attention.

The results showed that local journalists lack health system knowledge, research techniques, information analysis, and writing skills. Based on this, NFHP II organized a skill enhancement and capacity building training. In total, 41 journalists from 20 NFHP II CPDs participated in the three-day training. The training included sessions on identifying key health issues, looking for reliable sources/references, and analyzing validity of information. Post-training follow-up showed an increase in the number of articles written by the journalists.

**NFHP II trained 41 journalists from 20 core districts to help them identify key health issues and analyze information.**

#### LESSONS LEARNED AND CHALLENGES AHEAD

- Reaching health messages to target audience groups is quite challenging in Nepal because of its remoteness and cultural diversity. In addition, people's media habits are changing quite rapidly. The shift from radio listening to TV viewing and mobile technology is increasing, with the most recent DHS survey in 2011 showing that more families have mobile phones than radios. This presents both an opportunity and a challenge with regard to use of mass media for behavior change.
- Penetration of international television channels and audience preferences can be a challenge to national communication for development programs. In some areas, Indian channels dominate listenership in Nepal, limiting the ability of national channels to influence behavior.
- A successful health exhibition relies on strong coordination and community mobilization, and this depends on the motivation of district staff, community members and partners. Monitoring these activities is quite challenging.



*Prizes are distributed to the winners of a health education quiz program at a health exhibit.*

# STRATEGIC INFORMATION, MONITORING AND EVALUATION

## Results

- Provided 6,714 technical support visits to health facilities in core program districts, which included oversight, support, and technical assistance to strengthen programs.
- Helped improve the quality of Health Management Information System (HMIS) data, such as timely submission of monthly reports and matching records of Depo Provera and pills among new and current users between the recording and reporting forms at health facilities.
- Use of data at health facilities increased and is being used in decisionmaking in core program districts. Health facilities displaying catchment area maps, population, and service data improved considerably.
- The Public Health Analytics (PHA) course designed and piloted by NFHP II has been adopted and scaled up by MoHP in 15 districts and will further expand in the remaining districts.
- NFHP II produced 32 technical briefs, 19 articles, and 16 surveys/studies. Such information helped in policy and program development and scaling up pilot interventions. It also addressed programmatic issues and concerns.

## MONITORING & EVALUATION

NFHP II placed great emphasis on strategic information and monitoring and evaluation (M&E). To meet the complex information needs of the program, NFHP II created coherent M&E systems to measure and document program learning and performance management. NFHP II monitored and reported 15 operational plans and 12 program monitoring indicators to USAID, semi-annually.

The NFHP II evaluation plan aimed to ensure that inputs and outputs of program activities were effectively translated into desired outcomes. As such, it used the 2006 and 2011 DHS data to measure program impact and carried out a mid-term survey in 2009 in 40 districts. To evaluate its pilot initiatives, NFHP II conducted population-level surveys at the district level. Other information sources used included the health management information system, logistics management information system, technical support visits, pre and post tests, and other surveys.

### *Technical Support Visits in Core Program Districts*

The Technical Support Visits (TSVs) were the routine performance-improvement approach used by NFHP II. Program staff, often together with government personnel, visited HFs, community health workers (CHWs), *ilaka* meetings, outreach clinics, and mothers' group meetings to assess the situation, knowledge, and skills of service providers and FCHVs. Through the visits, staff actively collected information and provided technical assistance to develop action plans. TSVs were need-based and monitored using the geographic information system (GIS) to ensure HFs received required support.



*NFHP II staff review an FCHV's register and check ARI timer during a technical support visit*

Some visits focused on one or two services while some were integrated across all health areas. The integrated TSVs monitored FP, MNCH, logistic programs, reporting, health facility management, HF-level meetings, and behavior change. To learn more, please refer to *Technical Brief #18* (32). NFHP II conducted specific TSVs for pilot interventions. Between 2008 and 2012, a total of 6,714 TSVs were provided to 1,262 HFs in the CPDs. On an average, one HF received 5.3 TSVs during the project, and the number of TSVs conducted increased every year, except in 2012 (33).

