



Ministry of Health & Population



Remote Areas Maternal and Newborn Health (MNH) Pilot RAMP



Mid-term Review of Progress and Preliminary Lessons Learned

NHSSP Payment Deliverable RA2



Remote Areas Maternal and Newborn Health (MNH) Pilot - Mid-term Review of Progress and Preliminary Lessons Learned has been prepared by the Ministry of Health and Population (MoHP), Government of Nepal (GoN) with financial support from UKaid and technical and financial assistance from NHSSP.

This report has been funded by UKaid from the UK Government. However the views expressed do not necessarily reflect the UK Government's official policies.

This report is submitted to satisfy the requirements of NHSSP payment deliverable RA2: Mid-term Review of Project completed and shared.

*Remote Areas Maternal and Newborn Health (MNH) Pilot (RAMP):
Mid-term Review of Progress and Preliminary Lessons Learned*

A. Introduction

Background: Historically in Nepal, inadequate attention has been paid to improving health services for women and children in remote or mountainous¹ areas. This has resulted in below average health status in these areas. A 2013 Family Health Division (FHD) and Child Health Division (CHD) study found that remote village development committees (VDCs) in mountainous districts had fewer human resources, fewer facilities, more drug stock-outs, lower awareness levels on MNH issues and lower uptake of health services.

Based on this study's recommendations the Remote Areas Maternal and Newborn Health Pilot Project (RAMP) was designed and began in May 2014 in Taplejung district, eastern Nepal.

The project: RAMP is a pilot project designed to inform government plans for working in remote areas. The theory of change underpinning it is that:

“Increasing the availability of clinical staff and medical supplies and strengthening health facility governance will improve the quality and availability of services and result in increased access to and use of services”, and that:

“Strengthened the implementation of demand-side community-based programs (such as MoHP’s equity and access programme [EAP]) will translate into increased demand for maternal and neonatal health (MNH) services and healthy practices.”

The project involves:

- district-wide interventions that benefit all health institutions in the district
- health facility level supply-side interventions in ten primary health facilities of nine VDCs
- demand-side interventions in five of the nine VDCs.

The interventions are packaged in three different ways to test their impact and value for money in different sites and VDCs as follows:

- Package 1: district-wide interventions across the whole district (monitored as control sites)
- Package 2: Package 1 plus health facility supply-side interventions
- Package 3: Packages 1 and 2 plus demand-side interventions.

This mid-term review report provides details of progress made and other achievements to 19th February 2015 in the form of a narrative summary, but does not assess numerical progress against the project's results framework indicators. This will be carried out during the final project evaluation in the last August-September 2015.

B. Progress on Project Implementation

The design and inception phase for RAMP ran from January to April 2014 and implementation began in May 2014. In the nine months of implementation, good overall progress was made as follows:

¹ MoHP uses mountainous areas as a proxy for 'remote' locations

District-wide activities

The project ran obstetric first aid training for 40 paramedics from health facilities across the district. This complemented ongoing activities to strengthen the quality of care (QoC) at Taplejung District Hospital under a separate MoHP/NHSSP project. The achievements of the QoC project are also included in this report since the quality of hospital services available at the district headquarters affects district-wide MNH service delivery and outcomes.

Health facility strengthening activities

RAMP's supply-side interventions are strengthening the governance of the ten selected health facilities and their provision and quality of health services as follows:

- Taplejung district health office is managing an earmarked fund that has provided NPR 105,000 to bridge salary gaps for contracted auxiliary nurse-midwives (ANMs) and NPR 197,334 to buy essential equipment at the six project-supported health facilities with birthing centres.
- Training courses were run to increase the capacities of health facility management and operation committee (HFOMC) members in all ten facilities following which the HFOMCs carried out self-assessments and developed action plans. Project and DHO staff followed-up regularly to assess progress made with all HFOMCs found to have carried out at least one more self-assessment and executed most of the activities on their various action plans.
- Several activities were implemented to improve critical skills of health workers from the ten health facilities. Infection prevention (IP) training at all ten facilities provided practical instruction while IP self-assessments and action planning allowed appropriate action to be taken. Project staff followed-up regularly and further self-assessments were carried out at the six facilities having birthing centres.
- Seven auxiliary nurse midwives (ANMs) were sent on 15-day work placements at Koshi Zonal Hospital in order to refresh and update their skilled birth attendant (SBA) knowledge and skills while seven other health workers were trained on family planning implants and medical abortion.

Community and VDC level demand strengthening

The Equity and Access Program (EAP) component of the project is being implemented by a local NGO employing five social mobilisers. A capacity building workshop was run for these staff in June 2014, following which the following activities were implemented:

- A range of VDC and community level activities were conducted beginning with orientation and mapping exercises in all five EAP VDCs.
- 63 healthy mothers' groups took part in at least five of the 11 orientations offered on MNH, with an average of 198 women from each VDC taking part in each session.
- 16 types of interactions and social mobilisation activities were run including interactions with and between students, pregnant women, husbands, and mothers-in-law.
- 159 home visits were made to newly married, pregnant and recently delivered women who were group members and 51 home visits to women who were not group members.

District level EAP activities

To date that has been limited progress on mobilising other district programmes (specifically the Local Governance and Community Development Programme (LGCDP) and the Poverty Alleviation Fund (PAF)) to promote demand for MNH services in their working areas.

Progress on project monitoring

The M&E of the project is being carried out by the specialist agency HERD based on the project's M&E plan and results framework.

Process reviews

Ongoing supervision, monitoring, and review processes are paying close attention to improving project implementation. The RAMP project management committee has met regularly to address arising issues while implementation staff have reviewed activities in the field regularly, both at the district headquarter and central levels.

C. Progress towards Achieving Outputs

Output 1: The increased knowledge and social acceptability of MNH services and healthy practices by local people

- *Engagement, participation and mobilisation:* Around 50% of all households in the five EAP VDCs participated in the MNH awareness raising sessions. Field monitoring by the project team in three project VDCs found good community mobilisation in two areas and less good mobilisation in one area due to the change of the social mobiliser early on. All the mobilisers had successfully traced the majority of pregnant women in their communities - a key project target group.
- *Improved awareness and acceptability:* There are early signs of improved knowledge and social acceptability of MNH services and healthy practices in the project area. However, behavioural change activities need more time if they are to overcome the deep seated norms that drive personal behaviours including health seeking.

Output 2: The improved availability and quality of MNH services in focal VDCs

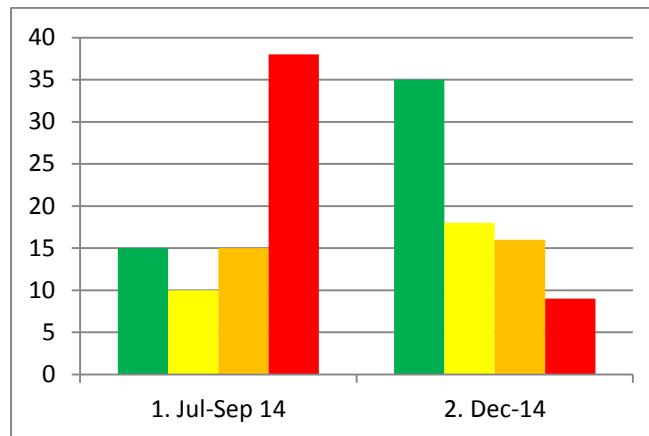
- *Staff availability:* Data on staff posts filled at the ten facilities show improved staffing levels in the first six months of 2014/15 (the project period) with an increase in the presence of at least one health assistant or senior auxiliary health worker (AHW) and the improved presence of auxiliary nurse midwives (ANMs).
- *Staff skills:* The before and after scores of staff who took training courses showed improved knowledge levels among almost all participants.
- *Improved availability of drugs and equipment:* The project has supported its target health facilities to acquire essential health service equipment and supplies resulting in the improved availability of drugs and equipment in at least those facilities having birthing centres.
- *Infrastructure improvements:* Sablakhu health post (HP) and Khejenim sub-health post (SHP) buildings have been improved using funding provided by the VDC and HFOMC. Project activities are actively encouraging such support from local bodies.
- *Improved availability of MNH services:* Project inputs have led to an increase in the availability of MNH services with five of the six health facilities having birthing centres now

providing 24 hour delivery care and long-term family planning, and the four non-birthing centre facilities now providing improved antenatal care (ANC) services.

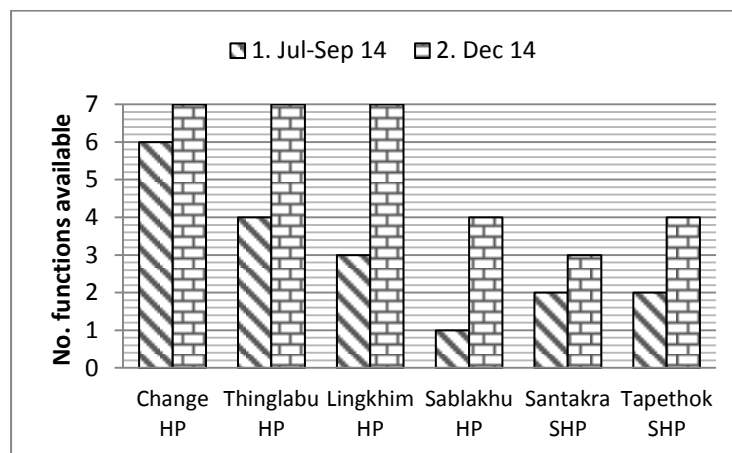
- *Improved service provision and quality of care:* The results of assessments carried out in July/September and follow-ups in December 2014 indicated large improvements in both the quality domains and availability of signal functions at the six facilities having birthing centres. The number of quality (green) scores more than doubled across the quality domains. The improved availability of the signal functions shows that the six birthing facilities are now better able to provide complicated and emergency care. All six facilities have increased their readiness to provide the signal functions with three having all seven functions (see Figure 0).

Figure 0: Scores of RAMP health facilities with birthing centres at initial & Dec-14 assessments

0.1: Quality domain scores



0.2: Number of signal functions available



Output 3: The improved management and governance of health services

- *HFOMC functioning:* There are indications that the management capability and decision-making capacity of HFOMCs have increased as a result of project inputs. The results of the assessments carried out by HFOMCs show large improvements between the first and most recent assessments (a six to eight month period) and indicate that all the HFOMCs feel that the performance of their facilities has improved across almost all areas. A review of health facilities' action plans found good overall implementation. Their preparation and execution have provided great impetus for the improved management of the health facilities. An important contributor to the improved performance is probably due to HFOMCs meeting more frequently.

- *Capacity of local groups*: The participation of healthy mothers' groups in MNH awareness raising sessions appears to have increased knowledge of key MNH messages and strengthened links between health facilities and their communities.
- *Resource mobilisation*: The HFOMCs contributed matching funds to those provided from the DHO's earmarked fund for retaining contracted ANMs between July and October 2014.

D. Progress towards Achieving Outcomes

Although it is too early to assess achievements at outcome level, several case studies suggest that service use is increasing. During this review, the trend of the Health Management Information System (HMIS) service use data for fiscal years 2012/13, 2013/2014, and the first six months of 2014/15 for the nine VDCs was analysed. However, shortcomings with the 2012/13 and 2013/14 data (see challenges below) raise questions over its utility for measuring project outcomes. This said, health facility in-charges noted that proper recording and reporting (for 2014/15) is now carried out largely as a result of RAMP project inputs including and increased technical support and closer monitoring.

E. Challenges

The major project implementation challenges identified to date are:

- the reluctance of the project's district managers (the district health officer and the public health nurse) to take responsibility for extra-financial management related to the project which lies outside of their annual workplans and budgets
- the transfer away of key district level project decision makers and implementers, principally the district health officer and health facility in-charges.

The main health service provision strengthening challenges are:

- imbalanced staffing at some facilities; the filling of some posts and the continuity and presence in post of others, and the tendency seen to post less capable staff to remote districts and VDCs
- the questionable capacity of most HFOMCs to monitor health worker and facility performance and improve health worker attendance

The principal demand-side strengthening challenges are:

- insufficient leadership and support for field staff by the implementing NGO and performance weaknesses of some social mobilisers
- lack of involvement by social mobilisers in other programmes (esp. LGCDP and PAF)
- delayed budget release to the EAP NGO

The main outcome monitoring challenge relates to shortcomings with the quality of HMIS data to assess project progress. These shortcomings include possible reporting errors for 2012/13 and 2013/14 data, local users attending health facilities in other VDCs (cross-use), and fluctuating targets with denominators (estimated populations) changing irregularly from year to year. These all serve to complicate and hinder the analysis of data and thereby question its usefulness.

F. Lessons Learned

- 1 Appropriate, intensive, and sustained support is needed to expand and improve the quality of care of MNH services in remote areas which needs to be underpinned by improvements in human resource management.
- 2 Long-term investments are needed to change behaviours and health seeking practices in local communities.
- 3 The DHO needs assistance to ensure that the support provided for strengthening health facilities via other agencies is appropriately coordinated.
- 4 It may be appropriate to begin scaling up this initiative by upgrading services at strategic locations, and then expanding efforts to other locations based on needs, DHO capacity, and the district's access infrastructure.
- 5 District planning and the hands-on involvement of DHO staff has strengthened DHO ownership of RAMP.
- 6 Work placements at training sites increase staff motivation, enhance knowledge and skills and appear well suited to increase the motivation of staff working in remote locations.
- 7 Strong and active HFOMCs have facilitated considerable improvements in their health facilities. However, further encouragement is needed to improve day-to-day service provision including the management of health workers.
- 8 More support is needed for implementing NGOs including increasing their capacities to implement EAP-type programs in remote areas.
- 9 Greater focus is needed on marginalised households during demand-side activities and on reaching such households during outreach clinics.
- 10 Many people access health services at facilities lying beyond their home VDCs.
- 11 There is a need for improved coordination of interventions to reach remote populations both within and across government line agencies.

G. The Way Forward for NHSP-3

Strengthening district health systems and demand for MNH in remote locations:

1. Strengthen district health systems as a whole through district planning, upgrading and improving the quality of strategically located health facilities and through slowly expanding the delivery of services. Select strategically located health facilities based on local knowledge and guidance from central and regional levels.
2. Institute intensive and sustained efforts to upgrade and improve the quality of MNH services in remote areas including improving staff motivation and skill retention.
3. Strengthen HFOMCs and various social accountability mechanisms to improve the performance of health facility personnel and stimulate improved human resource management by the health system.
4. Prioritise strengthening the demand for services, especially targeting women who have little or no contact with health services.

National strategies and programs:

5. Include disaggregated indicators in NHSP-3's national-level monitoring framework and encourage the use of data for decision making at all levels in order to improve the quality, availability of services and access to them.
6. Contract out community awareness and mobilisation activities to civil society organisations as well as some types of service delivery.
7. Include support for career development and other incentives in the proposed remote areas strategy to encourage capable and active personnel to serve in DHOs and DPHOs in remote districts.
8. Include extra activities to more intensively support Female Community Health Volunteers (FCHVs) to implement community-based interventions in remote areas.
9. Revise the Aama incentive rates based on the distance to a health facility to give birth.

Case: H. Basanti died soon after giving birth

The importance of improving access to MNH services was brought home by a women dying in childbirth in one project VDC in January 2015 (see Box A). This was a tragic example for the project of a woman who had not been reached.

Box A: She died soon after giving birth

A woman in the EAP program area had married when she was only 14 years old. She had a difficult marriage as her husband often got drunk and her in-laws did not support her. Her first child died after four days.

In 2014 the RAMP social mobiliser came to know that the woman, now 18 years-old, was pregnant with her second child. She had not been participating in the RAMP MNH awareness raising meetings. The mobiliser went to her home in September 2014 and after a long discussion the woman admitted that she was six months pregnant. She was alone as her husband and in-laws were in Jhapa district – a day's bus ride away - for their personal work.

The woman said she had never visited a health facility for an ante-natal care (ANC) check-up and had never taken iron supplements. The mobiliser invited her to participate in the next mothers' group meeting but she did not come. She eventually attended only after the mobiliser and local FCHV invited her once again.

At her first meeting, the other members tried to convince her to go for an ANC check-up. She said she would, but she did not. She also failed to go to the nearby primary health care outreach clinic for a check-up. The main reason for not attending was the negligence of her husband and in-laws and the fact that the health facility was far away (a 2.5 hours' walk).

On the 23rd January 2015, nine months into her pregnancy, her labour pains started at 4 am. She delivered the baby at home the next day. However, she had a retained placenta and due to heavy bleeding became unconscious. Even in that situation, her husband and mother-in-law did not take her to the health facility and instead called a traditional healer. After the woman had been unconscious for a long time, a neighbour went to the HP to call a health worker.

