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Strategic Review of the Equity and Access Programme

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Strengthening Health Systems-Improving Services

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EXECUTIVE SUMMARY

1. *BACKGROUND*

The Equity and Access Programme (EAP), which was launched in 2006, is a women's empowerment and rights-based community mobilisation programme for health. Between 2006 and 2009 it was funded by the Department for International Development (DFID) as part of the Support to Safe Motherhood Programme (SSMP). It was implemented by Action Aid Nepal (AAN) in association with New Era in village development committees (VDCs) of eight districts. Based on its success, the Department of Health Services (DoHS) funded and rolled out the model to two more districts in its 2008/09 annual work plan and budget (AWPB). In 2009/10, as donor funding withdrew, DoHS extended its financial assistance to additional districts. EAP is now in its fourth year of funding by DoHS and is operational in 21 districts.

Several implementation challenges have negatively affected the delivery and content of the programme during the latter period and have led DoHS's Primary Health Care Revitalisation Division (PHCRD) to undertake a strategic review of the programme; the results of which are reported here.

2. *FINDINGS AND RECOMMENDATIONS*

The achievements of EAP under SSMP (2005–2009) and experiences in other countries endorse the validity of EAP's design and its potential to raise access to health services and improve the well-being of targeted communities. However, this review found that implementation bottlenecks are strangling EAP's effectiveness and undermining its reach to the poor and excluded. These findings raise serious questions as to the value of continuing the programme.

The review team believes that EAP is a strategically valuable programme for MoHP as it speaks to policy priorities and addresses social inequities in access to, and the use of health services, especially by women, the poor and excluded people. And there is merit in this programme remaining under the stewardship of MoHP.

The following four strategic management conditions need to be met to enable the programme to deliver results and to provide value-for-money.

i. *The multi-year contracting of NGO partners with annual incremental budgets* — The current annual contracting of NGOs should be replaced with multi-year contracting to implement this empowerment-oriented social mobilisation programme. The Local Governance and Community Development Programme (LGCDP) has shown that this approach works and has administrative and governance benefits. With inflation likely to continue budget increases will need factoring into the multi-year contracts.

ii. *Increased central level involvement in district NGO selection process* — The NGO selection process needs to be better mediated to reduce political influence, increase transparency and more efficiently use the time and resources of district health office/district public health office (DHO/DPHO) staff and NGOs. We recommend greater central-level involvement with a third party technical support agency engaged to support NGO selection.

iii. *The strengthened supervision and monitoring of programme implementation* — The level of technical supervision and programme monitoring needs to be elevated to improve the quality and relevance of activities and to leverage more health services and local government resources.

iv. *Better coordination with MoFALD/LGCDP and other social mobilisation programmes* — Improved coordination is needed at the policy and implementation level while EAP, LGCDP and other social mobilisation programmes need to work together more closely. At the VDC level, opportunities for wider coverage and impact need to be grasped through better coordination between social mobilisers from EAP, LGCDP and other programmes, and by the integration of health topics into other programmes' agendas and activities.

If the above four conditions cannot be met then the review team recommends that the government consider terminating the programme or at least relocating management outside of government to a third party where the conditions can be met. If, however, the government can address these conditions and EAP continues, we recommend the reshaping of the following four areas to enable EAP to deliver the results it has demonstrated in the past.

v. *Coverage: Strengthen the targeting of the unreached* — The merit of EAP is in reaching unreached and excluded populations. Due to implementation bottlenecks, the targeting of the most vulnerable people has been compromised. Clarity of purpose and a plan for rolling out EAP to selected low-performing and underserved districts needs developing to:
   - set the pace of expansion and identify the number of districts to be covered;
   - define criteria to be used in selecting districts and VDCs;
   - reintroduce a strong focus on poor and excluded groups;
   - map out an exit strategy from successful VDCs and districts; and
   - include mechanisms for learning and dissemination.

   The next year, 2012/13, should be spent reshaping the programme, reviewing the portfolio of districts, developing exit plans for districts that no longer meet the criteria for inclusion, and sharpening the focus of activities in districts that are kept on.