**Improving Data Quality and Enhancing Data Use**

Although there has been gradual improvement in the quality of HMIS data, problems with both over-reporting and under-reporting still prevail. Because of this, NFHP II attempted to address HMIS data quality issues

*Using the GIS tool to monitor TSVs helped prioritize HFs for TSVs. HFs needing more support received more visits from project staff.*

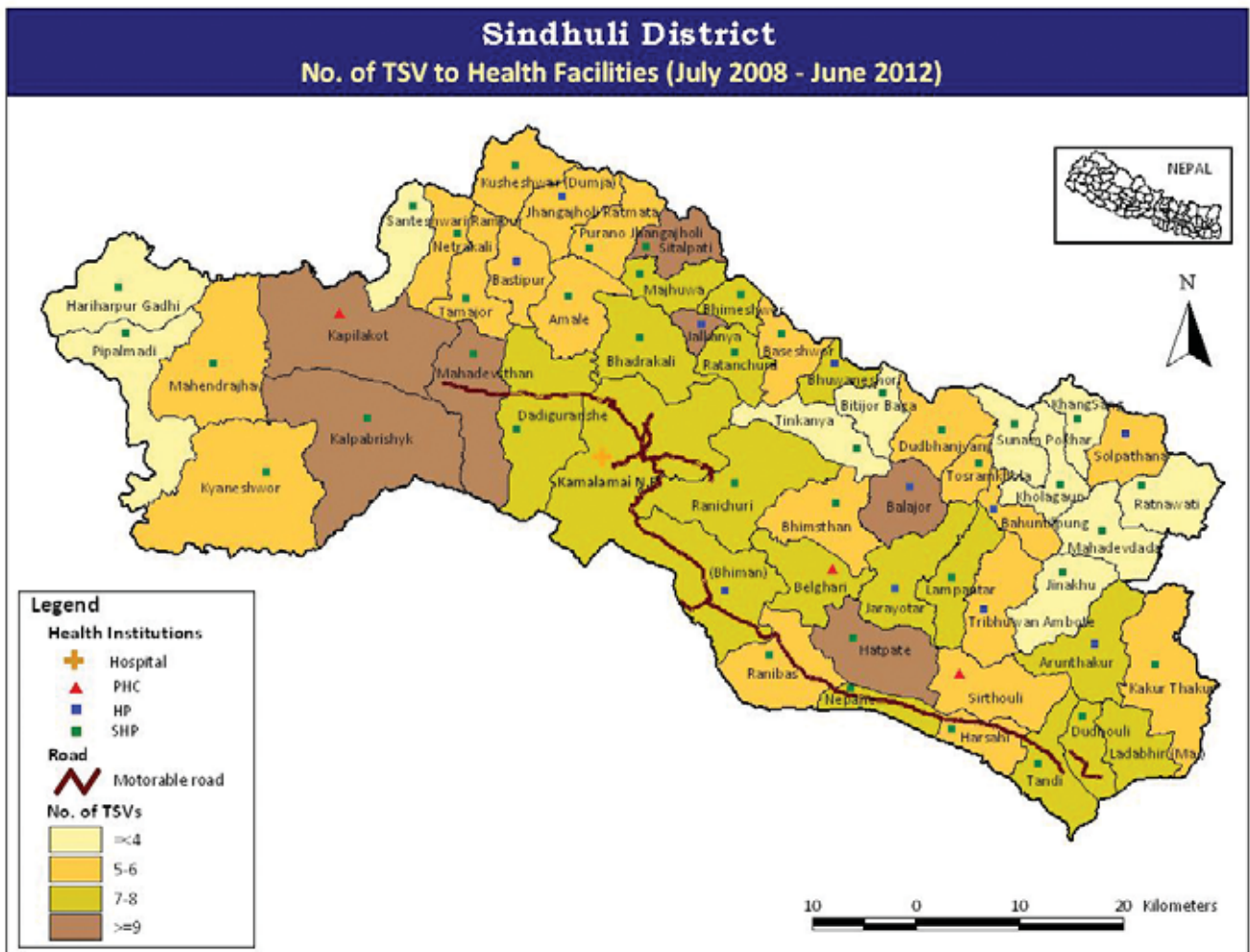
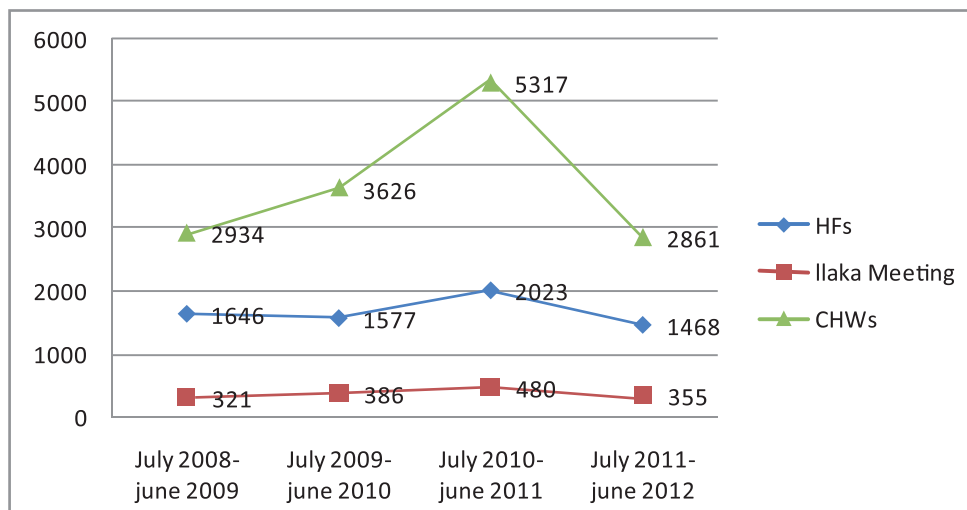