In the meantime, the woman became conscious for a short while but soon after became

unconscious again and died at 1 pm on 24 January 2015 leaving her baby daughter behind. *We cannot imagine the pain and feelings of despair she must have felt.*

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ACRONYMS

AHW	auxiliary health worker
ANC	antenatal care
ANM	auxiliary nurse-midwife
AWPB	annual workplan and budget
BEONC	basic emergency obstetric and newborn (neonatal) care
cl.	cluster
DDC	district development committee
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
EAP	Equity and Access Program
EHCS	Essential Health Care Services
FCHV	female community health volunteer
FHD	Family Health Division
GoN	Government of Nepal
HDC	hospital development committee
HERD	Health Research and Social Development Forum
HFOMC	health facility operation and management committee
HMIS	Health Management Information System
HP	health post
HQ	headquarters
IUCD	intrauterine contraceptive device
LGCDP	Local Governance and Community Development Program
LTFP	long-term family planning
MNCH	maternal newborn and child health
MNH	maternal and newborn health
MoHP	Ministry of Health and Population
MVA	manual vacuum aspiration
MWRA	married women of reproductive age
Na	not available
NHSP	Nepal Health Sector Program
NHSSP	Nepal Health Sector Support Program
NHTC	National Health Training Centre
NPR	Nepali rupees
NWEA	Nepal Women's Entrepreneurs Association
OFA	obstetric first aid
PANM	upgraded auxiliary nurse-midwife
PAF	Poverty Alleviation Fund
PHCRD	Primary Health Care Revitalisation Division
PMC	project management committee
ppt	participant
QI	quality improvement
RAMP	Remote Area MNH Pilot (Project)
SAHW	senior auxiliary health worker

SBA	skilled birth attendant
SHP	sub-health post
VDC	village development committee
WRA	women of reproductive age

1 INTRODUCTION

1.1 Background

Nepal's health system has focused on providing maternal, newborn, and child health (MNCH) services to the majority of the population and the achievement of population based targets. Less attention has been put into reaching the most disadvantaged people who face greater geographical, social and economic barriers to accessing services, particularly women and children in remote locations.

This has resulted in a below average health status in most mountain districts. (MoHP defines Nepal's remote districts as its mountain districts as many parts of these districts are remote from government and other services). The 2011 Nepal Demographic and Health Survey found that under-five and newborn mortality was 1.5 times higher in mountain than in hill and Terai districts (MoHP et al. 2012). Moreover, a recent study on maternal mortality in eight districts found a higher maternal mortality ratio in two mountain districts compared to the study's hill and Terai districts (Suvedi et al. 2009).

A 2013 Family Health Division (FHD) and Child Health Division (CHD) study on access to MNCH services in five of Nepal's remote districts (Regmi et al. 2013) found that remoteness affects access to, and the use of, MNCH services. The study's remote VDCs had:

- fewer human resources for health, fewer facilities (including birthing centres and long-term family planning services), and more drug stock-outs and expired drugs
- lower levels of awareness on maternal and newborn health (MNH) issues and uptake of health services.

Related to this:

- The limited availability of MNH services and providers increased the distance women have to travel to reach MNH services
- The increasing financial costs for patients related to the distance/time of travel were the main barrier for reaching maternal health care services and this especially hindered access to care for complicated deliveries.

The study recommended that a service delivery and demand-side package of interventions designed to overcome barriers to access in remote Nepal should be piloted to inform the development of strategies for improving MNCH in remote areas and the preparation of the next Nepal Health Sector Programme (NHSP-3). This concurred with the government's commitment to support targeted interventions to reach unreached populations, including those communities in geographically remote locations (HEART 2013: 54, and GoN 2013: 2).

Based on FHD and Primary Health Care Revitalisation Division (PHCRD) recommendations, the Remote Areas Maternal and Newborn Health Pilot Project (RAMP) began implementation in May 2014 in the mountainous district of Taplejung, eastern Nepal. This district was selected from among the five districts studied by Regmi et al. (2013) as its performance was particularly low on many MNH indicators and because of the low number of partners supporting MNH in this district.

1.2 Taplejung District and its Health Services

Taplejung is a large district covered in steep and rugged mountains. Regmi et al. (2013) reported that its geographical terrain, including its steep hills, difficult paths, and the presence of forests on the way to health facilities, were major barriers to accessing health care. Taplejung is one of Nepal's most remote districts and much of its population lives far from the district headquarters. Only 12% of the population live within two hours travel of the headquarters (HQ) while 26% live more than eight hours travel away.

In terms of health service availability, Taplejung has a district hospital and 54 health facilities. Regmi et al. (2013) found that the availability of birthing centres, long-term family planning, and their use mostly decreased with distance from the district HQ.

More details on the district's geography, health status, and health services can be found in RAMP's project proposal and project design documents (NHSSP 2014a and 2014b).

1.3 The RAMP Pilot Project

Objectives: RAMP is a pilot project whose main purpose is to inform government plans for working in remote areas of Nepal under NHSP-3 by identifying concrete lessons and strategies for increasing access to, and the uptake of, MNH services in such areas. Its objectives are as follows:

1. to demonstrate whether a supply-side package of health facility level and district-based interventions, tailored to the local context, and with or without demand-side interventions, will result in more equitable access to and use of MNH services in focal VDCs in one remote district of Nepal
2. to identify lessons on how supply- and demand-side interventions can be successfully delivered to improve equitable access to, and the use of, MNH services in remote VDCs
3. to establish if costs and outcomes justify scaling up the piloted intervention to other VDCs and districts.

The focus of the pilot project is therefore to demonstrate an effective package of interventions in selected areas.

Research questions: The project aims to answer the following questions:

1. How can essential MNH services be made available and how can demand-side interventions for MNH be delivered in remote areas?
2. Can supply-side interventions alone increase the use of, and access to, MNH services?
3. Can demand-side interventions complement supply-side interventions to work together to promote greater accessibility and use of MNH services and accountability in providing them?
4. What are the unit costs associated with reaching remote communities, and is scale-up justifiable from a cost perspective?

Theory of change, outputs and outcomes, monitoring: The pilot project's theory of change shows the intended progression from project inputs, through the achievement of outputs and outcomes, to the eventual impact (see Annex 1 and Table 1.1). The achievement of these outputs and outcomes will be monitored and evaluated against the project's results framework (see Annex 2).

Table 1.1: Intended outcomes and outputs of the pilot project

No.	Output and outcome statements
Outcome 1	Increased and more equitable use of MNH services
Secondary outcome 1	Increased and more equitable use of child health services
Outcome 2	Increased adoption of healthy MNH practices
Outcome 3	Reduced cultural and economic barriers to accessing MNH care services
Output 1	Increased knowledge and social acceptability of MNH services and healthy practices
Output 2	Improved availability and quality of MNH services in focal VDCs
Output 3	Improved management and governance of health services in the focal VDCs and at district level

1.4 Project Interventions

Pilot interventions: The project is implementing three types of interventions (inputs):

1. *District-wide interventions* that benefit all health institutions in the district through district health system strengthening, district hospital strengthening and capacity strengthening across the entire district (including obstetric first aid (OFA) training)
2. *Health facility level supply-side interventions* which are being applied to the project's ten primary health facilities across four clusters in nine VDCs (see Table 1.2). These interventions are strengthening the health facilities in various ways such as through the use of an earmarked MNH fund, quality of care improvements, health worker capacity enhancement and service expansion, and the strengthening of HFOMCs
3. *Demand-side interventions* are being applied in five VDCs across two of the clusters where the supply-side interventions are being implemented (see Table 1.2). These Equity and Access Program (EAP) activities are being implemented by a local NGO and include mobilising local stakeholders for increased access to MNH services and increasing local women's knowledge of MNH issues.

The interventions are being implemented in three different packages (see Figure 1.1) across the six clusters of VDCs and their health facilities (see Table 1.2) to test their individual impacts and value for money:

- Package 1: district-wide interventions across the whole district (the two Package 1 only clusters are monitored as control sites)
- Package 2: district-wide and health facility supply-side interventions
- Package 3: district-wide, health facility supply-side, plus demand-side interventions.

Note that clusters five and six are control clusters that will only benefit from the project's district-wide interventions under Package 1.

Figure 1.1: The three types of MNH packages and their interventions (Taplejung, 2014–2015)

Package 1	Package 2	Package 3	Interventions
			Demand-side interventions: <ul style="list-style-type: none"> • Behaviour change communication • Emergency fund and transport arrangements • Stakeholder mobilisation and advocacy
			Supply-side facility interventions: <ul style="list-style-type: none"> • District level Earmarked MNH Fund for human resources, equipment, supplies • Facility strengthening (including ANM skill enhancement and HFOMC capacity development, service expansion).
			District-wide interventions: <ul style="list-style-type: none"> • District-wide coordination for resource mobilisation and drugs distribution • District hospital strengthening • Obstetric first aid capacity development • FCHV based interventions

Table 1.2: Selected pilot clusters — health facilities and VDCs (Taplejung, 2014–2015)

Clusters	Package	Hub health facilities (HPs)	Peripheral health facilities (SHPs)
Cluster 1	2	Change VDC HP	Sobuwa SHP (Change VDC)
Cluster 2	2	Sablakhu VDC HP	Limbudin VDC SHP and Ankhop VDC SHP
Cluster 3	3	Linkhim VDC HP	Khejenim VDC SHP and Tapethok VDC SHP
Cluster 4	3	Thinglabu VDC HP	Oklabung SHP (Santhakra VDC)
Cluster 5	1	Sinam VDC HP	Thumbedin VDC SHP
Cluster 6	1	Thukhima VDC HP	Lingtep VDC SHP

1.5 Implementation Arrangements

The following committees and personnel are responsible for implementing the project:

- A central-level Technical Advisory Group (TAG), formed under the Safe Motherhood and Newborn Sub-Committee (SMNSC), is guiding the overall implementation and monitoring and evaluation process. The TAG will also support the articulation of the final recommendations and project learning
- The pilot project is being implemented on the ground by Taplejung DHO under the leadership of FHD and the support of the regional health directorate and NHSSP
- A district project management committee (PMC), which is chaired by the DHO, is responsible for implementation and coordination at district level, including the management of the earmarked fund.

- A district coordinator and a quality improvement officer are supporting the DHO to implement, supervise, and monitor the project at both district and VDC levels
- Technical support is being provided by two part-time national EAP consultants, NHSSP's EHCS advisor, and other NHSSP and Options (UK) advisers
- A Taplejung NGO (Nepal Women Entrepreneurs Association, NWEA) is implementing the EAP demand-side interventions through its five VDC-based social mobilisers led by the NGO's EAP coordinator and chairperson
- The national consultancy company Health Research and Social Development Forum (HERD) is responsible for the independent monitoring and evaluation of the project.

See the RAMP proposal (NHSSP 2014a) and the detailed project design document (NHSSP 2014b) for more details on the project's design.

1.6 This Document

This report has been prepared based on the progress and achievements of RAMP from its start in May 2014 through to the carrying out of its mid-term review on the 19th February 2015.

The mid-term review was held in Taplejung district headquarters and attended by 62 project stakeholders, including the DHO who stayed for the whole eight hour program (see participants list in Annex 3). The main part of the review meeting involved all ten health facility in-charges and the five EAP social mobilisers presenting progress made so far at their facilities and in the five EAP VDCs (see mid-term review schedule in Annex 4).

The rest of this report discusses the themes covered by the mid-term review meeting, progress on the implementation of activities, progress towards achieving the outputs and outcomes, and the challenges faced and lessons learned so far. It concludes with suggested ways forward under NHSP-3 for improving access to, and the use of, MNH services in remote areas.

Note that this report does not assess progress against the indicators in the project's results framework, but is rather a narrative summary of progress in implementation towards the overall objectives, and a review of early signs of changes and lessons learned. Progress made against the indicators will be captured in the final evaluation.

1.7 Dissemination of Results

The dissemination of the results of this pilot project to health decision makers in the government and external development partner communities is crucial for influencing policymaking. Dissemination activities will mostly take place after the project ends in August/September 2015. However, to keep central level policy makers and planners informed about the progress of RAMP, a presentation was made on progress and key findings to date to the Department of International Development (DFID) on the 15th January 2015, and another presentation is scheduled for FHD's Safe Motherhood and Neonatal Health Committee in March 2015.

2 PROGRESS ON PROJECT IMPLEMENTATION

2.1 Preparatory activities

The design and inception phase of the pilot project ran from January to April 2014:

- A three day project design and planning workshop was held at Taplejung DHO between 21st and 23rd February 2014 with the participation of 29 local stakeholders including all of the DHO's district supervisors. The workshop was facilitated by NHSSP. The directors of FHD and the regional health directorate provided feedback and advice on the third day of the workshop. A district-level mapping and situational assessment of MNH service availability and use was carried out, following which the project's health facilities were selected based on agreed criteria.
- Health facility-level needs assessments (see Figure 2.1) were carried out by a joint NHSSP–DHO team in April 2014 at five health facilities, which were selected to be upgraded to basic emergency obstetric and newborn care (BEONC) centres or birthing centres (Change HP, Linkhim HP, Mahashring HP [later changed], Sablakhu HP, and Tapethok SHP).
- The project design was finalised in Kathmandu in April 2014 and the project was approved for implementation by the Department of Health Services (DoHS) in July 2014.
- HERD developed an M&E framework and methodology for the project (see HERD 2015).



Figure 2.1: Needs assessment of Change HP. A DHO officer is checking the service use register along with other health workers

The implementation phase of the project began in May/June 2014 and is planned to run to August/September 2015. Annex 14 of the design document (NHSSP 2014b) gives an implementation schedule for all planned activities. The overall progress thus far is as follows:

2.2 District-wide Activities

The project has so far carried out the following activities to improve the district-wide provision of MNH care:

- *District orientation*: A district orientation and planning workshop marked the beginning of the project's implementation phase. The workshop was held on the 12th May 2014 and attended by the DHO and district development committee officers, in-charges, HFOMC chairpersons from all ten RAMP health facilities, and other stakeholders. An FHD representative informed participants about the project's design and approaches, planned activities at the district level and in the selected health facilities and communities, and the DHO presented the current condition of the health facilities (human resources, coverage area, available resources, and service use trends). The participants then agreed on the dates to run the HFOMC training workshops in all ten facilities.
- *Obstetric First Aid (OFA) training*: A three-day long OFA training (see Box 2.1) was run for 40 paramedical health workers from health facilities across the district. The participants were mainly health assistants, senior auxiliary health workers (SAHWs), AHWs, and upgraded AHWs. The training was run at Taplejung District Hospital in two batches (the 17th to 19th and 20th to 22nd June 2014). Note that this activity is included in FHD's 2014/15 annual workplan and budget (AWPB) and included under the project as a key initiative towards achieving the project's outputs and outcomes. NHSSP supported the provision of a competent trainer and training materials.

Box 2.1: Subjects covered in OFA training courses (Taplejung, June 2014)

1. Introduction to MNH status in Nepal
2. Rapid initial assessment and management of shock
3. Vaginal bleeding in early and late pregnancy
4. Headache, blurry-vision, convulsions, loss of consciousness, elevated blood pressure
5. Vaginal bleeding after childbirth
6. Diagnosis of prolonged labour, obstructed labour, ruptured uterus, and foetal distress
7. Fever during pregnancy and childbirth
8. Newborn care and resuscitation

- *District hospital strengthening*: Activities are ongoing at Taplejung District Hospital to strengthen the quality of care. NHSSP has helped put in place a quality improvement (QI) process at the hospital through the formation of a hospital QI committee, the carrying out of an initial quality of care self-assessment in June 2014, the production of an action plan for improvements, and reviews of progress on implementing the action plan through three further self-assessments. The progress up to November 2014 is detailed in a separate report (NHSSP, FHD, and Management Division 2014). This work is taking place under a separate FHD and Management Division initiative that is supported by NHSSP and is included as a related activity here as the quality of hospital services affects district-wide MNH service delivery and outcomes.
- The district coordination meeting for improving the distribution of drugs and supplies was planned for February 2015, but has yet to happen.

2.3 Health Facility Strengthening Activities

The project's supply-side interventions are aimed at strengthening the governance of the ten selected health facilities and their provision of health services. The following activities took place up to mid-February 2015.

2.3.1 DHO support for RAMP's selected health facilities

Taplejung DHO is coordinating the implementation of all the health facility strengthening activities. A PMC was formed at DHO level to oversee and manage project implementation at district level. Its tasks include managing an earmarked fund to improve the availability of human resources and critical equipment for providing continuous MNH services at RAMP's intervention sites. Up to mid-February 2015 the fund has allocated the following amounts:

- NPR 105,000 to bridge the gap in paying the salaries of contracted ANMs, which was caused by the delayed release of the government budget to the DHO. This amount covered a half of the salaries of the ANMs (NPR 6,000/month), with an equivalent amount provided from HFOMC funds at:
 - Santhakra SHP, Thinglabu HP, Change HP, and Sablakhru HP for Shrawan up to Asoj 2071 (Jul/Aug to Sep/Oct 2014)
 - Linkhim HP for Bhadra up to Asoj (Aug/Sep and Sep/Oct 2014)
 - Tapethok SHP for Asoj (Sep/Oct 2014)²
- NPR 197,334 to buy critical equipment for RAMP's six birthing centres (see equipment list in Annex 5). This equipment was distributed to the birthing centres to fill gaps identified in their needs assessments. This fulfilled their minimum needs for delivery instruments (critical equipment), including two delivery sets, an episiotomy set and an autoclave for sterilizing instruments.

Box 2.2: Nepali fiscal years (FY) and equivalent western dates and years

- Nepali FY 2069/70 = mid-July 2012 to mid-July 2013 (2012/13 in this report)
- Nepali FY 2070/71 = mid-July 2013 to mid-July 2014 (2013/14 in this report)
- Nepali FY 2071/72 = mid-July 2014 to mid-July 2015 (2014/15 in this report)

2.3.2 Strengthening the HFOMCs

Three-day long capacity building trainings were run for the HFOMCs of the ten health facilities starting in May 2014 (see Table 2.1). All trainings of HFOMCs were completed by June 2014 except in Khejenim, where the training was only run in September 2014 due to the absence of a health facility in-charge. The trainings were facilitated by the DHO and NHSSP staff using the National Health Training Centre's (NHTC's) HFOMC training manual to cover:

- the roles and responsibilities of HFOMC members
- the carrying out of self-assessments of the performance of health facilities and HFOMCs
- the envisioning and planning of health facility improvements
- the production of action plans

These training events gave participants the opportunity to put into practice what they had learned. They carried out self-assessments and produced action plans to improve institutional capacity and the governance and delivery of services. An example of an action plan is given in Annex 6.