   A new approach to reaching the ultra-poor also needs developing, especially given the difficulties of involving them in group mobilisation activities. We therefore recommend that MoHP collaborates with LGCDP and the Poverty Alleviation Fund to develop ways of improving the access of the ultra-poor to health information, and to integrate health into the activities of these programmes that target the ultra-poor.

vi. *Extend the focus of the EAP package* — The broadening of the scope of work of EAP should continue to include nutrition, water, sanitation and hygiene, and to have a strengthened focus on rights and accountability. EAP's demand side focus fits many geographical and service contexts across the country where basic services are available. However, the specific challenges faced by populations in remote areas, where service availability is often weak, suggests that an expanded EAP package is needed for these areas.

vii. *Ensure quality* — The transfer of EAP from SSMP to government in 2008/09–2009/10 saw a large reduction in technical support and monitoring and NGO partners have at times received insufficient technical support, training, supervision and monitoring. Implementation bottlenecks and the short implementation window further undermined the quality of efforts. This situation needs to be corrected by investing more resources in quality assurance and capacity strengthening. In view of constraints within government, we recommend that a third party agency is engaged to ensure the quality of EAP implementation by providing technical support, field supervision, training and programme monitoring. This agency should be hired on multi-year contracts.

viii. Financing for an effective package of inputs — Over the past four years, the budget for EAP per district has decreased while the number of VDCs has increased. This has resulted in activities being scattered more thinly. The financial management discipline that multi-year contracting will bring will help guard against shrinking budgets being spread ever more thinly.

3. *NEXT STEPS*

It is recommended that PHCRD takes the lead implementing the following next steps:

i. The government health authorities to review the findings and recommendations of this strategic review and then agree with the major stakeholders on how to shape EAP for the future.
ii. Undertake the necessary administrative procedures for securing the multi-year contracting of NGOs to implement EAP from 2012/13.
iii. Undertake a comprehensive costing exercise and develop performance criteria for the multi-year contracting of implementing NGOs.
iv. Develop a work-plan for 2012/13 to undertake the reshaping of EAP in line with the recommendations of this review.
v. Develop a five year strategy for EAP implementation in consultation with other stakeholders in MoHP and MoFALD and among external development partners.
vi. Develop terms of reference for hiring a third party technical support-cum-programme monitoring agency.

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LIST OF ACRONYMS

ANC	antenatal care
ANM	auxiliary nurse midwife
AWPB	annual work plan and budget
CAC	community action centre
CBO	community based organisation
CMA	community medicine assistant
DACAW	Decentralized Action for Children and Women
DDC	district development committee
DFID	Department for International Development (UK Aid)
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
EAP	Equity and Access Programme
EoI	expression of interest
FCHV	female community health volunteer
FHD	Family Health Division
IEC/BCC	Information and Education Communications/Behaviour Change Communications
LDF	local development fund
LGCDP	Local Governance and Community Development Programme
MNH	maternal and new-born health
MoFALD	Ministry of Federal Affairs and Local Development
NHSSP	Nepal Health Sector Support Programme
PAF	Poverty Alleviation Fund
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
RHCC	Reproductive Health Coordination Committee
RHD	Regional Health Directorate
SHP	sub-health post
SSMP	Support to the Safe Motherhood Programme
VDC	village development committee
WCF	ward citizen forum

1. *BACKGROUND AND PURPOSE OF THE REVIEW*

The Equity and Access Programme (EAP) was launched in 2006 as a women's empowerment and rights-based community mobilisation programme for health. This programme evolved from the experiences of the Nepal Safe Motherhood Programme, which demonstrated the need for targeted community-based interventions to enable poor and excluded populations to overcome the social, cultural, financial and geographical barriers they faced to access maternal health services.