Figure 9: TSV Trends (July 2008-June 2012)



by providing human resource support at the HMIS section of the MD by orienting 53 private institutions in five districts on HMIS, and supporting *ilaka*-level meetings, data verification programs, and review meetings. These efforts resulted in some improvement in data quality. Timely submission of monthly reports by health facilities improved from 87% to 96%, health facilities updating monthly monitoring worksheets from the last month increased from 37% to 49%, and consistency of data between the records and reports improved from 51% to 62% for pill users, and from 50% to 59% for Depo users (34).

To maximize the use of disaggregated data in management of D/PHO programs, NFHP II piloted the Public Health Analytics (PHA) intervention in Kanchanpur and Surkhet in 2010, in collaboration with NHTC and the MD. The PHA consisted of D/PHO performance need assessment and a series of workshops for district focal persons where gaps in programs and HF performance were analyzed using HMIS data. The districts developed methodologies and action plans to address the gaps. See *Technical Brief #24* (35). This experience influenced the MD to scale up this approach to enhance data use at the district level.

In FY 2011/12, a simplified version of the PHA was expanded in 15 new districts by the MD. The intervention also stimulated the government to design the district-level *Data Micro Analysis and Planning Workshops* to enhance data use. Other efforts included distribution of data display in flex boards to all *ilakas* of the CPDs, and data compilation forms from ward registers for CHWs. As a result of these initiatives, the display of a map of the catchment area at health facilities increased from 17% to 31%, display of summary population increased from 17% to 40%, and data display increased from 29% to 44%. There was also improvement in displaying the most recent data from 65% in 2008 to 71% in 2011 (34).



Use of the NFHP II-supported data display flex boards has been useful in reviewing HMIS data at health facilities and has enhanced evidence-based decision-making.



### Surveys for Evidence-based Programming

A number of studies were carried out during NFHP II which included:

- A midterm survey on the FP/MNCH situation in rural areas of Nepal in 2009. The survey was an important source of information that filled the data gaps between the 2006 and 2011 DHS. The results were used extensively during the development of the Nepal Health Sector Program IP-2 document, particularly to review progress made after the 2006 DHS and to set future targets in line with MDG goals.
- As the midterm survey showed stagnation in contraceptive prevalence rate possibly due to spousal separation, a qualitative study, *Family Planning Needs of Migrant Couples in Nepal*, was subsequently conducted to explore FP in this population group.
- NFHP II conducted pilot program studies, including the use of chlorhexidine, to address neonatal infection. The hospital-based trials on CHX liquid vs. aqueous formulations and acceptability study of two different CHX formulations helped the DOHS decide that the gel formulation was more effective for newborn cord care. This was subsequently piloted in four districts. Similarly, an NFHP II study on acceptability (tablet vs. powder) and compliance of calcium helped to initiate discussion on introduction of calcium in a tablet form resulting in a new pilot being started. NFHP II also conducted a survey on the newborn vitamin supplementation pilot program.
- A *Health Systems and Service Assessment Survey* was conducted in 2008 by NFHP II, followed by an endline assessment in 2011. The purpose of the HSSA was to measure readiness of HFs to provide different services. The 2008 HSSA results helped NFHP II, DPHOs, and other organizations develop district specific activities, while results from the 2011 HSSA revealed good progress in service delivery and management of HF services.
- Health profiles of 30 VDCs participating in the LHGSP were prepared in 2011 using participatory rural appraisal techniques. These profiles were instrumental in developing the VDC specific plans under LHGSP as well as for resource allocation.