² See Box 2.2 for Nepali financial years and the equivalent dates as per the Western calendar, for the three years referred to in this report.

Table 2.1: HFOMC capacity building training events

	Health facilities	Dates	No. participants
	Sablakhu HP	15-17 May	17
	Limbudin SHP	18-20 May	12
	Aangkhop SHP	22-24 May	12
	Change HP and Sobuwa SHP	29-31 May	24
	Linkhim HP	31 May-2 June	13
	Santhakra SHP	31 May- 2 June	13
	Tapethok SHP	4-6 June	18
	Thinglabu HP	3-5 June	13
	Khejenim HP	25-27 Sep 2014	12

Project and DHO staff have been regularly following up with the HFOMCs to make sure they are using the skills learned and encouraging them to carry out further self-assessments and to implement their action plans. Project staff have visited the health facilities about once every two months for this purpose and have also phoned them from time-to-time to discuss progress against action plans and to provide guidance on HFOMC issues. Most HFOMCs have been reviewing their progress monthly and all have carried out at least one further self-assessment, with Limbudin SHP carrying out three more. See Table 3.6 for the progress so far on implementing these action plans. Note that these plans are serving as the ten HFOMCs' plans for 2014/15.

2.3.3 Equipment support

The health facility needs assessments and infection prevention trainings identified serious shortages of equipment, health commodities, and drugs at the health facilities. This project has helped fill these gaps by providing items at the infection prevention trainings and from the earmarked fund (see above). A list of the items provided is given in Annex 5. Furthermore, based on the ongoing needs assessments, in January 2015 the PMC approved the purchase of further equipment and supplies. These have now been purchased and will be handed over in March/April 2015.

2.3.4 Staff capacity enhancement

The following activities have been run up to mid-February 2015 to improve the skills of health workers and some active HFOMC members from the ten health facilities and local FCHVs:

- *Infection prevention training and action planning:* Whole-site infection prevention trainings were run following NHTC's training manual at all ten health facilities (see Table 2.2) for their health workers, one or two active HFOMC members, and a local FCHV. The participants received practical instruction on the prevention of infections, on waste management, and on using a quality improvement self-assessment tool. Brief infection prevention action plans were also developed; and health facility QI committees were formed to follow up on QI related activities at the six facilities with birthing centres. The main points in the action plans were to prepare chlorine solution regularly, build pits for different types of waste, and to properly manage all related equipment and medicines (see example of one of these plans in Table 2.3). Participating health facilities were provided with a range of equipment and materials to use for infection prevention and waste management (see Annex 6 for materials provided).

Note that more in-depth training and follow-ups have been provided to the six facilities with birthing centres on the use of equipment (e.g. sterilisation process and use of autoclaves),

maintaining the no-touch technique, the proper use of goods related to infection prevention, and the management of delivery rooms. Thus, three-day training events were run for the facilities with birthing centres and two-day training events for the ones without.

Table 2.2: Whole-site infection prevention training for RAMP health facilities

Cluster	Health facility	Date	No. participants
1	Change HP	7-9 August 2014	6
1	Sobuwa SHP	10-11 August 2014	3
2	Sablakhu HP	27-29 July 2014	8
2	Limbudin SHP	31 July-1 August 2014	3
2	Aangkhop SHP	16-17 Oct 2014	7
3	Linkhim HP	18-20 Sep 2014	7
3	Tapethok SHP	21-23 Sep 2014	8
3	Khejenim HP	27-28 Sep 2014	5
4	Santhakra SHP	16-18 August 2014	5
4	Thinglabu HP	19-21 August 2014	6

- *Self-assessments:* An infection prevention checklist was worked through at the beginning of each infection prevention training to review the status of each health facility's infection prevention facilities and practices. On the last day of the training, quality improvement self-assessments were carried out at facilities with birthing centres and action plans prepared (see results in Chapter 3).

Table 2.3: Example of an infection prevention action plan — Santhakra SHP (18th August 2014)

	Areas to improve (gaps identified)	Actions		
		Activities	By when	Responsible persons
1	Arrange drinking water supply at the SHP	Coordinate with HFOMC to arrange water tank and pipe, then request local community to fit pipeline and tank	Mid-October 2014	HFOMC members
2	Display progress report of service use on wall	Collect necessary material from DHO, prepare chart and display on wall	End of August 2014	SHP staff
3	Need skilled ANM	Coordinate with DHO and send available ANM on SBA training	Mid-November 2014	HFOMC
4	Have basic equipment and medicines	Coordinate with HFOMC and DHO, then bring as needed	Mid-October 2014	SHP staff and HFOMC
5	Postnatal service recording system needs maintaining	Coordinate with DHO and collect necessary supplies	Mid-August 2014	SHP staff
6	Need to prepare waste disposal pits	Coordinate with SHP staffs, HFOMC, and community, then dig four pits	End of August 2014	SHP staff and HFOMC

- *Follow-up:* Project and DHO staff have carried out regular on-site coaching and follow-ups by phone with all ten health facilities in the months following the infection prevention training workshops. The public health nurse and project staff also provide ongoing support to facility staff on the management of obstetric complications and service provision. All ten facilities were

regularly visited by project staff. Follow-up QI self-assessments were carried out in December 2014 at the six health facilities with birthing centres (see Table 2.4).

Table 2.4: Quality of care self-assessments at RAMP health facilities with birthing centres

Health facility	Assessment 1	Assessment 2
Change HP	09 Aug 14	05 Dec 14
Thinglabu HP	21 Aug 14	08 Dec 14
Santhakra SHP	18 Aug 14	07 Dec 14
Limkhim HP	20 Sep 14	14 Dec 14
Tapethok SHP	23 Sep 14	12 Dec 14
Sablakhu HP	29 Jul 14	13 Dec 14

- *SBA placements (rotation)*: Seven ANMs from RAMP health facilities benefitted from 15-day long placements at Koshi Zonal Hospital to refresh and update their skilled birth attendant (SBA) knowledge and skills. They attended in two batches (the 6th to 20th November 2014 and the 21st December 2014 to 3rd January 2015). Participants' knowledge was first assessed and then strengthened through class room sessions using the standard SBA training manual and by carrying out practical exercises supervised by SBA trainers.
- *Implant and medical abortion training*: Three health workers from RAMP health facilities took part in a training on family planning implants from the 22nd to 29th January 2015, while four others were trained on carrying out medical abortions (the 4th to 8th February 2015). These courses were run at Koshi Zonal Hospital by NHTC.

2.4 Community and VDC-Level Demand Strengthening

The project is implementing an adapted version of the government's EAP to strengthen community and VDC-level demand for health services. The EAP capacity building training for the implementing NGO and its social mobilisers went ahead as planned from June 2014. However, the implementation of subsequent EAP activities has been a little behind schedule due to the delayed contracting of the implementing NGO while awaiting official approval for the pilot project. The implementation timeframe for EAP program activities has subsequently been adjusted by a month to finish in July 2015. The program is being run in five of the nine VDCs where the supply-side project activities are also being implemented (the Cluster 3 VDCs of Khejenim, Linkhim, Tapethok, and the Cluster 4 VDCs of Santhakra, and Thinglabu). These are the Package 3 VDCs.

2.4.1 Preparatory activities

The main preparations for launching the EAP program were as follows:

- Guidelines were produced for implementing the program (NHSSP 2014c).
- Proposals were invited and Taplejung NGO NWEA was subsequently recruited in May 2014 as the implementing NGO.
- Five social mobilisers and one district coordinator were recruited at the beginning of June 2014. Note that their contracts were only signed a month later after the DoHS had officially approved the project.
- A five-day long capacity building workshop for the implementing NGO and the five social mobilisers was held in Taplejung from the 15th to 19th June 2014. The workshop was also

attended by the social mobilisers of two other community development programs that are running in the five EAP VDCs in Taplejung- the Local Governance and Community Development Program (LGCDP) and the Poverty Alleviation Fund (PAF). NGO staff and social mobilisers prepared the VDC level activities at this workshop.

2.4.2 VDC and community-level activities

Orientations and mapping

The EAP program began in September 2014 with VDC-level orientations and mapping exercises in all five EAP VDCs. There was a good turnout at all of the orientations with more than 50 local teachers, social workers, FCHVs, health facility in-charges, VDC officials, and women’s groups’ members at each event (see Table 2.5). Participants were informed about the EAP activities in their VDCs, their support was solicited, and VDC action plans were finalised for implementing the project. The participants also did the social mapping of their VDCs to identify disadvantaged and remote populations and to show which households have less access to health services (see Figure 2.2).

Table 2.5: EAP VDC orientations (Taplejung 2014)

Cluster	VDCs	Date held	Participants		
			Male	Female	Total
3	Khejenim	24 Sep 14	32	24	56
3	Linkhim	20 Sep 14	18	40	58
3	Tapethok	22 Sep 14	25	34	59
4	Santhakra	10 Sep 14	21	33	54
4	Thinglabu	9 Sep 14	22	37	59
	Total		118	168	286



Figure 2.2: The social mapping of Santhakra VDC and the map produced of the VDC’s nine wards (Sept 2014)

Awareness raising and mobilisation activities

The EAP program has run a range of MNH awareness raising and mobilisation activities (see Table 2.6).

Table 2.6: EAP Awareness raising and mobilisation events ran up to mid-February 2015

EAP activity type	No. planned	No. implemented	Details
Healthy mothers' group MNH sessions	378	366	See Table 2.7
Home visits	—	210	See Table 2.9
Interactions and mobilisations	98	85	See Table 2.10

a. Healthy mothers' groups MNH awareness sessions: The series of 11 orientations on MNH for local mothers' groups amongst other groups are designed to improve the knowledge of local women on MNH and increase their use of MNH services. The first half of the meetings (six sessions) have been completed or almost completed in all five EAP VDCs (see Table 2.7).

Table 2.7: Attendance at RAMP EAP group MNH sessions (Aug-14 to Feb-15)

Cluster	VDC	No. participating groups	Attendance at MNH sessions 1–6 across all participating groups						No. sessions
			1	2	3	4	5	6	
3	Khejenim	12	163	182	164	190	194	196	72
3	Linkhim	12	200	181	186	206	205	226	72
3	Tapethok	12	183	219	209	231	237	-	60
4	Santhakra	14	222	250	202	251	280	310	84
4	Thinglabu	13	222	210	224	227	208	212	78
Total		63	990	1042	985	1105	1124	944	366

The first six sessions covered:

1. Introduction and orientation to the program
2. MNH in general
3. Care to be taken during pregnancy and pregnancy danger signs
4. Family planning
5. Preparing for childbirth and emergency management
6. Care during the childbirth period

An average of 200 women from across a total of 12–14 groups attended each session in each VDC. These groups were the FCHV-led healthy mothers' groups (*aama swastya samuha*) plus the VDC-level LGCDP community awareness centre (CAC) groups. An example of the participating groups and the number of women attending in one of the five VDCs is given in Table 2.8.

Table 2.8: Groups and participants in EAP MNH sessions in Santakhra VDC (Aug 2014 to Feb 2015)

Cl	Group name	No. members	MNH sessions					
			1	2	3	4	5	6
1	Faktaanglung healthy mothers' group	18	13	16	10	12	18	18
2	Himchuli healthy mothers' group	27	18	21	11	16	13	24
3	Pathivara healthy mothers' group	44	9	17	24	14	28	31
4	Numaphung healthy mothers' group	38	23	16	13	26	19	28
5	Smarika healthy mothers' group	35	11	18	11	19	22	23
6	Himali healthy mothers' group	49	16	19	14	23	27	20
7	Shreejanga healthy mothers' group	26	25	16	16	18	19	17
8	Pokharitar healthy mothers' group	24	18	13	21	16	15	23
9	Sewalung healthy mothers' group	38	9	19	11	17	28	27
10	Community awareness centre	48	19	21	24	20	21	22
11	Bihani healthy mothers' group	26	15	17	11	14	16	18
12	Jhulke gham healthy mothers' group	34	23	25	12	17	21	24
13	Suryamukhi healthy mothers' group	48	16	19	17	21	20	16
14	Faktaanglung healthy mothers' group	27	7	13	18	18	13	19
	Total	482	222	250	213	251	280	310

b. Home visits: The home visit program is designed for the social mobilisers to make individual contact with newly married, pregnant and recently delivered women to assess their situation, counsel them on MNH issues and encourage their attendance at the group MNH sessions.

A particularly important part of the program is the home visits for newly married women and women who are not in a healthy mothers' group as they tend to have less knowledge and support on MNH and are more vulnerable to maternal and newborn morbidity and mortality. A total of 210 home visits were made to the beginning of February 2015 including 51 to women who are not group members (see Table 2.9). The social mobilisers found the names of women for home visits from local FCHVs.

Table 2.9: Home visits by EAP social mobilisers

Cluster	VDC	Visits to pregnant and recently delivered women (group members)	Visits to households not involved in a group
3	Khejenim	30	14
3	Linkhim	33	0
3	Tapethok	25	0
4	Santhakra	51	22
4	Thinglabu	20	15
	Total	159	51

c. Interactions and social mobilisation: As well as the MNH sessions with mothers' groups, the EAP program has run a range of other types of interactions, social mobilisation, and awareness raising activities, which are listed in Table 2.10. They include interactions with and between stakeholders (FCHVs, teachers, students, husbands, pregnant women, mothers-in-law, and local political, social, and club members) as well as orientations for traditional healers and students.

In the first eight months of the program (Trimesters 1 and 2) all of the interaction and mobilisation programs were planned to run at least once in each VDC. Progress in this has been good (see Table 2.10):

- All planned Trimester 1 activities (August to November 2014) were completed on time except for the 'local event celebrations' where three out of five activities have been completed.
- The majority of the activities planned for Trimester 2 (December 2014–March 2015) had been completed by mid-February 2015 (with six weeks of the trimester remaining).

Table 2.10: Progress on EAP interaction and mobilisation program in Trimesters 1 (Aug-Nov-14) and 2 (Dec-14 to Mar-15), up to mid-Feb 2015

	Activities	Trimester 1 (Aug-Nov 14)		Trimester 2 (Dec 14 to Mar 15)	
		Target	Progress	Target	Progress
1	Program induction workshop at VDC level (1 event per VDC)	5	5	–	–
2	Social mapping	5	5	–	–
3	Quarterly coordination meeting with local social mobilisers	5	5	5	3
4	Program progress review workshop	1	1	1	1
5	Quarterly meeting with FCHVs	–	–	5	3
Awareness raising home visits, orientations, and interactions (no. VDCs)					
6	Course of MNH sessions with healthy mothers' groups (no. groups)	65	63	63	63
7	Home visits (total of 210 in Trimesters 1 and 2 to mid-Feb 2014)				
8	High school student orientations on MNH and mobilization	5	5	5	5
9	MNH orientation for dhami-jhankris (traditional healers)	–	–	5	5
10	Interactions with school teachers	5	5	–	–
11	Interactions with FCHVs	5	5	–	–
12	Interactions between service providers & consumers/rights holders	5	5	5	3
13	Interactions between pregnant women and mothers-in-law	5	5	5	5
14	Interactions between pregnant women and their husbands	5	5	5	5
15	Interactions between a newly married couple		–	5	3
16	Interaction programs with adolescents and youths	–	–	5	5
17	Interactions with political, social and local club members	–	–	5	3
18	Street drama performance in three places per VDC (dramas)	–	–	15	0
19	Local event celebration for MNH message delivery (VDCs)	5	3	–	–
Logistical support					
20	Seed money support to establish emergency funds (per group)	–	–	63	0
21	Support to establish emergency transport (per group)	–	–	63	0

Due to contractual problems, the NGO received less money than the projected budget required to run all the EAP activities during the second trimester. The implementation of street dramas, emergency fund support, and stretcher distribution activities is planned for March/April 2015.

2.4.3 District level EAP activities

A key part of the EAP program is to mobilise district stakeholders to support their staff to promote demand for MNH services in their working areas. The main planned activity was for the district's Reproductive Health Coordination Committee (RHCC) to discuss how this can happen. The committee has, however, only met once during the project period (on the 23rd November 2014) when the DHO and NHSSP discussed RAMP and its EAP program and invited the committee's participation and support. The committee is scheduled to meet again in March 2015 when it is hoped that the coordinated raising of demand for MNH services will be discussed. The project seeks to encourage enhanced DHO coordination with the various social mobilisation programs in the district, specifically LGCDP, the Poverty Alleviation Fund, and the Suaahara nutrition project. The project team and the EAP program coordinators have made informal contacts with the above initiatives and local LGCDP groups (CACs) are taking part in the group MNH sessions.

2.4.4 EAP review

The first quarterly review of the EAP program was held in Taplejung on the 14th and 15th November. The workshop reviewed progress, addressed implementation issues, and helped build the capacity of the NGO personnel on program implementation (NHSSP 2014d). The EAP program was also reviewed in-depth at the mid-term review in February 2015.

2.5 Progress on Project Monitoring

The M&E of the project is being carried out by the M&E agency HERD based on the project's M&E plan (HERD 2015). The main part of the plan is the results framework (see Annex 2). The impact of the project's three packages will be measured by looking at the situation before and after their implementation and comparing the achievements of the three sites where the packages are implemented. The final evaluation is planned for August/September 2015.