Between 2006 and 2009, EAP was funded by the Department for International Development (DFID) as part of the Support to Safe Motherhood Programme (SSMP). It was implemented by Action Aid Nepal (AAN) in a consortium with New Era in focal village development committees (VDCs) in eight districts. Action Aid Nepal managed the programme and provided overall planning, monitoring and technical support. The programme was implemented by district-level NGO partners in coordination with district health authorities (district health offices [DHOs] and district public health offices [DPHOs]) with the support of the Department of Health Services (DoHS). Based on the success of the programme, the DoHS decided to fund and roll out the equity and access model to two districts through the government's 2008/09 annual work plan and budget (AWPB). In 2009/10, as donor funding withdrew, DoHS extended its financial assistance to additional districts. Table 1 shows the pattern of EAP funding and management between 2005 and 2012. As of fiscal year 2011/12, EAP is in its fourth year of funding and management by DoHS and is operational in 21 districts.

Table 1: EAP funding and management from 2005 to 2012

EAP management	Fiscal year						
	2005/06	2006/07	2007/08	2008/09	2009/010	2010/011	2011/12
Managed by Action Aid Nepal	6 months design and 30 months implementation						
Shift from project to government management				Each year's implementation period varied from district to district with an average of 2–4 months implementation time			

Several implementation challenges have negatively affected the delivery and impact of the programme during this period. The capacity to manage the community-based programme at the national and district levels has arisen as an important issue. Given the persistent implementation and management constraints, the Primary Health Care Revitalisation Division (PHCRD) of the Department of Health Services decided to undertake a strategic review of the achievements and implementation challenges of EAP during the time it has been funded by DoHS.

This report presents the findings of the review and proposes a set of management and implementation recommendations to the government to enable EAP to achieve its expected objectives and potential impact.

2. *METHODOLOGY*

This strategic review was undertaken between June and August 2012 by a team of international and national consultants alongside staff of the PHCRD and advisers from the Nepal Health Sector Support Programme (NHSSP). The review was consultative and collected a wide range of stakeholder views on the progress and challenges of implementing EAP through AWPBs, and suggests possible remedies and future directions.

A sample of seven districts was purposively selected to include districts with varying lengths of involvement in EAP (Baitadi, Gorkha, Kanchanpur, Morang, Myagdi, Rukum and Parsa) so as to provide insights into the EAP experience. See Table 2 for the EAP-related characteristics of these districts and notes on the relative performance of each district.

In each of these districts, consultations were held with the district health team, members of the district development committee, implementing NGO partners (including their social mobilisers), local government health staff, and women's group and community members. At the national level, consultations were held within government and with external development partners (see list of all persons consulted at Annex 1). The breadth of the consultations allowed for the triangulation of data and brought out a range of perspectives and voices.

Quantitative outcome oriented data that could attribute change to EAP was not available for the period of the programme under review. However, to assist in positioning EAP, this review drew on the quantitative evidence of outcome improvements in EAP sites under the SSMP period (2005–2009). The bank of evidence and documentation that has been collected over the life of EAP since its initiation under SSMP was also used.

Table 2: Characteristics of focal districts for the review

	District	Description	EAP implementation period	Performance
1	Baitadi	Far-western region, hill district with terrain that provides access challenges	Completed 2 years of implementation under government AWPB	EAP started in 2010/2011, but due to limited follow-up the level of performance is not clear. In 2011/12, there was only limited monitoring by DHO/DPHO. NHSSP provided EAP orientation to implementing NGOs in 2010/11 and 2011/12.
2.	Gorkha	Western region with mix of midhills and mountains and more and less accessible areas	Completed 4 years of implementation under DoHS AWPB	EAP started in 2008/09. Performance has been relatively good. Slow increment in maternal health service use.
3.	Kanchanpur	Far-western region, Terai district with easy access	Completed 4 years of implementation under DoHS AWPB	EAP started in 2008/09. The programme has performed well and there has been increasing use of maternal health services with an increasing number of birthing centres. *(Table continued on next page)*