*District health staff discussing and analyzing disaggregated data during a Public Health Analytics workshop.*

**NFHP II “has been a highly successful program with substantial accomplishment in support of the Government of Nepal and USAID’s health sector objectives.”**

- Other key studies included evaluation of the HFMS, a qualitative assessment of IYCF behaviors, evaluation of special FP approaches, capacity assessment of three family planning sites, post-training assessment of VSC providers, evaluation of the radio broadcast component for MCH project *Ghar Aagan* radio magazine program, and sustainability assessment of NFHP II interventions.

Based on the evaluation recommendation by USAID, NFHP II discontinued its technical and financial support in December 2011 in five districts in order to monitor the effect of transition from NFHP II support. Results in the transition districts were mixed. Monitoring data indicated some declines in holding QAWG, RHCC and *ilaka* meetings, including supervision from district to health facilities. However, availability of commodities at health facilities remained stable and service utilization data did not suggest much change after NFHP II’s departure.

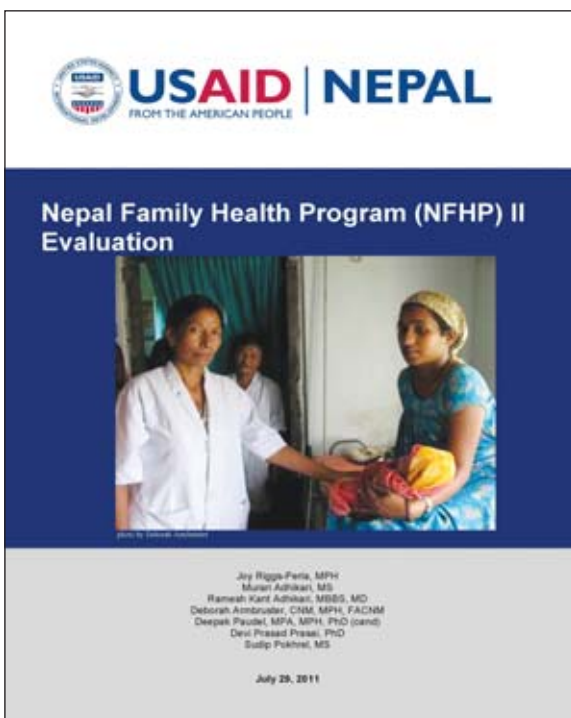
#### **Evaluation of NFHP II**

In 2011, NFHP II underwent a formal evaluation by a USAID team that included a series of interviews with staff, partners, government officials, and others; data review; and field visits to several program sites. The NFHP II staff presented detailed descriptions of each technical area and provided the team with relevant materials generated by the project.

The purpose of the evaluation was “to assess progress, identify challenges, and make recommendations for any changes needed during the final year of program implementation.”

The evaluation noted that NFHP II was designed to support the Government and the goals and objectives of the NHSP 2, with a focus on strengthening health service delivery. It went on to say that overall, NFHP II “has been a highly successful program with substantial accomplishment in support of the Government of Nepal and USAID’s health sector objectives.”

The evaluation report noted the value of continuing efforts launched under NFHP II, which helped **institutionalize important contributions**, particularly with community-level service delivery through FCHVs. In addition, the evaluators found that the **quality of MNCH services had improved with NFHP II support**, and some health system support (e.g. logistics) had been particularly valuable. It also noted some challenges with improving supervision, which was a known weakness, and with institutionalizing a more comprehensive quality improvement system. In addition, the report highlighted a specific challenge in ensuring sustainability of the achievements



Cover of the NFHP II Evaluation report conducted by USAID/Nepal.

made and institutionalizing the technical and programmatic approaches successfully introduced (36).