The following progress has been made on project monitoring and evaluation:

- A baseline study was conducted in the nine intervention and four control VDCs between the 9th July and 2nd August 2014. A draft report has been produced and the final report is due soon.
- HERD was contracted in November 2014 to carry out the independent monitoring and endline evaluation of the project.
- HERD developed the M&E framework and methodology for the project (HERD 2015).
- The regular monitoring of project implementation started in February 2015 against the project's results framework. A field monitor has been recruited and is stationed in Taplejung. He began to make field visits to project sites at the beginning of February 2015 to monitor the implementation of project activities and any changes in the district that could affect the outcomes of the pilot project. He is doing this using a set of monitoring tools.

2.6 Process Monitoring and Reviews

The project's results framework has indicators to monitor the process of project implementation at district and VDC level (see Annex 2). The monitoring will examine:

- whether or not planned activities have been carried out
- the reason why activities have not been carried out as planned
- the impressions of project implementers and target groups concerning the practicality and usefulness of interventions and the support received from implementing agencies to implement them
- the quality of the implementation of activities

The on-going supervision, monitoring, and reviewing is giving close attention to the proper and improved implementation of the project. The PMC has met regularly to address issues as they arise (see Table 2.11). Personnel involved in implementing the project have regularly reviewed project activities. Reviews have taken place at most PMC meetings. Two reviews of the EAP program were carried out in November 2014 and February 2015, along with two supervisory and review field visits by the project team (see Table 2.13). The implementing NGO has also carried out regular supervisory visits.

Table 2.11: Meetings of RAMP's Project Management Committee

	Meeting date	Main agenda item
1	4 May 2014	Evaluated proposals of candidate EAP implementing agencies
2	13 May 2014	Evaluated proposals of candidate EAP implementing agencies
3	24 Aug 2014	Formal agreement with EAP implementing agency (NWEA)
4	3 Sep 2014	The funding of 50% of salaries of contracted ANMs at the project's birthing centres
5	2 Nov 2014	Decided on the health worker participants for SBA placement/training
6	3 Dec 2014	Discussed status of transport of medicines from district to peripheral health facilities
7	17 Dec 2014	Discussed forthcoming activities of RAMP
8	18 Jan 2015	Decided on participants for implant training
9	26 Jan 2015	Decided on further materials to be procured for the birthing centres
10	10 Feb 2015	Discussed the arrangements for the mid-term review.

Table 2.12: RAMP project review activities

	Review activity	Participants	Details
1	Project management committee meetings	DHO, public health nurse, account officer, NHSSP coordinator, and quality improvement officer (PMC team). The DHO family planning supervisor is an invitee.	10 meetings held between May 2014 and February 2015 (see Table 2.11)
2	EAP review field visit 1	EAP consultant and NGO coordinator	12 to 13 November 2014, Santhakra VDC
3	EAP program review meeting	23 project stakeholders (social mobilisers, DHO, several DHO supervisors, DDC representative, NHSSP staff, and project coordinator)	14-15 November, Taplejung
4	EAP review field visit 2	EAP consultant, district coordinator, QI officer and NGO coordinator	12 to 16 February 2015, Limkhim, Tapethok & Khejenim VDC
5	Mid-term review of all parts of the pilot project	62 project stakeholders (NGO staff, ten HFOMC chairpersons and in-charges, 6 birthing centre ANMs, DHO and district supervisors)	19 February 2015, Taplejung

3 PROGRESS TOWARDS ACHIEVING OUTPUTS

The pilot project's results framework has three main outputs and 25 indicators (see Annex 2). Progress is presented here against these three output areas.

Box 3.1 lists the main sources of information used for assessing progress. Note that the systematic carrying out of the several assessments themselves has spurred self-reflection and encouraged improved performance by health workers and HFOMCs.

Box 3.1: Main sources of information for measuring progress on outputs

The health worker knowledge assessments which were carried out at the start and end of the following training events:

- infection prevention training (held at all ten health facilities)
- OFA training (for 40 health workers)
- 15-day SBA placements at Koshi Zonal Hospital (for seven ANMs)
- family planning and medical abortion training events (for seven health workers)

Health facility management and service provision:

- health facility assessments by all ten HFOMCs using tools A, B, and C (first assessments produced at HFOMC capacity building workshops and between one and three more by all ten HFOMCs)
- health facility action plans (produced for all ten facilities at HFOMC capacity building workshops)
- quality of care improvement self-assessments of birthing centre health facilities, carried out by health facility personnel at the infection prevention workshops, and follow-up assessments carried out in December 2014 at the six health facilities with birthing centres (see Table 2.3)
- field visit observations by the project team
- project quarterly progress reports

Progress of EAP community-level activities:

- field visit observations by the project team
- progress reports and case studies produced by the EAP social mobilisers
- EAP program trimesterly progress reports

3.1 Increased Knowledge and Social Acceptability

The increased knowledge and social acceptability of MNH services and healthy practices by local people is Project Output 1.

3.1.1 Community engagement participation and mobilisation

Good participation: An extensive range of MNH awareness raising activities has been run under the EAP comprising interactions, mobilisation activities, healthy mothers group MNH sessions, and home visits. About 50% of all households in the five EAP VDCs have participated in the MNH awareness raising sessions with about 200 women per VDC taking part in each of the six sessions.

Activity implementation: The mid-term review presentations showed that social mobilisers are conducting most planned activities, except for those delayed by the late implementation of EAP and contractual problems in releasing the budget to the EAP implementing NGO. The mobilisers have successfully traced most of the pregnant women in their communities, a key project target group. Note that the number of pregnant women they identified was more than expected. This could be due to a higher rate of pregnancies in the communities than was estimated by the HMIS. This showed a good commitment from mobilisers in tracking them all down, including those who were not attending mothers' group meetings, often some of the more high risk women, and this is important in terms of ensuring the coverage and targeting of outreach activities.

Community mobilisation: A visit by the project team to the project VDCs (Khejenim, Tapethok, and Linkhim VDCs) in November and December 2014, and February 2015 found good community mobilisation at Khejenim, Santhakra, and Thinglabu VDCs, but less good mobilisation at Linkhim VDC and Tapethok VDC. In the latter case this was due to the change of the social mobiliser after only three months.

Mothers' group functionality: Participation in the healthy mothers' groups MNH awareness raising sessions appears to have resulted in increased knowledge on MNH key messages and strengthened the links between health facilities and their communities. Another achievement has been the increased involvement of FCHVs in healthy mothers' group meetings. Further, home visits by the EAP NGO have increased attendance at mothers' groups of more vulnerable women which has consequently increased their use of MNH services.

3.1.2 Early signs of improved awareness and acceptability

There are some early signs of improvements in the knowledge and social acceptability of MNH services and healthy practices. The project team and implementing NGO have noticed increased awareness about MNH services and the key MNH messages such as the importance of four ANC visits, iron tablets, institutional deliveries, postnatal care, essential newborn care, and of danger signs during pregnancy, delivery, and postpartum. Quite a few participants in the various interaction and social mobilisation activities have become more aware about good MNH practices and given positive answers on the subject to outsiders.

However, behavioural change usually requires significant time to overcome deep seated norms that drive behaviours and health seeking practices, as was also found by the Suaahara project. No fundamental change has been observed so far in health seeking and most local people first seek care from traditional healers. The household survey in the final evaluation will measure the extent to which health practices and health-seeking behaviour have changed.

3.2 Improved Availability and Quality of MNH Services

The improved availability and quality of MNH services in focal VDCs is Project Output 2.

3.2.1 Staff availability and skills

Number of staff: The fulfilment of staff posts at the ten health facilities in the project's nine VDCs is detailed in Annex 7. The data show significant improvements in staffing levels in the first six months of 2014/15 (the project period) in most facilities:

- There was an increase in the presence of at least one health assistant, SAHW, or AHW to provide health services in all ten health facilities.

- In 2012/13 and 2013/14, only two of the four established birthing centres had a full-time ANM (in 12 months). During the first six months of 2014/15, as the project got underway, the absence of an ANM was reported from only one health facility and only for a single month. At the newly established birthing centre at Tapethok the ANM stays quite far away and is thus sometimes not available for delivery care, although she does live in the VDC.

The project's earmarked fund made an important contribution by allowing for the continuation of contracted ANMs at the six HPs with birthing centres. Note that two of these health facilities only established birthing centres after the project started (see Table 3.2).

Contracted ANMs: The delayed release of each year's government budget to the district causes problems in paying for and retaining contracted health workers. The project's contribution of matching funds (see Section 2.3 above) enabled the retention and continued services of contracted ANMs at the six RAMP birthing centres. This funding mostly ran up to the Nepali month of Asoj (September/October) when government funds from the New Year's budget became available.

Health worker knowledge and skills: The following points indicate that project activities have improved the service delivery skills of health workers in the whole district and in RAMP's ten health facilities:

- The scores of the participants of the first OFA training on their knowledge of the subject matter rose from 56% at the start of the training to 70% at its end, and from 70% to 82% for the second batch.
- The average score on the pre-placement assessments for the seven ANMs was 78% across the SBA subjects evaluated. They were tested again at the end of their placements by which time the average score had risen to 97%.
- The seven ANMs who were placed at Koshi Zonal Hospital have since shown an improved ability to carry out complicated deliveries (by doing two vacuum deliveries), to insert long-acting family planning devices (IUCDs and implants), and to manually remove placentas.
- The knowledge of all participants during the infection prevention training events increased, with the average score moving from 10 out of 25 at the beginning to 17 out of 25 at the end (see Annex 8).

3.2.2 Improved availability of drugs and equipment

As detailed in Chapter 2, the project has supported its health facilities acquire critical health service equipment and supplies. The results of the quality improvement self-assessments carried out by health facility personnel show improvements in the availability of drugs and equipment at the six supported health facilities having birthing centres:

- There was an improvement in the availability of essential drugs in the delivery room from a score of four reds and two oranges in the initial assessment to one red, one orange, and four yellows at the assessments carried out three to four months later (see Annex 9.1 for results and Table 3.1 for an explanation of scoring system).
- There was an improvement in the availability of supplies and equipment from three reds, two oranges, and one yellow in the initial assessment to one red, two oranges, and three yellows.
- Note that the colour scores for drugs and supplies were unchanged at Tapethok SHP with a red scored at both the initial and December 2014 assessments. However, the number score increased from zero to five, indicating some improvements.

Table 3.1: Traffic light colour scoring system for quality domains and signal functions

	For 13 quality domains	For 7 signal functions
Green	Fully meets standards	Full score- signal function in operation
Yellow	Partially meets standards (almost there)	Not applicable
Orange	Partially meets standards	Not applicable
Red	Does not meet standards (half or fewer than half items met)	Less than full score- function not available

Although the availability of drugs and supplies has improved, more support from HFOMCs for procuring emergency drugs and supplies for delivery care could improve the situation even further by ensuring the use of the Aama unit cost funding (NPR 1,000 for a normal delivery and NPR 3,000 for a complicated delivery) which is meant to be used for buying such items.

Based on the assessment findings, in January 2015, the DHO agreed to support the supply of more critical equipment from the earmarked fund. The project has already bought this and plans to hand it over soon.

3.2.3 Infrastructure improvements

Figure 3.1: Before and after photos of infrastructure improvements at Khejenim SHP



The project’s support for HFOMC strengthening and action planning was a catalyst for rebuilding Khejenim SHP. This facility now has a much more spacious and clean space to work in.

There has been progress on improving the infrastructure of the project’s health facilities with:

- A new health facility building at Sablaku HP was constructed (although there are concerns about the quality of its construction).

- Khejenim SHP’s building for providing institutional deliveries was renovated. This was done with funds provided by the VDC and the personal contributions of HFOMC members (see Figure 3.1). Project activities served as a catalyst for this to happen.

3.2.4 Improved availability of MNH services

Project inputs have increased the availability of MNH services:

- Five of the six health facilities with birthing centres (except Tapethok, see Table 3.2) are now providing 24 hour delivery services as they have at least two ANMs. They have also started running primary health care outreach clinics (PHC-ORCs) regularly with support from ANMs and established links between communities and health facilities for delivery services and the early referral of complicated cases. Note the progress and shortcomings at Tapethok SHP (see Box 3.2).

Box 3.2: Improvements at Tapethok SHP, but service provision challenges still persist

A visit by the project team in December 2014 found improvements in the quality of care at Tapethok SHP compared to before RAMP’s interventions. However, it also found that its birthing centre was not operating 24/7 due to the frequent absence of the contracted ANM, who lives three hours away. The facility had only handled two births since it opened in October 2014 with most other births happening at the district hospital or at home due to staff unavailability or delayed decision making to seek care. Project personnel have held frequent discussions with the HFOMC on providing quarters (a room) for the ANM close to the health facility.

- The availability of long-term family planning (LTFP) has improved in five health facilities (see Table 3.2). Several staff have also been trained to carry out medical abortions. However, they are yet to bring these skills into use as they only recently completed the training and a district orientation is yet to be conducted by FHD.
- The four non-birthing centre health facilities are now providing improved ANC services and their upgraded ANMs (PANMs) have started running PHC-ORCs to provide MNCH services in outlying parts of their VDCs.
- Note that the HFOMC of Khejenim SHP is planning to establish a birthing centre due to the large number of callouts for home deliveries that are disrupting service delivery at the facility.

Table 3.2: Details of obstetric care facilities in RAMP health facilities

Cl.	Health facility	Birthing centre date of establishment/status	Baseline availability of LTFP	LTFP service availability
1	Change HP	Birthing centre established January 2014	None	IUCDs and implants
1	Sobuwa SHP	OFA centre	None	Not applicable (as is only OFA centre)
2	Angkhop SHP	OFA centre	None	Not applicable
2	Limbudin SHP	OFA centre	None	Not applicable
2	Sablakhu HP	Birthing centre established c. 2009	None	IUCDs and implants
3	Khejenim SHP	OFA centre (planning to establish a birthing centre)	None	Not applicable

Cl.	Health facility	Birthing centre date of establishment/status	Baseline availability of LTFP	LTFP service availability
3	Linkhim HP	Birthing centre established c. 2009	None	IUCDs and implants
3	Tapethok SHP	Birthing centre established October 2014. First delivery in Nov/Dec 2014	None	Not applicable
4	Santhakra SHP	Birthing centre established August 2014	None	IUCDs and implants
4	Thinglabu HP	Birthing centres established c. 2009	None	IUCDs and implants

3.2.5 Improved service provision and quality of care

Improved quality of care: The six health facilities with birthing centres have all undertaken an initial quality of care assessment and a second such assessment in December 2014 (see Table 2.4). Clinical and managerial staff used a self-assessment tool to rate performance against 13 quality domains. Composite scores are used for the quality domains to give a rating of green (high quality) and yellow, orange, or red (low quality), seen in Table 3.1. See Figure 3.2 for some photos of infection prevention improvements at RAMP’s health facilities.

Figure 3.2: Some before and after photos of infection prevention improvements

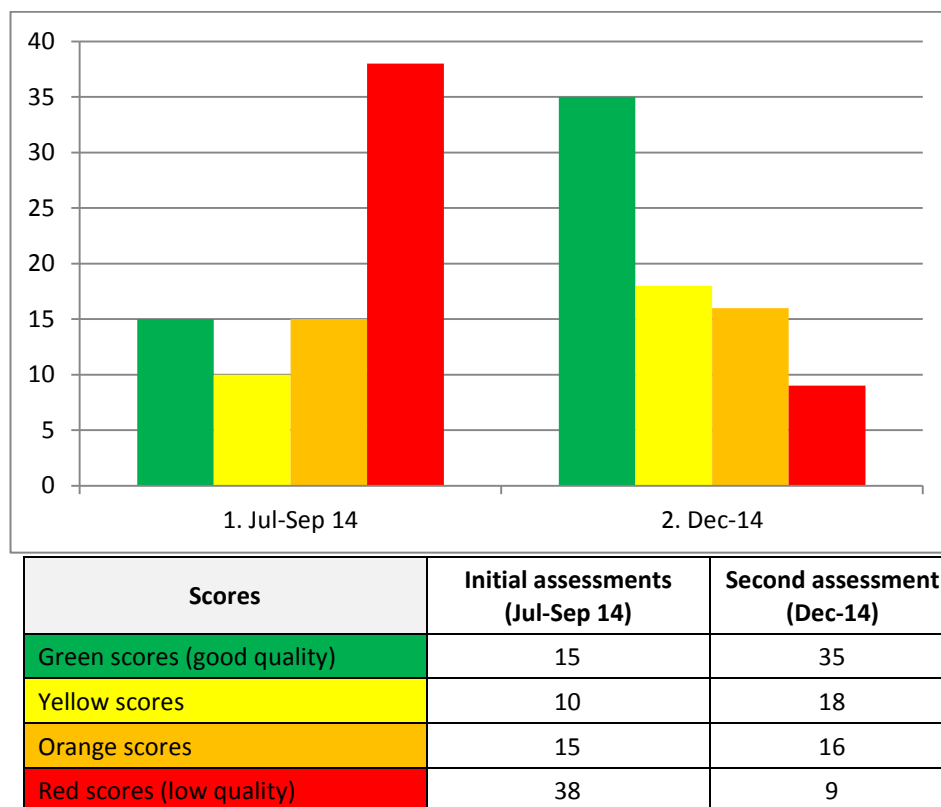


Tapethok SHP has been cleaned and the facilities much improved following the infection prevention training.

The before photo shows the bad practise of leaving instruments to soak too long (24 hours) in chlorine solution (Santhakra SHP), while the after photo shows the proper preparation of dressing kits ready to use as taught in the infection prevention training (Sobuwa SHP)

The results of these assessments show a large improvement between the first and second assessments (Figure 3.3). The number of good quality (green) scores has more than doubled while the number of low quality (red) scores has been greatly reduced. These results and follow-up observations by project personnel have found improved infection prevention practices at all ten health facilities.

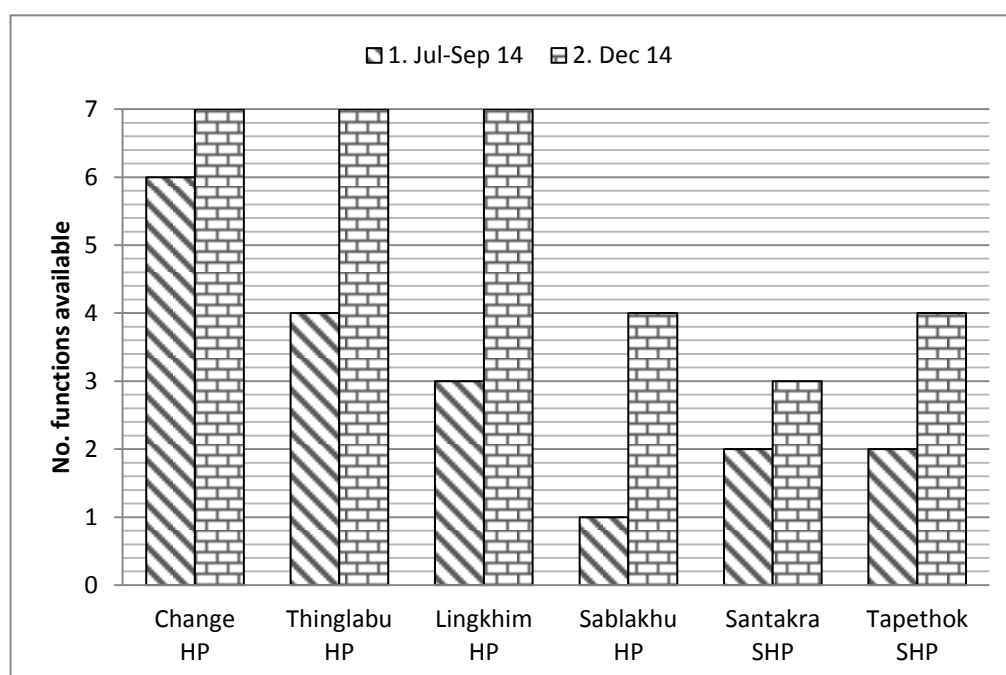
Figure 3.3: Scores for the 13 quality domains achieved by RAMP’s six health facilities with birthing centres at initial and December 2014 assessments (see Annex 9.1)



Complicated and emergency care: The availability of and readiness to provide complicated delivery and emergency maternity care is crucial for saving the lives of mothers and babies during emergencies. The seven signal functions are shown in Annex 9.2.

When baseline data was collected (in July, August, and September 2014), none of the six facilities with birthing centres had all the seven signal functions required to qualify as fully operating basic emergency obstetric and neonatal care (BEONC) centres. By December 2014, when a second round of assessments was undertaken, all six health facilities with birthing centres had increased their readiness to provide signal functions of BEONC services, and three facilities had all seven functions ready (see Figure 3.4 and Annex 9.2). However, two of the other birthing centre facilities only fulfilled three of the functions while the other one fulfilled four of them. Weak signal function scores were observed for parenteral antibiotic and anticonvulsants, which could be easily remedied, and readiness for assisted vaginal deliveries, which two of the birthing centres are not qualified to provide as they are SHP level facilities.

Figure 3.4: The availability of signal functions at the six RAMP health facilities with birthing centres in initial and December 2014 assessments (see Annex 9.2)



3.3 Improved Health Service Management and Governance

The improved management and governance of health services in the focal VDCs and at the district level is Project Output 3.

3.3.1 HFOMC functioning

Capacity: The HFOMCs are important local stakeholder and governance bodies for Nepal’s rural health facilities. There are several indications that the management capability and decision-making capacity of HFOMC members has increased as a result of project interventions. This has resulted in more key decisions being taken to improve the functioning of health facilities (see below) and the lobbying of the VDC for allocating budgets for health.

HFOMC self-assessments: The HFOMCs of all ten health facilities have carried out self-assessments on their institutional capacity (using tool A), the management of the health facility (using tool B), and the health services provision (using tool C). The first self-assessments were carried out at the HFOMC training events. Second and subsequent assessments were carried out during DHO/NHSSP follow-up visits. The facilities have each carried out between two and four such assessments (see scoring system at Table 3.3).

Table 3.3: Health facility operation management committee self-assessment scoring system (as per NHTC guidelines)

Score	Category	Colour
13 to 17	Very good	Green
8 to 12	Good	Yellow
0 to 7	Very poor	Red

Improvements: The results of these assessments show large improvements between the first and most recent assessments (a six to eight month period in most cases). They show that all the HFOMCs feel

that their performance has improved across all three areas except for health facility management at the Khejenim and Linkhim facilities (see Table 3.4). The average scores have increased from 4 to 11, 4 to 10, and 6 to 11 across the three assessment areas.

Good progress has been made in supporting human resource recruitment, local resource mobilisation, support for service readiness (including drugs and supplies), supporting FCHVs, and meeting regularity. The weakest areas appear to be related to required efforts by health workers in sharing health service performance at HFOMC meetings and areas related to staff monitoring (see Annex 10 for a more comprehensive listing). Note that in being self-assessments, the results are not necessarily objective, but they do show that those responsible for health facility management perceive improvement.

Table 3.4: Percentage scores achieved by HFOMC on the three self-assessment tools

	HF	Tool A Institutional capacity & HFOMC empowerment		Tool B Health facility management		Tool C Health service provision	
		First	Most recent	First	Most recent	First	Most recent
1	Change	8	14	7	14	9	14
1	Sobuwa	6	11	2	8	6	11
2	Sablakhu	6	9	2	9	7	12
2	Limbudin	0	13	2	11	4	11
2	Ankhop	6	10	2	8	3	11
3	Khejenim	2	9	2	7	7	8
3	Tapethok	2	11	3	11	6	10
3	Linkhim	3	9	8	9	6	10
4	Santhakra	1	11	4	11	4	12
4	Thinglabu	3	9	8	9	7	12
	Totals	37	106	40	97	59	111
	Averages	4	11	4	10	6	11

Challenging areas for improvement: The most commonly action points not-carried-out were:

- the presentation of health facility progress reports at monthly HFOMC meetings (four facilities not achieved)
- the preparation and implementation of HFOMC health facility supervision plans (three not achieved)
- the discussing and implementation of supervision plans at regular HFOMC meetings (three not achieved)
- the taking of measures to meet four ANC and iron supplement targets (three not achieved)

More regular meetings and more activities: A good part of the improved performance is probably due to most (seven out of ten) HFOMCs meeting more frequently. Of the ten RAMP health facilities, only Change HP reported regular monthly meetings in the previous two years whilst only three other facilities were meeting regularly (see Table 3.5). After project implementation (corresponding to the first six months of 2014/15), almost all ten facilities are now meeting monthly or just less than monthly. This has resulted in more key decisions being made to create an enabling environment for MNH

services and to increase the use of MNH services. Decisions have been made to procure essential medicines for delivery services, to promote increased service use, to recruit contracted ANMs, and to support building renovation.

Table 3.5: Number of meetings held by RAMP HFOMCs, 2012/13 to 2014/15

FY	Aangkhop SHP	Change HP	Khejenim SHP	Limbhudin SHP	Linkhim HP	Sablakhu HP	Santhakra SHP	Sobuwa SHP	Tapethok SHP	Thinglabu HP
2012/13 (12 months)	1	11	0	4	8	4	7	6	2	1
2013/14 (12 months)	2	12	0	5	10	6	8	4	2	2
2014/15 (first 6 months)	4	6	8	7	5	8	6	10	6	4

3.3.2 HFOMC action planning

The preparation and implementation of action plans for all ten health facilities has provided a large impetus for the improved management of these facilities and provided lessons for more systematic and forward thinking management. Most HFOMCs have sought to implement most parts of their action plans with an average of 11 out of the average 17 activities for implementing in 2014/15 having already been carried out (see Table 3.6). The good progress made is also reflected in the improved scores for quality of care (see Figure 3.3 and Annex 9.1).

Table 3.6: Number of planned and completed activities by RAMP health facilities in 2014/15 to mid-Feb 2015 (based on 2014/15 action plans- mid-July 2014 to mid-July 2015)

	Planned activities	Completed activities	Not completed activities
Aangkhop SHP	33	18	15
Change HP and Sobuwa SHP	14	10	4
Khejenim SHP	10	7	3
Limbudin SHP	26	15	11
Linkhim HP	13	10	3
Sablakhu HP	22	19	3
Santhakra SHP	12	9	4
Tapethok SHP	13	10	3
Thinglabu HP	8	4	4
Total	151	102	50
Average	17	11	6

3.3.3 Resource mobilisation

Funding contracted ANMs: The HFOMCs provided matching funds to the support provided by the DHO's earmarked fund for continuing the contracted ANMs in the July to October 2014 period to cover the gap until new FHD AWPB funding became available. They would not have provided this important funding if they had not been challenged by the DHO-led earmarked fund pledging 50% of the salaries.

These posts had not been funded in this way in the previous year (2013/14) except for Sablaku HP where two ANMs worked for a single shared salary.

VDC funding: The nine EAP VDCs pledged a total of NPR 879,000 for the intervention's health facilities (see Table 3.7) for the next fiscal year (2015/16). The proposed use of this money is for infrastructural improvements, transporting medicine to facilities, FCHV-related payments, running primary health care outreach clinics (PHC-ORC), emergency funds for obstetric referrals, and health worker's salaries. These amounts are in some cases an increase, and in some cases a decrease, compared to the previous year's allocations.

Table 3.7: Budget allocated for 2015/16 by VDCs for local health facilities at VDC councils held Magh 2071 (Jan/Feb 2015)

Cluster	VDC	Amount allocated Magh 2017 (NPR)	Proposed use
1	Change HP	39,000	Toilet construction, transport of medicines and FCHV, and primary health care outreach clinics (PHC/ORC)
1	Sobuwa SHP	39,000	FCHV and PHC-ORC
2	Aangkhop SHP	0	This VDC did not allocate any money this year as the NPR 35,000 it had previously allocated for building a toilet has not been spent.
2	Limbudin SHP	110,000	Emergency fund, FCHV, and PHC-ORC
2	Sablaku HP	41,000	Emergency fund, FCHV, and PHC-ORC
3	Khejenim SHP	200,000	Building renovation and transport of medicines.
3	Linkhim HP	31,000	Emergency fund, FCHV, and PHC-ORC
3	Tapethok SHP	65,000	Emergency fund and salary of office assistant
4	Santhakra SHP	194,000	Plastering delivery room, emergency fund, and salaries of ANM and office assistant
4	Thinglabu HP	160,000	Toilet construction, emergency fund, FCHV, and PHC-ORC
Total		NPR 879,000	
Average for 9 health facilities		NPR 87,900	

4 PROGRESS TOWARDS ACHIEVING OUTCOMES

4.1 Introduction

RAMP's results framework has three primary outcomes, a secondary outcome and 19 indicators:

- *Primary Outcome 1:* Increased and more equitable use of MNH services
- *Secondary Outcome 1:* Increased and more equitable use of child health services
- *Primary Outcome 2:* Increased adoption of healthy MNH practices
- *Primary Outcome 3:* Reduced cultural and economic barriers to accessing MH care services (see Annex 2)

In the final program evaluation, achievements against these indicators will be assessed by comparing baseline (July 2014) and endline (September 2015) data from household surveys and HMIS data from 2013/14 and 2014/15 collected from facilities' service registers. The data will be disaggregated for distance from health facilities. Also, data from an endline household survey will be used to measure the extent to which health practices, support given to women, and health seeking behaviour has changed.

At this point in the pilot, it is still very early to formally assess achievements at outcome level. However, qualitative data (in the form of case studies and key informant interviews) and quantitative data (in the form of HMIS data) has been collected in order to give an early indication of progress towards outcomes.

4.2 Initial trends emerging from HMIS data

At the mid-term review, the HMIS service use data was presented for the two and a half-year period of mid-July 2012 to mid-January 2015 (i.e. fiscal years 2012/13, 2013/2014, and the first six months of 2014/15) for the project's nine VDCs. The data used to calculate the changes in Table 4.1 for 2014/15 assumes that the achievements in the first six months of 2014/15 represent 50% of the year's changes.

The seven indicators represented in Table 4.1 are key MNH indicators. The data shows the following between the 2013/14 data and the data for the period of project implementation (first half of 2014/15):

- At the intervention sites there have been improvements on two indicators, no change for one indicator, and a negative trend for four indicators. The most positive result is for institutional deliveries and pregnant women who received iron folic acid supplements.
- There is a negative trend for all seven indicators at the control sites.³

At the mid-term review, the health facility in-charges suggested the possibility that some of the data sent to the DHO office by their health facilities in 2012/13 and 2013/14 was irregular. They also said that there was now proper recording and reporting (for 2014/15) largely due to the implementation of the pilot project and the resulting closer monitoring and increased support.

However, the downward trends at the control sites for 2014/15 cannot be explained by improved recording and reporting in 2014/15. The in-charges and DHO supervisors also mentioned problems in recording due to the newly introduced HMIS tools, as most new staff are still learning to use the revised HMIS. Also, fluctuating denominators (populations) were observed across the period.

³ Note that the staff from the project's control sites were not invited to the mid-term review. The control site data are therefore from the DHO's HMIS report (and not the review).

Poor quality of HMIS data raises a question mark over the reliability of using this data source for evaluation purposes, and puts greater emphasis on the household surveys undertaken at baseline, and planned for endline, to assess changes in behaviours and health service uptake.

Table 4.1: Service Use in the 9 RAMP VDCs, Taplejung (according to HMIS data)

	HMIS indicators	Intervention sites		Control sites	
		Changes 2012/13–2013/14 (2070/71–2071/72)	Changes 2013/14–2014/15 (2070/71–2071/72)	Changes 2012/13–2013/14 (2070/71–2071/72)	Changes 2013/14–2014/15 (2070/71–2071/72)
1	1 ANC visit	-12%	-16%	-6%	-27%
2	4 ANC visits	4%	-21%	-22%	-8%
3	% pregnant women getting IFA tablets	-16%	8%	-49%	-5%
4	Institutional deliveries coverage	7%	88%	-48%	-34%
5	Measles immunisation coverage	-4%	0	7%	-37%
6	No. under-fives with diarrhoea treated with ORS and zinc	18%	-51%	0.5%	-17%
7	No. under-fives with pneumonia treated with antibiotics	-12%	-19%	-9%	-16%

Note: 2071/72 data was produced by doubling the achievements of the first six months (mid-July 2014–mid-January 2015)

4.3 Qualitative data

Interviews have been conducted with women and health workers from RAMP implementation sites in order to gain an in-depth understanding of what barriers to quality care remain at the intervention sites in Taplejung and what challenges facilities in the district face. Several case studies show improved service use (see Box 4.1). However, the case of a woman who died in childbirth shows that some women still do not have access to life-saving MNH services (see executive summary).

Box 4.1: Case studies of impact of RAMP’s EAP program (prepared by the social mobilisers)

1. She got her first ANC check-ups during her tenth pregnancy

A 37 year-old woman from one of the EAP program VDCs became pregnant for the tenth time in March 2014. Of her previous pregnancies, two foetuses had died in the womb leaving her with seven children. She had never had an antenatal check-up, was unaware about birth spacing and modern family planning and had given birth to all her children at home.

She started taking part in her local healthy women’s group during her tenth pregnancy after the RAMP program came to her area. At first she refused to go to the health facility for an antenatal check-up because she said it was not necessary. The RAMP social mobiliser visited her and convinced her of the importance of getting check-ups and told her about the risks of giving birth at home. At last, at seven months pregnant, she attended her first ever ANC check-up at the local HP.

She had two such check-ups, took iron tablets regularly, and subsequently had an institutional delivery at the

HP on the 1st December 2014. It was a good job that she did not give birth at home as the baby was asphyxiated. Prolonged efforts by the auxiliary nurse-midwife revived the baby.

Soon after, the auxiliary nurse-midwife and social mobiliser advised her to start using a long term family planning method. She started using an IUCD and has committed to not become pregnant again for the sake of her health. She came to know about modern family planning methods at the group MNH sessions.

2. She left behind her superstitious traditional beliefs

A 25 year old woman had two sons and was pregnant again. She had only attended school to early primary level. Her lack of education and deep-rooted traditions had prevented her from receiving health services during her first two pregnancies. Six months pregnant Anita had never visited a health facility for an ANC check and did not know that such check-ups were available. She was unaware about their potentially lifesaving importance.

She had low attendance at her local healthy mothers' group meetings. So the RAMP social mobiliser found her address from the local FCHV and went to her home several times to counsel her. She subsequently started to attend group meetings regularly from October 2014, from the third MNC session. She also took part in a husband-wife interaction and other interactions on safe motherhood. As a result, at six months pregnant in January 2015, she started to go for regular ANC check-ups at her local HP.

An interesting point that she made at one meeting was that pregnant women did not need to take iron tablets as they get iron from the local millet alcohol. She was later convinced of the need to take iron supplements. She now says that she was very backwards to follow the superstitious traditional beliefs and now has good knowledge about MNH from the group sessions. She said that she would go to the health facility to give birth and then would not get pregnant again as three children are enough.

3. She found giving birth much easier at the HP

A 35 year old woman had recently had her ninth child in the safe surroundings of a health facility. Due to her lack of education, poverty, and geographical difficulties with attending a health facility, she had never taken an ANC check-up nor iron tablets and had given birth to all her first eight children at home.