### **Sustainability Assessment**

Since its inception, NFHP II has been concerned about whether the activities undertaken would have a sustainable impact. During the preceding project (NFHP), an approach to assess sustainability was piloted in five districts, using a tool developed by Macro International. Radar diagrams reflect the current status for health outcomes, quality of health services, organizational capacity, organizational viability, community capacity, and the enabling environment.

In 2012, NFHP II repeated this sustainability assessment in three of the five original districts in order to review both the current status and any progress made during the project period (37). The assessment results and the comparison with the previous assessment suggest that NFHP II efforts are making progress toward lasting change. Based on an analysis of the 51 indicators contributing to the element scores, the assessment concluded that community capacity was in a strong position to be sustained—reflecting a priority strategy for NFHP II. Health outcomes made marked improvement over the five-year period, nearly doubling its score in all three districts. Health services and organizational capacity lagged behind other indicators, with less consistent results across districts with regard to the strength of these elements, in relation to sustainability. The consistently weakest element was enabling environment, which remained intermediate or at risk, although there were improvements in all districts. This exercise, reflecting an assessment of both current status and progress over time, has been valuable in the critical analysis of NFHP II efforts, and suggests that such assessments should be built into any new project.

### **Gender Equality and Social Inclusion (GESI) Self-Assessment**

In 2010, NFHP hired a GESI specialist to complete a workshop for NFHP II staff on sensitivity and biases that might adversely affect gender equity and social inclusion within NFHP II, and for program workplan development and implementation. The workshop included an in-depth analysis of the current situation and resulted in specific activities designed to ensure adequate GESI sensitivity. This process was repeated in 2011 to assess progress made, and reassess the current situation.

The conclusion from these activities was that NFHP II was performing reasonably as an institution—although further effort was needed

**The assessment concluded that NFHP II's community capacity was in a strong position to be sustained.**

to ensure better gender balance among technical staff—and doing quite well in GESI sensitivity for workplan development and program implementation. Some improvement could be made regarding representation from marginalized groups during workplan development at multiple levels, although this has proven difficult.

### LESSONS LEARNED AND CHALLENGES AHEAD

- NFHP II included a strong project monitoring element, and the data generated from this has been repeatedly helpful for both NFHP II and for the GoN in understanding how successful program implementation can be. The lessons learned with respect to individual indicators and their performance, data collection, data quality audits, and piloting have all been useful in making program implementation more efficient, and strengthening overall implementation. Selected surveys and qualitative efforts have also helped clarify gaps and contributors to those gaps. Large projects should include this type of strong monitoring system to ensure adequate information with which to inform the Government.
- Using of different methods to expand the data available for program monitoring and evaluation has been very helpful for NFHP II. Assessing various indicators through surveys, HMIS, TSVs, and qualitative studies helps triangulate information and provide a better picture of overall program implementation and progress made. In addition, ensuring strong monitoring for pilot programs is critical in order to be sure that there is adequate information with which to inform the Government on future policies related to the pilot. NFHP II's approach in regard to these issues was very useful in facilitating discussion with the Government and partners on subtle program implementation issues.
- Using the DHS data to measure project impact is useful, provided that the project's population coverage is fairly large and also the project's timeline matches with DHS fieldwork. This greatly saves resources and also provides reliable data. Moreover, surveys—such as the midterm conducted by NFHP II—using methodology consistent with the DHS fill the data gap between the two DHSs, and can be done at a low cost if there is in-house capacity to conduct such a survey.
- Data quality and data use in program management by program staff and stakeholders persist as two major issues. Addressing both issues is important for effective M&E. NFHP II's strategic information and M&E efforts should contribute to strengthening the national

HMIS and M&E, in line with NHSP 2. Endeavors such as the PHA and HSSA have potential for use by government and other partners, if coordinated properly.

- A sustainability assessment of a program is important in order to prioritize the program efforts. This assessment should be done at the beginning, mid-line and at the end of the program in order to understand gains and limitations for different program domains, and use this information to prioritize program efforts as well as to monitor and evaluate them. Such an assessment should be built into any new project.