After the RAMP program came to her area in 2014, she did not attend the first and second MNH sessions. Because of this, the social mobiliser visited her and convinced her to attend starting from the third session. She came to know about the benefits of institutional delivery and delivered her ninth child at the local HP on 27th October 2014. She said that it had been much easier to deliver her baby there and was happy to receive the NPR 1500 Aama incentive.

4. She is supported by her family for safe motherhood

A 16 year old woman of Tapethok VDC was pregnant for the first time. However, neither she nor her family knew about ANC check-ups and had thus never got such a check-up. She went for her first ANC check after the RAMP social mobiliser visited her home and continued to take three more check-ups.

When her labour pains started her family took her to the local SHP and she delivered her first child there on the 2nd December 2014. She said that she had been worried about her delivery but felt safe and reassured when her family had taken her to the SHP.

She now encourages other local healthy women group members to have ANC check-ups, to know about the danger signs of pregnancy, delivery and the postnatal period and to give birth in a health facility.

See the executive summary for the story of a local women who died soon after childbirth in January 2015.

5 CHALLENGES

5.1 Health Services Delivery Strengthening Challenges

1. *Financial responsibilities:* The project's district managers (the district health officer and the public health nurse) have been reluctant to take responsibility for extra-financial management related to the project that lies outside their AWPB. This has included buying equipment for health facilities and funding transfers to HFOMCs for extra staff and emergency funds. A reason given for this is that the current heightened scrutiny by auditors and the CIAA is discouraging government staff from taking on extra financial responsibilities. As a result, the project management committee has been deciding on the use of the earmarked fund for supporting health facilities while NHSSP has been responsible for purchasing equipment and transferring funds to HFOMCs.
2. *The transfer away of decision makers:* The transfer away of government staff who were involved in designing and implementing RAMP has had a negative effect as their replacements only have a limited understanding and ownership of the project. The main person responsible for overall implementation, the district health officer, was transferred away in October 2014. His replacement is yet to be posted although a doctor from one of the district's PHCCs was deputed as acting district health officer on the 9th November 2014 and is taking an active interest in the project. Moreover, two health facility in-charges have been transferred away during the project period (at Angkhop SHP and Limbhudin SHP) and their replacements have only been recently appointed after a gap of a month or so. The in-charge of Khejenim HP was posted only in September 2014 and has again since been transferred elsewhere. Seven of the ten health facility in-charges changed between May 2014 and February 2015 and Tapethok and Khejenim had no in-charge in post at the start of the project.
3. *Staffing issues:*
 - Some health facilities have an imbalance of staff, for example Change and Sablakhu HPs have three ANMs each, too many for the limited amount of work they have. This issue was discussed both at district- and central-level. FHD is in the process of strategizing supporting and facilitating DHOs/DPHOs to give emphasis and support to strategically located birthing centres.
 - The continued presence of health workers in terms of posts filled and presence at post has been a challenge at all health facilities due to weak facility management.
 - Less capable staff tend to be appointed to remote districts and in remote VDCs.
4. *Miscellaneous health facility service delivery challenges:*
 - Limbhudin SHP lacks enough room, although one room is rented out to another agency (NEA). Furthermore, all activities in Aangkhop SHP take place in one room.
 - Khejenim SHP lacks staff and has many home-visit callouts, which often leaves it unstaffed. Note that this issue is being addressed as this facility plans to start a birthing centre.
 - There was a nationwide shortage of measles and BCG vaccine for two months.

5.2 Demand-Side Strengthening Challenges

5. *NGO weaknesses:* Although the implementation of the EAP component is proceeding well, better mobilization and coordination were expected from the NGO. The NGO's leadership and the coordinator's capacity is not strong. Apart from the coordinator and social mobilisers, too few other NGO staff attended the initial capacity building training, though these staff have an important

supervisory and management role to play and should bridge and manage staffing gaps. Future EAP programs in remote areas need to include capacity building and greater support for implementing NGOs to enable them to carry out their work effectively.

6. *Social mobiliser issues*: The challenges related to the EAP social mobilisers are that two of them have not worked so well: there was inadequate support from the NGO and the recruitment of a new mobiliser for Tapethok VDC was delayed for 1.5 months. Furthermore, the fact that mobilisers' salaries are less than their LGCDP (who receive extra incentives from their VDCs) and Suaahara counterparts could have led to the project getting less experienced mobilisers. The design of future programs should pitch social mobiliser payments at the market rate to attract quality staff.
7. *Support from other social mobilisers*: The expected support from social mobilisers of other programs (LGCDP and PAF) to help implement some EAP activities has not materialised because of their limited presence in their working VDCs. Better coordination between these programs at district-level may help to address the above issues.
8. *Delayed budget release*: Delayed budget release by the NHSSP to the EAP NGO (due to contractual problems) has affected the implementation of a few activities. This is the main reason why no street dramas, emergency fund support, or stretcher purchases could go ahead. The related issues have been resolved following discussions at the mid-term review.

5.3 Outcome Monitoring Challenge

9. *Shortcomings of HMIS data*: The project planned to use HMIS service use data to assess progress so far for this review. The plan was to compare trends during the first six months of the previous two fiscal years (2012/13 and 2013/14 [2069/70 and 2070/71]) against the data for the first half of 2014/15 (mid July 2014 to mid-January 2015), which matches the period of project implementation so far. However, the mid-term review has experienced problems in analysing and determining any changes that may have occurred using the HMIS data. Note that the main evaluation of the project will be based on the project's community-based baseline and endline surveys.

The following data issues probably explain the apparently declining trend of service users according to the HMIS data for RAMP's health facilities for most MNCH services from 2013/14 to 2014/15 (except for institutional deliveries and IFA use). This point applies to both intervention and control sites. Most participants at the mid-term review said that the data (in numbers) for the first half of 2014/15 (2014/15) from intervention sites are probably accurate.

- *Possible reporting errors*: Discrepancies in the data and discussions at the mid-term review by the health facility in-charges suggest that the HMIS data may have been over-reported for 2012/13 and 2013/14. *Cross-use*: Cross-use (health facility shopping) by users makes it difficult to calculate some achievement indicators. People often travel to another VDC's health facilities (see Annex 11) for reasons of geographical proximity or convenience. For example, many pregnant women of Khejenim VDC visit both Khejenim SHP and Linkhim HP for ANC check-ups. This results in a very high number of first ANC users in Linkhim HP and good coverage on first ANC check-up at Khejenim SHP, but 0% achievement of the four ANC visits target at Khejenim SHP (see Box 5.1). At least part of the reason for this is that Linkhim has a regular market which people from surrounding areas often visit to buy goods from and also some women do not take their ANC cards to their ANC visits. This all serves to complicate the analysis of HMIS data.

- *Fluctuating targets:* Some denominators (estimated populations), which are used to estimate expected service use, have fluctuated over the three years in question. For example, the three denominators in Table 5.1 decreased from 2012/13 to 2013/14 and then increased from 2013/14 to 2014/15. This would result in the achievement against expected service use figures being greater for 2013/14 and less for 2014/15, thus undermining the usefulness of this data for monitoring project impacts. Also see example in Box 5.2.

Box 5.1: Example of clients using other VDCs' health facilities

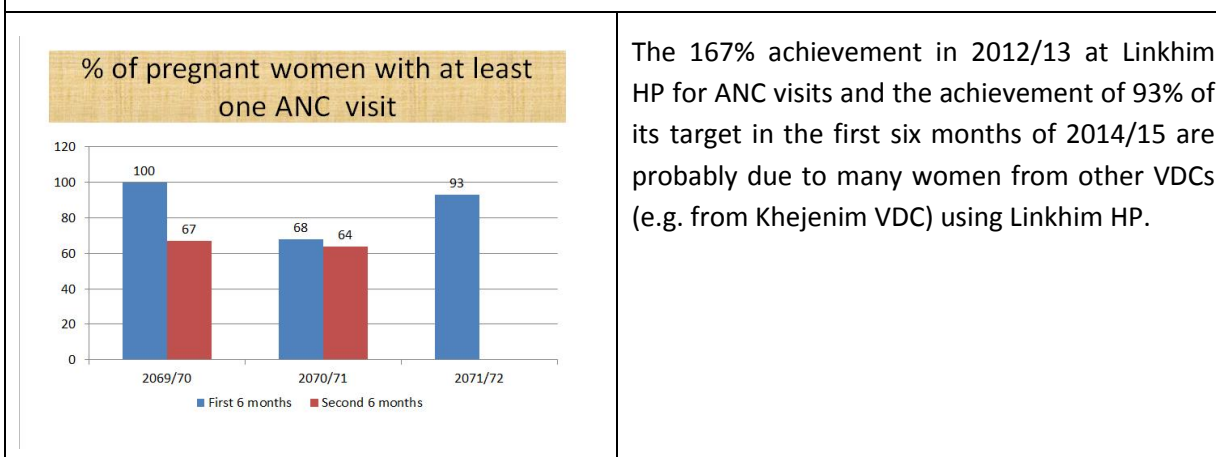


Table 5.1: Changes in denominators (populations) for three HMIS indicators over three fiscal years (in nine intervention VDCs)

	2012/13	2013/14	% change 2012/13 to 2103/14	2014/15	% change 2013/14 to 2104/15
Under children under 1 year	629	537	-14.6	606	+12.8
Expected pregnancy	661	559	-15.4	619	+10.7
Married women of reproductive age (MWRA)	4904	4755	-3.0	5367	+12.9

Box 5.2: Changed target leads to low achievement

There was a large increase in the HMIS's number of estimated expected pregnancies at Thinglabu HP, from 54 in 2013/14 to 70 in 2014/15. If the health facility had a similar number of four ANC visits in these two years (36 pregnant women in 2013/14), the achievement would decline from 67% in 2013/14 to 49% in 2014/15.

6 LESSONS LEARNED

6.1 Lessons from Current Implementation

- 1 *Appropriate and intensive support needed:* It is possible to expand and improve quality of care of MNH services in remote health facilities if appropriate and intensive support is provided. Intensive efforts are needed to make health facilities functional for providing the defined service package. Sustained support will be needed to continue these services in remote areas and to tackle the more systemic human resource management problems that impact on leadership, management, and service delivery.
- 2 *Long-term investments needed:* Bringing about behavioural change and affecting the habits and practices that underpin behaviour are slow and require longer term investments and presence. Remote area initiatives need to plan for three to five years of targeted demand-side programming.
- 3 *Coordinated support needed:* The DHO needs supporting to ensure that support provided for strengthening health facilities via other agencies (including FHD, the Logistics Management Division, NHTC, the regional health directorate, and training sites) is coordinated. This particularly relates to the organisation of staff training and placements, the supply of equipment and other health commodities, and supervision and monitoring.
- 4 *Start with improvements at strategically located facilities:* It could be appropriate to start with upgrading services at strategic locations, and then expand to other locations based on identified needs and a district's capacity, to improve service delivery in remote areas. The selection of strategic health facilities should be done at the district level using agreed criteria and knowledge of the local situation, including road networks and service use. However, local interests and bias must be avoided by strictly using agreed criteria.
- 5 *DHO ownership and capacity:* District planning and the involvement of DHO staff has led to better ownership of the pilot project. This has resulted in the DHO focussing more on the selected health facilities, especially when posting health facility in-charges. However, the management of staff absenteeism requires a strong district health officer. A hindrance to this is that MoHP's policy does not provide attractive incentives for capable district health officers to commit themselves and stay in the more challenging conditions of remote areas.
- 6 *Value of placements:* Placement at training sites increases staff motivation, enhances their knowledge and skills, leads to better service provision including emergency obstetric care, and seems to be appropriate for motivating staff in remote locations.
- 7 *Importance of capable and active HFOMCs:* The weak capacity of many HFOMCs and their many illiterate members makes it difficult for them to take on responsibilities for health facility management. The opposite is true with strong and active HFOMCs which have experienced considerable improvements at Khejenim, Change, and Tapethok health facilities. For example, Tapethok SHP has started its own birthing centre with community initiative and funding. Their understanding of the use of the Aama fund for service delivery improvement is crucial as HFOMCs often tend to focus on improving infrastructure and fulfilment of staff. The capacity of HFOMCs to manage health workers is central to the implementation of the collaborative framework for health with the Ministry of Federal Affairs and Local Development if it is to be implemented in this kind of remote area. Leading on from this it may be necessary to re-form some HFOMCs to recruit more active members, or to add advisory bodies of capable local stakeholders. Identifying enabling

factors for the capacity and activeness of HFOMCs are important issues for the final evaluation. Better linking HFOMCs and community groups is also important, especially to identify and focus more on reaching marginalised women.

- 8 *NGO support for implementation:* There is a need to provide more support for the implementing NGO by:
 - holding monthly review meetings for the NGO coordinator, social mobilizers, implementing NGO's administrative and account staff, NGO chairperson, and NHSSP coordinator
 - the EAP coordinator providing more support to the weaker social mobilisers
 - support for improved coordination at district level
- 9 *NGO capacity building:* Related to the above point, projects in remote areas also need to build the capacity of all NGO members, not just those directly involved in the project, as well as organisational and management systems.
- 10 *EAP approach to focus more on marginalised households:* The EAP program is meant to focus on marginalised women and people who do not normally go for health services. However, the current program has tried to enrol *all* households and has thus lost its focus on the marginalised groups. An amendment in community mobilisation is required to focus more on reaching women from more remote locations and encouraging the participation of women who do not participate in their local healthy mothers' group (or any other group) in the MNH awareness raising sessions. This may require the establishment of additional women's groups in remote areas where groups are not functional and thus has time and resource implications for the project. With the support of FCHVs and HFOMCs, new healthy mothers' groups could be established in remote areas as a more sustainable approach than stand-alone project created groups.
- 11 *Where users access services:* The selection of EAP areas and health facility supply-side improvement needs a proper understanding of which communities use which facilities. Approximately 30% of the population from the five EAP VDCs use services from outside the current supply-side interventions and a number of people from non-intervention VDCs use services from the intervention sites (see Annex 11). This could dilute the effects of EAP, as mobilised communities may be using services which may not be supported for improving quality of care, and therefore could dilute the results of Package 3.

6.2 Coordination with Other Remote Health and Community Development Programs

- 12 *Coordinated program planning and implementation:* Different divisions and centres within MoHP and other line ministries are implementing separate interventions for reaching populations in remote areas. For example, under MoHP:
 - The PHCRD is running integrated public health campaigns in 40 districts in 2014/15 (covering public health and curative services) and community health units to reach hard to reach parts of VDCs.
 - The Management Division has allocated flexible funds to 20 districts in 2014/15 to improve service provision to unreached communities and geographically remote areas.

Improved coordination between such interventions, both within and across line agencies, would reduce duplication and produce better impacts at a reduced cost.

7 THE WAY FORWARD FOR NHSP-3

Based on the lessons learned so far from the pilot project, it is recommended that the Nepal Health Sector Program-3 improves access to and use of MNH services in remote areas under the following two overarching areas.

A. District-wide planning and strengthening of the district health system to deliver services and demand for health services in remote locations

1. This approach calls for strengthening district health systems as a whole through district planning, upgrading and improving the quality of strategically located health facilities, and slowly expanding the delivery of services at these facilities based on needs, the capacity of the DHO, the infrastructure of the district, and the presence of other supporting agencies. Strategically located health facilities should be selected based on local knowledge and strong guidance from central or regional levels. The involvement of health facility staff and local NGOs in this is more likely to result in the selection of appropriately located health facilities and VDCs, as long as political pressure to favour non-strategic locations is resisted.
2. This approach will also need intensive and sustained efforts to upgrade and improve the quality of MNH services in remote areas. Activities for staff motivation and skill retention of service providers should be included. To be effective these initiatives need the strong leadership of district health officers who are willing to work in remote districts for a longer period.
3. Service delivery improvements need to be coupled with measures that encourage more accountability from health facility staff. There is therefore a need to continue to strengthen community participation in health facility management through HFOMC strengthening and other accountability mechanisms (such as social audits) to improve the accountability of facility personnel while also strengthening the health system's management of human resources.
4. It is very important to strengthen the demand for services and address the barriers that families face in accessing services, including access to information, especially reaching out to women who have no or very limited contact with health services and FCHVs.

B. National strategies and programs need to be flexible to adapt to remote areas' needs and contexts

5. Include disaggregated indicators in NHSP-3's national level monitoring framework to provide evidence for the need to increase access to health services in remote areas. It is also very important for NHSP-3 to encourage the use of data for decision making at all levels for service improvement and access.
6. National policymakers should consider:
 - the contracting-in of health workers
 - the contracting-out of service delivery, especially in the most remote areas and for certain services such as laboratory services and drug supplies and distribution
 - the contracting out of community awareness and mobilisation activities to civil society organisations
7. Include career development and other incentives in the proposed remote areas strategy to encourage capable and active personnel to serve in DHOs and DPHOs in remote districts.
8. Include extra activities to more intensively support FCHVs in implementing community-based interventions (such as misoprostol, CHX, and IMNCI) in remote areas. This may be achieved by

linking community-based demand creation and mobilisation programs, such as EAP, LGCDP, and Suahara, with FCHV strengthening to improve FCHV-based community-based interventions in a sustainable way.

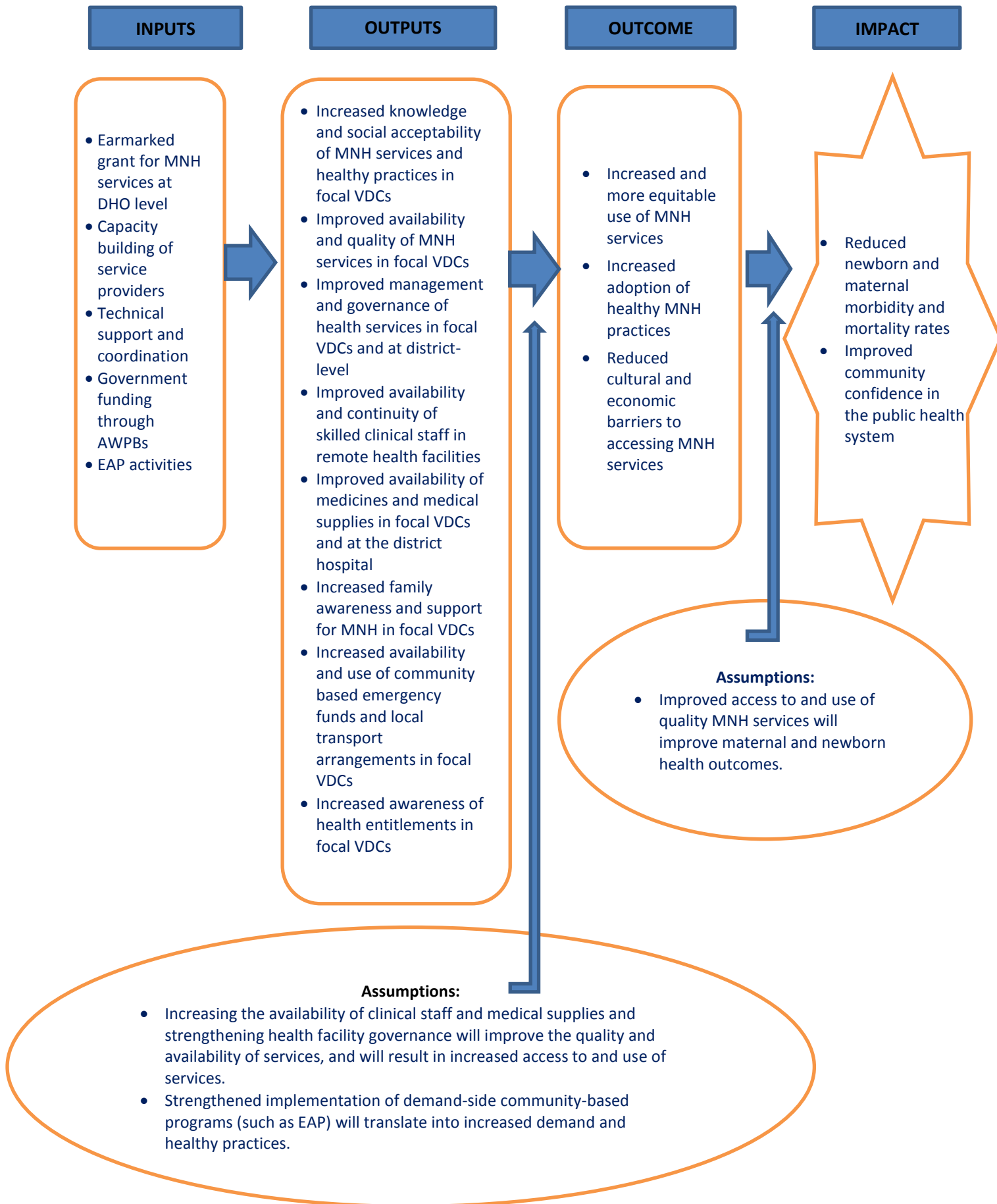
9. *Level of Aama incentives*: Revise the levels of the Aama incentive for giving birth in a health facility based on a households' distance from its nearest facility.

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Annex 1: Theory of Change for the Remote Areas MNH Pilot Project (2014-2015)

Source: Figure 4 of NHSSP 2014b



Annex 2: Results Framework of the Remote Areas Maternal and Newborn Health Pilot Project

Annex 2.1: Indicators for monitoring achievement of outcomes

Pilot outcomes	Potential indicators
<i>Primary Outcome 1:</i> Increased and more equitable use of MNH services	<ol style="list-style-type: none"> 1. % of pregnant women with at least one ANC visit 2. % of pregnant women attending four ANC visits as per protocol 3. % of pregnant women receiving IFA tablets or syrup during their last pregnancy 4. % of deliveries conducted by a SBA 5. % of institutional deliveries 6. % met need for emergency obstetric care 7. % of deliveries by caesarean section or CS rate 8. CPR - modern methods (%) 9. % of women who received contraceptives after safe abortion (surgical or medical)
<i>Secondary Outcome 1:</i> Increased and more equitable use of child health services	<ol style="list-style-type: none"> 1. % of one-year-old children immunised against measles 2. % of children under five with diarrhoea treated with Zinc and ORS 3. % of children under five with pneumonia who received antibiotics
<i>Primary Outcome 2:</i> Increased adoption of healthy MNH practices	<ol style="list-style-type: none"> 1. % of neonates breast fed within one hour of birth 2. % of babies who had delayed bathing (24 hours)
<i>Primary Outcome 3:</i> Reduced cultural and economic barriers to accessing MNH care services	<ol style="list-style-type: none"> 1. % of women of reproductive age (WRA) who report their families give permission for pregnant women to leave their domestic and productive work to attend ANC services 2. % of WRA who report that their families provide special care to pregnant and recently delivered women 3. % of recently delivered women who received (i) four ANC or (ii) Aama benefits. 4. % of recently delivered women who received funds from (i) local government or (ii) community based emergency funds to access obstetric care 5. % of WRA who report that their community has transport arrangements in place for health emergencies

Note: Indicators will be disaggregated by sex, caste, and ethnicity and travel time to health facilities

Annex 2.2: Indicators for monitoring achievement of outputs

Pilot outputs	Potential indicators
1. Increased knowledge and social acceptability of MNH services and healthy practices	<ol style="list-style-type: none"> 1. % of WRA aware of three pregnancy related danger signs 2. % of WRA aware of at least three danger signs in newborns 3. % of WRA giving birth in the last two years aware of at least three danger signs in newborns 4. % of WRA aware of immediate breast feeding (within one hour) 5. % of WRA aware of delayed bathing of newborns (after 24 hours) 6. % of WRA who are aware of an emergency referral fund 7. % of WRA who reported that their mothers-in-law encourage daughters-in-law to attend four ANC 8. % of WRA who reported that mothers-in-law prefer for their daughter-in-law to deliver at a health facility 9. % of WRA who reported that mothers-in-law encourage delayed bathing of newborns 10. % of WRA aware of health care entitlements (free care, Aama incentive and amount) <p>Indicators to be disaggregated by travel time to nearest facility, and caste/ethnicity</p>
2. Improved availability and quality of MNH services in focal VDCs	<p><i>Availability, readiness, and functionality of MNH services:</i></p> <ol style="list-style-type: none"> 11. % of outreach clinics conducted 12. % of health facilities with no stock out of selected emergency obstetric drugs* 13. % of health facilities with no stock out of the tracer drugs* 14. % of health facilities with no stock out of the free care drugs* 15. % health facilities with infection prevention practice rated as good** 16. % improvement health facilities with rating based on quality of care self-assessment test** <p><i>Quality of care/ service provided:</i></p> <ol style="list-style-type: none"> 17. % of institutional deliveries with partograph use 18. % of institutional deliveries with oxytocin used for speeding delivery (PHCC/HP/SHP) 19. % of institutional deliveries with mothers checked for blood pressure before discharge 20. % of institutional deliveries with babies umbilical cord checked before discharge 21. % of clients satisfied with their health care at public facilities
3. Improved management and governance of health services in the focal VDCs and at district-level	<ol style="list-style-type: none"> 22. % of HFOMC/HDC meeting regularly (monthly) 23. % of health facilities that have undertaken social audits as per MoHP guidelines in the last FY 24. allocation of resources based on needs: HR, equipment, fund 25. increased local resource allocation (from DDC, VDC etc.) for MNH

* See detailed implementation guidelines for list of emergency drugs and tracer drugs

** A ranking/rating guideline will be developed for this pilot (see detailed implementation plan)

Annex 2.3: Indicators for monitoring the process of intervention

Pilot Process	Potential areas to monitor
District level processes	<ol style="list-style-type: none"> 1. DHO coordination process and effects 2. DHO use of funds and its allocation of resources 3. HDC involvement and process/plans for improving hospital management 4. perceptions of other district stakeholders
VDC level	<ol style="list-style-type: none"> 5. HFOMC-related issues (based on HFOMC self-assessment tools) 6. community level changes; how and what may be the causes of changes or no changes 7. establishment of community based emergency referral funds and their use 8. development of community-led transport solutions to reaching emergency care 9. women’s groups’ participation, processes, and effects including % of women’s groups that had regular meetings in last three months
Other	<ol style="list-style-type: none"> 10. how differing contexts affect the delivery of the package, including impacts at health facility- and community-levels

Annex 3: Participants at Mid-term Review of Remote Area MNH ProjectTaplejung, 19th February 2015

	Name	Post	Organization
1	Ashok Gurung	Account Officer	NWEA
2	Babu Ram Niraula	Senior AHW	Limbudin SHP
3	Babu Ram Thulung	Health Assistant	DHO
4	Bal Bahadur Okhrabu	Account Officer	DHO
5	Bhagawati Shrestha	QI officer	NHSSP
6	Bhagiman Lingden	Field Monitoring Officer	HERD
7	Bharat Mani Dahal	Health Education Technician Officer	DHO
8	Bhim Limbu	HFOMC Chairperson	Sobuwa SHP
9	Bhupendra Chaulagain	HFOMC Chairperson	Khejenim HP
10	Bipin Dulal	Computer Operator	DHO
11	Buddhi Prasad Bhattarai	HFOMC Member	Saablakh HP
12	Chandra Lal Giri	Office Assistant	DHO
13	Deepak Limbu	HFOMC Chairperson	Tapethok SHP
14	Dhan Bahadur Limbu	HFOMC Chairperson	Santhakra SHP
15	Dharma Devi Sherma	ANM	Sablakhu HP
16	Dinesh Ray	Cold Chain Assistant	DHO
17	Dr Deepak Banjade	Medical Officer	DHO
18	Dr Guru Prasad Poudel	Medical Officer	DHO
19	Dr Krishna Hari Subedi	District Health Officer	DHO
20	Dr Kumud Bhattarai	Medical Officer	DHO
21	Dr Maureen Dariang	EHCS Advisor	NHSSP
22	Durga Maya Okhrabu	EAP Social Mobiliser	EAP/NWEA
23	Durgananda Das	AHW	Santhakra SHP
24	Hem Raj Kathayat	Statistical Assistant	DHO
25	Hima Devi Gurung (Dahal)	Public Health Nurse	DHO
26	Hom Nath Subedi	Consultant	NHSSP
27	Hridaya Narayan Chaudhary	Senior AHW	Change HP
28	Kabita Limbu	ANM	Santhakra SHP
29	Kamala Ramtel	EAP Social Mobiliser	NWEA
30	Krishna Maya Limbu	ANM	Sinwa HP
31	Kumar Yangden	Office Assistant	DHO
32	Laxmi Devi Limbu	ANM	Change HP
33	Laxmi Maya Wonem	AHW	DHO
34	Laya Kumar Shrestha	HFOMC Member	Limbudin SHP
35	Lila Bokhim	Chairperson	NWE
36	Muna Libang	EAP Social Mobiliser	NWEA
37	Narayan Prasad Nepal	Accountant	DHO
38	Narendra Prasad Katuwal	EAP Project Coordinator	NWEA

	Name	Post	Organization
39	Om Kumari Gurung	Senior ANM	DHO
40	Parmendra Prasad Yadav	Lab Assistant	DHO
41	Phulgendra Prasad Singh	RAMP District Coordinator	NHSSP
42	Pramila Niraula	AHW	Sinwa HP
43	Premika Labung	ANM	Kejenim HP
44	Prthbi Bikram Khadaka	Lab Technician	DHO
45	Rabin Rai	AHW	Aangkhop SHP
46	Ram Prabodh Mandal	Senior AHW	Khejenim SHP
47	Rama Adhikari	ANM	Thinglabu HP
48	Ranjita Hellok	ANM	Tapethok SHP
49	Sandip Nayong	Health Assistant	DHO
50	Sanjay Kumar Yadav	AHW	Sobuwa SHP
51	Santosh Ghimire	Consultant	NHSSP
52	Sarita Limbu	AHW	Tapethok SHP
53	Shekhar Limbu	HFOMC Member	Thinglabu HP
54	Stephen Keeling	NHSSP Editor	NHSSP
55	Surendra Chaudhary	Family Planning Supervisor	DHO
56	Surya Aangbuhang	HFOMC Chairperson	Change HP
57	Surya Man Okhrabu	Senior AHW	Thinglabu HP
58	Tabita Lingden	EAP Social Mobiliser	NWEA
59	Tek Bahadur Tamling	HFOMC Chairperson	Aangkhop SHP
60	Thag Bahadur Gurung	Health Assistant	Sablakhu HP
61	Yam Kumar Gurung	Office Assistant	DHO
62	Yamkantha Gurung	Office Assistant	DHO

Annex 4: Schedule of Mid-term Review of Remote Area MNH Project

8am to 5:30 pm, 19th February 2015

1. Breakfast and Registration
2. Introduction and Opening (Dr KH Subedi, Dr K Bhattarai, PP Singh, and Om K Gurung)
3. Break
4. Presentations of Sablaku HP, Limbudin SHP and Aangkhop SHP by health facility in-charges
5. Presentations of Linkhim HP, Khejenim SHP and Tapethok SHP by health facility in-charges
6. Lunch
7. Presentations of Change HP, Sobuwa SHP, Thinglabu HP and Santhakra SHP by health facility in-charges
8. Synthesis of issues (PP Singh) and EAP at a Glance (Narendra Katuwal, NWEA)
9. Presentations of five EAP VDCs by social mobilizers
10. Tea break
11. Synthesis of issues by Hom Nath Subedi, the district health officer and Dr Maureen
12. Action points for way forward (mostly developed at follow-up meeting on the next day).

Annex 5: Equipment, Drugs, and other Commodities Support for Health Facilities

	Equipment	Number
A. From earmarked fund		
	Tray with cover 8x11	5
	Plain forceps	9
	Tooth forceps	9
	Suture cutting scissors	3
	Glycerine	10 bottles
	Spirit 100 ml	10 bottles
	Suction bulb	5
	Virex	60 bottles
	Jar for cover for swab	3
	Cord cutting scissors	3
	Sponge holding forceps, 20 cm	5
	Episiotomy scissors	8
	Needle holder	3
	Kocher forceps	9
	Episiotomy scissors, big	4
	Artery forceps	8
	Stainless steel bowl, small	3
	Episiotomy scissors, 8.22cm	8
	Dissecting forceps, non-tooth	9
	Chromic catgut 2.0	120
	Surgical gloves, 6 boxes	300 pairs
	Liquid soap	10
	Endomax antiseptic cidex	6
	Dressing wrappers	30
	Stainless steel bowl, big	12
	Surgical drum, medium	6
	Test tube brush	10
	Op. theatre mask	30
	Op. theatre cap	30
	Wall clock	3
	Torch light	3
	Delee suction	36
	Urinary (plain) catheter	45
	Gloves powder	3 bottles
	Gas stove, single burner	5
	Tourniquet rubbers	4
	Cheatle forceps with jar	2
	IV stand	3

	Equipment	Number
	Ambu bag baby	2
	Baby weight scale, pan type	4
	Surgical drum, 9x11	9
	Autoclave drum (double)	3
	Puncture proof container	5
	Macintosh rubber sheet	6
	Plastic aprons	18
	Autoclave tape	6
B. Provided to all 10 RAMP health facilities at infection prevention training		
	different coloured bowls to prepare chlorine solution	3
	Utility gloves	4 pairs
	Soap cases	2
	Wiper towel	
	Wiper	1
	Funnel wiper set	1
	20 ltrs bucket with tap	1
	Different coloured big buckets to collect waste	3
	Hand towel for each health worker	Many
	Gumboots	2
	Dressing set wrapper	2
	Baby wrapper (birthing centre only)	8
	Wrappers (birthing centre only)	2
C. Other equipment provided to all 10 health facilities (via LMD)		
	Manual vacuum aspiration (MVA) set	6
	Small oxygen cylinders (LMD)	6

Annex 6: Example of Action Plans Produced by RAMP Health Facilities

Sablakhu HP Action plan (produced on 17th May 2014)

	Problem	Reason	Solution	Date to implement	Responsible person(s)	Achievement indicator
1	No regular HFOMC meetings	Decisions not taken to hold meetings	Make decision to hold regular meetings and follow up on it	Meet 2pm on 12 th of each month	All HFOMC members	Meeting minutes register
2	No HFOMC letter pad or stamp	Lack of awareness of this requirement as per HFOMC guidelines	Give responsibility to somebody to prepare it	3 rd June 2014	Member secretary	Availability of HFOMC's letter pad and stamp
3	More than half of HFOMC members often do not participate in many HFOMC meetings	Irresponsible HFOMC members, and some live far away	Re-form HFOMC as per guidelines, ask all members to participate in all meetings, and if they miss three meetings in a row their membership will be automatically cancelled	Re-form HFOMC by 26 th May 2014	All members	Meeting minutes and list of new HFOMC members
4	Names of HFOMC members with photos not displayed	Lack of awareness of requirement as per guidelines	Display photos of HFOMC members after it has been re-formed	By 28 th July 2014	HFOMC chairman	Displayed chart with photos
5	Meetings not held on time	Always have to wait for late participants	Do not take any financial decisions If meetings have less than half of members present	From June/July 2014	HFOMC members	Meeting minutes register
6	Last year's progress report not displayed at the HP	Lack of awareness of this requirement as per guidelines	Prepare annual progress report on a chart and display at the HP	Start of each year & update monthly	In-charge and responsible persons of each dept.	Displayed at HP
7	No review of progress on previous meeting's decision made at next meeting	Lack of awareness of this requirement as per guidelines	At every meeting review and evaluate previous meeting's decisions and display meeting guidelines in the HP	From 26 th May 2014	HFOMC	Recorded in meeting minutes
8	Unavailability of essential drugs	Drug stock records not kept properly	Regularly check stock of essential drugs and submit stock list to in-charge each month	Regularly	Storekeeper	Meeting minutes and observation
9	Lack of essential equipment for maternity ward	No maintenance and replacement of faulty equipment	Maintain equipment and request DHO for new supplies to replace defunct equipment	By 24 th May 2014	Storekeeper	Request letter copy & availability of equipment
10	HP not open for all the time from 10 am to 4/5 pm	Bad practice	Open HP for all office hours, prepare supervision plan and implement it	From 19 th May 2014	HP in-charge	Supervision report
11	No HFOMC health facility supervision plan	Lack of awareness of need to do this as per guidelines	Prepare and implement supervision plan	From 26 th May 2014	HFOMC members	Supervision plan and records
12	HP progress report not discussed at monthly meetings	Lack of awareness of requirement as per guidelines	Start from next monthly meeting	At each monthly meeting	HFOMC and HP staff	Meeting minutes