# ACRONYMS

ANC	Antenatal Care
CBC	Communication and Behavior Change
CB-IMCI	Community-Based Integrated Management of Childhood Illness
CB-NCP	Community-Based Neonatal Care Package
CHD	Child Health Division
COFP/C	Comprehensive Family Planning and Counseling
CPD	Core Program District
CHX	Chlorhexidine
DHS	Demographic and Health Survey
DPHO	District Public Health Office
DHO	District Health Office
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FP	Family Planning
GATE	Girls Access to Education
GESI	Gender Equality and Social Inclusion
GHI	Global Health Initiative
GIS	Geographic Information System
GoN	Government of Nepal
HEAL	Health Education and Adult Literacy
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee
HFMSPP	Health Facility Management Strengthening Program
HMIS	Health Management Information System
HSSA	Health System and Services Assessment
LHGSP	Local Health Governance Strengthening Program
LMD	Logistics Management Division
LMIS	Logistics Management Information System
MCHW	Maternal and Child Health Worker
MD	Management Division
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MNCH	Maternal, Neonatal and Child Health
MoHP	Ministry of Health and Population
NFHP II	Nepal Family Health Program II
NHEICC	National Health Education Information and Communications Centre

NHSP 2	Nepal Health Sector Program 2
NHTC	National Health Training Center
NRCS	Nepal Red Cross Society
NTAG	Nepali Technical Assistance Group
NVAP	National Vitamin A Program
ORT	Oral Rehydration Therapy
PHA	Public Health Analytics
PI	Performance Improvement
PPH	Postpartum Hemorrhage
PSBI	Possible Severe Bacterial Infection
QAWG	Quality Assurance Working Group
SBA	Skilled Birth Attendant
TSV	Technical Support Visit
TWG	Training Working Group
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception

# ANNEXES

## ANNEX 1:

### NFHP II Policy Support Matrix

NFHP II (NFHP) is recognised as one of the leading technical assistance agencies working towards strengthening the Government of Nepal's health service delivery. NFHP's work at the policy-level has often been overshadowed by the project's heavy involvement in activities at the district and community levels. This document has therefore been drafted to highlight NFHP's support for policy, using the *stages heuristic* public policy framework (Walt et al. *Health Policy and Planning* 2008;23:308-317). *Stages heuristic* is one of many, but one of the most simple frameworks used during policy-making and to analyse policy decisions, by breaking down the policy process into 4 areas: 1) agenda setting 2) formulation 3) implementation 4) evaluation. NFHP's work\* with regards to policy has been placed within these four dimensions of the framework, in the columns below.

	Agenda Setting	Formulation	Implementation	Evaluation
Neonatal Health	Advocated for use of chlorhexidine to address neonatal sepsis and to include it in the health agenda	Assisted to draft the <i>Use of 4% Chlorhexidine to Prevent Newborn Infection – A Policy for Nepal</i> (yet to be endorsed)	Piloted chlorhexidine in 2009 in 4 districts and implemented it as a national program in 2011	Carried out two studies to assess efficacy, and acceptability and ease in use of aqueous or lotion chlorhexidine formulations prior to piloting the program; conducted the <i>Chlorhexidine Compliance and Coverage Study</i> to assess the pilot
	Advocated for inclusion of chlorhexidine in the essential medicine list and endorsed its use as a component of essential newborn care practices			
		Assisted to draft the <i>Community Based Newborn Care Package (CB-NCP)</i>	Implemented CB-NCP in 4 districts in 2009	Currently assisting with the final evaluation of CB-NCP
		Assisted to draft the <i>National Communication Strategy on Maternal, Newborn and Child Health (2012-2016)</i>		
Child Health		Assisted to draft the <i>Operational Guidelines for the Community Based Integrated Management of Childhood Illness (CB-IMCI) Program</i>	Implemented CB-IMCI maintenance activities in all core program districts at different times but starting in 2007	
		Assisted to draft the <i>Orientation Booklet on Use of Zinc and ORS in the Treatment of Diarrhoea at the Health Facility Level</i>		
		Assisted to draft the <i>National Communication Strategy on Maternal, Newborn and Child Health (2012-2016)</i>		
Maternal Health	Advocated to include use of misoprostol to address postpartum hemorrhage on the health agenda	Assisted to draft the <i>Implementation Guideline for use of Misoprostol at Community Level</i>	Piloted misoprostol in Banke between 2005 and 2009 and implemented it as a national program in 2010	Carried out the study <i>Maternal and Newborn Health (MNH) Activities at Community Level Baseline and Endline Survey in Sindhuli 2011</i> which included assessment of knowledge about postpartum hemorrhage and use of misoprostol tablets by recently delivered women
		Revised the birth-preparedness package (BPP) to promote continuum of care from pregnancy to post-partum mothers and newborns		
		Assisted to draft the <i>National Communication Strategy on Maternal, Newborn and Child Health (2012-2016)</i>		
Local Health Governance	Brought to the MOHP's attention the need to increase fiscal and human resource authority of HFOMCs	Contributed to develop the <i>LHGSP A Package of Health Sector Devolution Framework; LHGSP Implementation Guideline – 2010; LHGSP District Level Advocacy Framework</i>	Piloted the Local Health Governance Strengthening Program (LHGSP) in Dang and Surkhet in 2010	Currently compiling lessons learned and evaluation of LHGSP
		Assisted to draft the <i>Review Workshop Manual of Health Facility Operations and Management Committee; Facilitators Manual for Conduction of Capacity Building Training of Health Facility Operations and Management Committee; Participants Manual for Conduction of Capacity Building Training of Health Facility Operations and Management Committee</i>	Implemented the Health Facility Management Strengthening Program (HFMS) in 2009	Currently evaluating HFMS



	Agenda Setting	Formulation	Implementation	Evaluation
FCHV	Ensured recommendations from <i>A Study on FCHV Endowment Fund</i> were carried out, leading to creation of the FCHV Fund	Assisted to draft the <i>FCHV Fund Utilization Guideline</i>	Started FCHV Fund utilization training in 2010 to FCHV Fund Committee members	Carried out <i>A Study on FCHV Endowment Fund</i>
	Advocated to revise the FCHV Strategy	Helped revise the <i>National Female Community Health Volunteer Program Strategy (2010)</i>		
		Assisted in drafting the <i>FCHV Program Review Guideline</i>		
Family Planning		Assisted to draft the <i>National Family Planning Policy</i> ;		
		Assisted to draft the <i>National Family Planning, Behaviour Change Communication Strategy (2012-16)</i>		
		Assisted to draft the <i>National Family Planning Service Delivery Guideline</i> ; <i>National Family Planning Remote Area Guideline</i> ; <i>Family Planning Satellite Clinics Guideline</i>		
		Assisted to draft the <i>National Medical Standard for Reproductive Health, Volume I: Family Planning</i>		
		Assisted to draft the <i>Postpartum Family Planning Service Reference Manual</i>		
				Carried out the study <i>FP Needs of Migrant Couples in Nepal</i>
Logistics	Advocated for the need to quantify FP commodities	Assisted to draft the <i>National Reproductive Health Commodity Security (RHCS) Strategy (2007-2011)</i> ; <i>National Level Annual Consensus Forecast and Quantification of FP/RH, MNCH Commodities, Essential Drugs, Vaccines and HIV and AIDS Commodities for Next Five Years</i>		
		Assisted to draft the <i>Guideline for Auctioning and Write Off</i>	Assisted the government auction and write-off commodities at the central, regional and district levels	
Performance Improvement		Assisted to draft the <i>Health Facility Level Quality Improvement System Implementation Guideline</i>	Assisted the government establish Quality Assurance Working Groups in 22 districts	
			Implemented quality assurance activities at health facilities based on the <i>Policy on Quality Health Services 2064</i>	
Behavior Change and Communications		Assisted to draft the <i>IEC/BCC Program Guide on Climate Change and Public Health</i>		
		Assisted to draft the <i>Health Content Document for Communication</i>		
		Assisted to draft the <i>Information Booklet on Effect of Climate Change on Human Health</i>		
Others				Carried out <i>Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal: A Midterm Survey for NFHP II</i> . The findings were used to set targets for the Nepal Health Sector Program 2
		Heavily involved to develop the <i>Nepal Health Sector Programme 2</i>		
		Participated in various technical working groups/committees.		

\* Please note that all the work mentioned in the matrix has been carried out as part of NFHP's support to the Ministry of Health and Population.

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