	Problem	Reason	Solution	Date to implement	Responsible person(s)	Achievement indicator
13	Not achieving institutional delivery target	Lack of public awareness, staff behaviour, health workers doing home deliveries	Coordinate with local NGO/CBOs, women's groups, FCHVs to promote deliveries at HPs, improve services, provide 24 hour services, discourage home deliveries, provide quality services at outreach (ORC) clinics	From June/July 2014	HFOMC members and facility staff	Increased service use
14	Irregular primary health care outreach clinics (PHC-ORC)	One health worker conducts immunisation and ORC clinic at a time	Send ANM to conduct ORC clinics with the <i>padhanam</i> ANM (upgraded AHW)	From May/June 2014	HP staff	Supervision reports, service register, and local people
15	Citizens charter not displayed in front of the HP	Unavailability of safe place to display it	Until new building is built, hang charter outside the HP from 10 to 5pm	Start 19 th May 2014	HP office assistants	Is displayed outside in office hours
16	Unavailability of HFOMC's annual plan	Lack of awareness of requirement as per guidelines	This action plan will serve as HFOMC's annual plan	From today	HFOMC members and staff	Implemented plan
17	Discussion not happening at meetings on which local people use/do not use HP	Lack of awareness of this requirement as per guidelines	From now on discuss who does and does not use the HP at each meeting	At each HFOMC meeting	HFOMC and HP staff	Minutes records
18	Inaccessibility of HP for transporting emergency cases to hospital	No vehicle and road is in bad condition for much of year	Organize mass discussion meeting about requesting Indian army/government to donate ambulance	On 28 th July 2014	HFOMC	Related request documents
19	24 hour electricity not available	No mains electricity and solar battery not working	Connect to mains by coordination of HFOMC and fix/maintain the solar battery	By mid-June 2014	HFOMC	24 light will be in use
20	Contracted ANM is not available year round	Delayed government budget release	Form sub-committee to coordinate with VDC/DDC to continue contracted ANM	26 th May 2014	HFOMC	Meeting minutes, continuation of contracted ANM
21	Lack of emergency fund to pay for referrals to hospitals	Lack of awareness of it and no money for it	Establish an emergency fund in coordination with respective people, prepare fund mobilization guidelines and form committee for fund disbursement	From 26 th May 2014	HFOMC	Fund being used
22	Insufficient stretchers	Only four stretchers available	Coordination with DHO, SUA AHARA, and local NGO	From 26 th June 2014	HFOMC	Each ward has a stretcher

Annex 7: Fulfilment of Posts at Project Health Facilities, 2012/13 to first six months of 2014/15

1. Ankhop SHP

Year	AHW	PAHW	PANM	OA
2012/13 (12 months)	100%	100%	0%	100%
2013/14 (12 months)	100%	100%	0%	100%
2014/15 (6 months)	83%	67%	33%	100%

- PANM for only two months of 2014/15, but other staff posted for most of the time

2. Limbudin HP

	HA/SAHW	AHW	ANM	PAHW	PANM	OA
2012/13 (12 months)	0%	100%	0%	0%	100%	100%
2013/14 (12 months)	0%	100%	0%	0%	100%	100%
2014/15 (6 months)	100%	0%	0%	33%	100%	100%

- PAHW/vaccinator appointed for two months of 2014/15, but can't provide MNH services

3. Sablaku HP

	HA/SAHW	AHW	ANM	PAHW	C. ANM	OA
2012/13 (12 months)	100%	0%	100%	100%	67%	100%
2013/14 (12 months)	92%	0%	25%	100%	58%	100%
2014/15 (6 months)	100%	0%	100%	100%	100%	100%

- Contracted SBA ANMs stayed eight and seven months in the previous two years, but in the current year they have stayed for all six months so far.
- Permanent staff are in post full-time compared to previous years.
- There are now have three ANMs (two SBAs contracted and one non-SBA permanent).

4. Change HP and Sobuwa SHP

	HA/SAHW	AHW	ANM	PANM	C. ANM	OA
2012/13 (12 months)	100%	100%	100%	100%	0%	100%
2013/14 (12 months)	100%	100%	100%	100%	58%	100%
2014/15 (6 months)	100%	83%	100%	100%	100%	100%

- The last contracted ANM worked only seven months in the previous year, but is working full time in the current year.

- There are three ANMs (one permanent, one DHO contracted and one from the National Development Volunteer Service).

5. Thinglabu HP

	SAHW	HA	C. ANM	PAHW	PANM	OA
2012/13 (12 months)	100%	0%	25%	100%	0%	100%
2013/14 (12 months)	100%	0%	50%	100%	0%	100%
2014/15 (6 months)	100%	50%	100%	100%	0%	100%

- The health assistant started work from 2014/15.
- The contracted ANM is working full time in the current year compared to part-time in previous years.
- Two contracted ANMs are in post, both DHO contracted. One is continuing from the previous year and one started in October/November 2014.

6. Santhakra SHP

	HA/SAHW	AHW	C.ANM	PAHW	PANM	OA
2012/13 (12 months)	0%	100%	100%	0%	100%	100%
2013/14 (12 months)	0%	100%	100%	0%	100%	100%
2014/15 (6 months)	0%	100%	100%	0%	100%	100%

- There are three contracted ANMs (one recruited by HFOMC, two from DHO), but one is on maternity leave.

7. Lingkhim HP

	HA/SAHW	AHW	ANM	PAHW	PANM	OA
2012/13 (12 months)	0%	92%	100%	100%	0%	100%
2013/14 (12 months)	100%	25%	100%	100%	0%	100%
2014/15 (6 months)	67%	100%	83%	100%	0%	100%

- There are two contracted ANMs, both DHO contracted; one is continuing from the previous year and one started in October/November 2014.

8. Tapethok SHP

	AHW	ANM	PAHW	PANM	OA
2012/13 (12 months)	0%	0%	0%	100%	100%
2013/14 (12 months)	0%	0%	0%	100%	100%
2014/15	100%	67%	0%	100%	100%

(6 months)					
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- In coordination with HFOMC, this facility has kept AHW for six months (three months recruited by HFOMC and next three months came from the National Development Volunteer Service).
- One ANM was hired by HFOMC when they set up the delivery room and equipped it (around mid-September 2014). The DHO has since continued this position. Note that the 67% presence of the ANM reflects that this post was fulfilled for four months of 2014/15, i.e. from mid-September 2014, which is 100% of the time since the birthing centre was established.

9. Khejenim SHP

	HA/SAHW	AHW	ANM	PAHW	PANM	OA
2012/13 (12 months)	0%	100%	0%	100%	100%	100%
2013/14 (12 months)	0%	0%	0%	100%	0%	100%
2014/15 (6 months)	6	0%	0%	0%	0%	100%

- A poor situation with only one health assistant there full time in the last six months and the senior AHW only present from time to time

Annex 8: Pre and Post Infection Prevention Training Test Scores

The knowledge of all the participants in the infection prevention training events increased with the average score increasing from ten out of 25 at the beginning to 17 out of 25 at the end of the training events (see Annex 9 for details).

	Post at health facility	Score at start (out of 25)	Score at end (out of 25)
Sablakhu SHP			
1	In-charge	20	23
2	ANM	17	23
3	ANM	13	20
4	ANM	0	20
5	P. AHW	0	17
6	Office helper	7	11
Limbudin SHP			
1	P. ANM	12	15
2	Office helper	5	10
3	HFOMC member	13	17
4	HFOMC member	9	13
5	In-charge	21	24
6	FCHV	2	4
Change HP			
1	HFOMC M	11	22
2	In-charge	17	19
3	ANM	19	24
4	ANM	22	25
5	FCHV	19	25
6	HFOMC member	15	17
Sobuwa SHP			
1	FCHV	6	18
2	HFOMC member	6	22
3	P. ANM	10	21
4	HFOMC member	11	23
5	In-charge	16	24
Santhakra SHP			
1	FCHV	7	19
2	HFOMC member	8	18
3	In-charge	18	22
4	ANM	14	21
5	P. ANM	14	20
6	Office helper	8	25
7	ANM	0	21

	Post at health facility	Score at start (out of 25)	Score at end (out of 25)
Thinlabu HP			
1	In-charge	21	24
2	ANM	15	19
3	P. AHW	16	18
4	Office helper	4	13
5	FCHV	Not done	Not done
6	HFOMC member	Not done	Not done
Limkhim HP			
1	In-charge	20	22
2	ANM	22	24
3	HA	15	23
4	FCHV	12	21
5	Office helper	8	17
6	P. AHW	8	21
Tapethok SHP			
1	P. ANM	3	14
2	ANM	18	22
3	FCHV	15	18
4	Office Helper	11	11
5	HFOMC member	6	18
6	HFOMC member	0	12
7	HFOMC member	4	10
8	HFOMC member	0	9
Khejenim SHP			
1	Office Helper	5	8
2	In-charge	18	20
3	HFOMC member	10	13
4	HFOMC member	12	18
5	FCHV	2	10
Ankhop SHP			
1	In-charge	17	21
2	Bijaya	5	14
3	Office helper	1	13
4	Tek Bdr	4	15
5	HFOMC member	5	18
6	Laxmi	8	18
Total			
		625	1,067
Average score			
		10	17

Annex 9: Quality of Care Tool Results for RAMP Health Facilities with Birthing Centres, 2014

Annex 9.1: Quality of Care Tool Results for RAMP Health Facilities with Birthing Centres- Quality Domain Results

	1. Change HP		2. Lingkhim HP		3. Sablakhu HP		4. Thinglabu HP		5. Santakra SHP		6. Tapethok SHP	
	071/4/24	071/8/19	071/6/4	071/8/28	071/4/13	071/8/27	071/5/5	071/8/22	071/5/2	071/8/21	071/6/7	071/8/26
Indicators	09-Aug-14	05-Dec-14	20-Sep-14	14-Dec-14	29-Jul-14	13-Dec-14	21-Aug-14	08-Dec-14	18-Aug-14	07-Dec-14	23-Sep-14	12-Dec-14
1. Mgt demand	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Red	Orange
2. Referral	Orange	Orange	Red	Red	Red	Yellow	Red	Red	Orange	Orange	Red	Red
3. Electricity	Green	Green	Green	Green	Red	Green	Red	Green	Green	Green	Red	Green
4. Water & sanitation	Red	Green	Red	Green	Red	Green	Red	Green	Red	Orange	Red	Green
5. Patient dignity	Orange	Orange	Orange	Green	Red	Yellow	Red	Orange	Red	Yellow	Red	Red
6. Management	Yellow	Green	Orange	Orange	Orange	Yellow	Yellow	Orange	Orange	Yellow	Orange	Yellow
7. Staffing	Yellow	Green	Yellow	Green	Green	Green	Green	Green	Red	Orange	Yellow	Green
8. Equipment	Yellow	Yellow	Orange	Yellow	Red	Orange	Orange	Yellow	Red	Orange	Red	Red
9. Medicines	Orange	Yellow	Red	Yellow	Red	Orange	Red	Yellow	Orange	Yellow	Red	Red
10. Postnatal care	Green	Green	Red	Yellow	Red	Yellow	Orange	Yellow	Red	Red	Red	Orange
11. Partograph	Green	Green	Green	Green	Red	Green	Green	Green	Red	Red	Red	Green
12. Family planning	Yellow	Green	Red	Red	Orange	Yellow	Yellow	Yellow	Orange	Orange	Red	Orange
13. Infection prevention	Green	Green	Yellow	Green	Red	Green	Yellow	Green	Red	Orange	Red	Green
Green scores	5	9	3	7	2	6	3	6	2	2	0	5
Yellow scores	4	2	2	3	0	5	3	4	0	3	1	1
Orange scores	3	2	3	1	2	2	2	2	4	6	1	3
Red scores	1	0	5	2	9	0	5	1	7	2	11	4

Annex 9.2: Quality of Care Tool Results for RAMP Health Facilities with Birthing Centres- Signal Function Results

		1. Change HP		2. Limkhim HP		3. Sablakhu		4. Thinglabu		5. Santhakra SHP		6. Tapethok SHP	
		09-Aug-14	05-Dec-14	20-Sep-14	14-Dec-14	29-Jul-14	13-Dec-14	21-Aug-14	08-Dec-14	18-Aug-14	07-Dec-14	23-Sep-14	12-Dec-14
1	Parenteral antibiotics (mother and newborn)	Green	Green	Red	Green	Red	Red	Red	Green	Red	Red	Red	Red
2	Parenteral uterotonic drugs	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Red	Green
3	Parenteral anti-convulsants	Red	Green	Red	Green	Red	Red	Red	Green	Red	Red	Red	Red
4	Manual removal of placenta	Green	Green	Green	Green	Red	Green	Green	Green	Red	Green	Green	Green
5	Removal of retained products of conception	Green	Green	Red	Green	Red	Green	Green	Green	Red	Red	Red	Green
6	Assisted vaginal delivery	Green	Green	Red	Green	Red	Red	Green	Green	Red	Red	Red	Red
7	Newborn resuscitation	Green	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green	Green
	TOTALS												
	Green	6	7	3	7	1	4	4	7	2	3	2	4
	Red	1	0	4	0	6	3	3	0	5	4	5	3

Annex 10: Capacity Strengthening of HFOMCs as per Results of HFOMC Self Assessments

For institutional capacity and empowerment: Achievable objectives have included holding monthly meetings, participation by a quorum at meetings, the representation of the issues of marginalized communities, decision-sharing with local people, preparing annual work plans, producing meeting minutes, and monthly follow-ups on recorded decisions. Objectives that have been less implemented are the timely arrival of members at meetings, displaying HFOMC members and photos, and preparing a headed letter pad and an office ink stamp.

For health facility management: Achievable objectives have included keeping the area outside the facility clean, fulfilling sanctioned posts, stocking basic medicines, mobilising VDC resources, remaining open during all office hours, and supporting the local FCHV. The less implemented activities include having basic furniture and equipment and producing a facility monitoring plan with action plan.

On health services' delivery status: Achievable objectives have included providing basic services such as immunizations, the presence of an ANM at birthing centres, stocking family planning devices, holding ORC clinics, trying to serve marginalized community members, stocking basic essential medicines, and displaying the citizens' charter and annual plan. The following activities are happening less: data monitoring and sharing data with the HFOMC at monthly meetings, the use of maternity services such as four ANC visits, iron tablet distribution, and progress report presentation by MCHWs/VHWs.

Annex 11: Service User Mapping of 9 RAMP VDCs, Taplejung

	Health Facility and its VDC	Incoming service users from other VDCs	Outgoing service users to other VDC/wards
1	Aangkhop SHP (Aangkhop VDC)	None	From Aangkhop VDC wards 6, 8 and 9 to Oyam SHP, Panchthar district
2	Change HP (Change VDC)	Dhungeshanghu VDC wards 1,2, 4 and 6; Hangpang VDC wards 1 and 2; Khamlung VDC ward 1	From Change VDC ward 7 to Hangpang VDC
3	Khejenim SHP (Khejenim VDC)	None	From Khejenim VDC ward 3 to Linkhim VDC
4	Limbudin SHP (Limbudin VDC)	Mehele VDC wards 8 and 9	From Limbudin VDC wards 1, 2, 3 and 4 to Sablakhu HP
5	Linkhim HP (Linkhim VDC)	Khejenim VDC wards 2, 3 and 5; Sawadin VDC wards 4 and 7	From Linkhim VDC to District Hospital
6	Sablakhu HP (Sablakhu VDC)	Aangkhop VDC wards 1, 2 and 3; Limbudin VDC wards 1, 2, 3 and 4	From Sablakhu VDC wards 1, 2, 3 and 4 to Tharpu HP, Panchthar district
7	Santhakra SHP (Santhakra VDC)	Lingtep VDC wards 6 and 9; Khamlung VDC wards 4 and 6	From Santhakra wards 3, 4, 5 and 7 to Thinglabu VDC
8	Sobuwa SHP (Change VDC)	Hangpang VDC ward 1	None
9	Tapethok SHP (Tapethok VDC)	Ikkhabu VDC ward 9 Lelep VDC wards 1, 2 and 3	From Tapethok VDC wards 7, 8 and 9 to Lelep VDC
10	Thinglabu HP (Thinglabu VDC)	Santhakra VDC wards 3,4,5 and 7; Phakumba VDC ward 6 (some)	4 Dalit households from Thinglabu VDC ward 8 to Dhungeshanghu VDC