	District	Description	EAP implementation period	Performance
4.	Morang	Eastern region, Terai district with easy access	Implemented EAP under SSMP and 3 years under DoHS AWPB	An SSMP district from 2006–2009 and since then supported under DoHS AWPB. Performance has varied since shifting to AWPB support. In 2009/10 an active NGO was selected without any problems; but in 2010/11 six NGOs were selected, and in 2011/12 NGO selection was delegated to the centre due to local political pressure for NGO selection. Only conducted event-based activities in 2010/11. There has been a slow increment in maternal health service use.
5.	Myagdi	Western region, midhill district with comparatively easy access	Implemented EAP under SSMP and 3 years under DoHS AWPB	Good performance of EAP with an increasing number of birthing centres being established. But use of maternal health services has not improved in peripheral facilities.
6.	Parsa	Central region, Terai district with easy access	No implementation in 2010/11 and very limited implementation in 2011/12 under DoHS AWPB.	EAP budget allocated from 2010/11, but unable to implement. 2011/12 implementation period was very short.
7.	Rukum	Mid-western region, mountain district with terrain that provides access challenges	Completed 2 years of implementation under government AWPB	EAP started in 2010/11, but performance has been poor with a focus only on running events. Orientation was provided in Kathmandu to focal person in 2010/11, but he has since never asked for support from the centre.

3. *THE EQUITY AND ACCESS PROGRAMME UNPACKED*

3.1 EAP OBJECTIVES

EAP is a rights-based, social mobilisation programme that aims to empower women to realise their rights to health, and by so doing raise the demand for health services. EAP is founded on the rationale that for some communities, raising demand for health services and improving well-being requires a social mobilisation process that addresses the deep and underlying social determinants of health. EAP is therefore a targeted programme to reach the unreached, with the pursuit of equity and social inclusion as a central approach. The programme works for equity and social inclusion through:

- the geographical targeting of poor and socially excluded communities;
- social mapping to identify excluded families within focal areas;
- socially inclusive ways of working; and
- rights based advocacy.

The origin of EAP under SSMP has meant that the focus of the programme has mainly been on safe motherhood and new-born health. In the past year the focus has however broadened to cover reproductive and women's health.

3.2 THE EAP PACKAGE

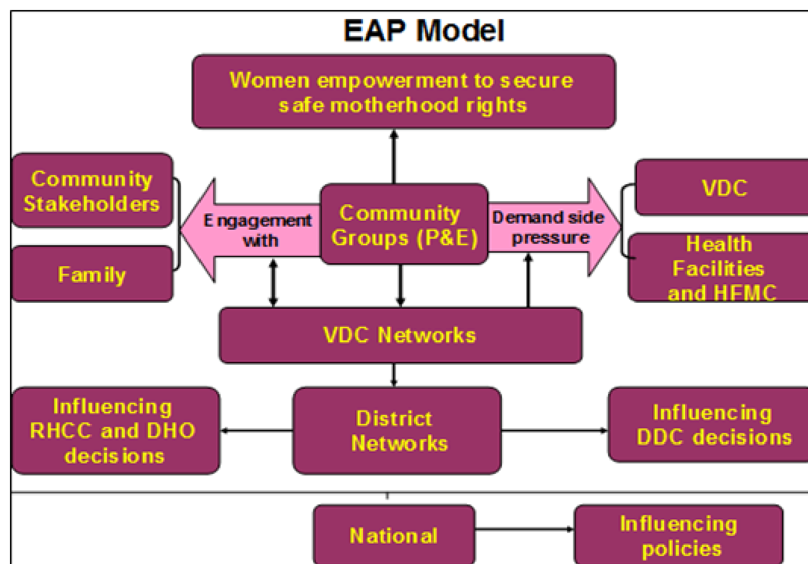
The EAP model is built on the following 'tried and tested' package of inputs, which work together to empower women and create an enabling environment for social change:

- Building women's organisational structures and capacity through the formation and strengthening of women's and mothers' groups and networks.
- Increasing women's and their family's knowledge and confidence to identify and take action against maternal and new-born health problems, and to facilitate their access to the services and associated incentives provided by the government.
- Developing localised behaviour change communications to help mobilise communities.
- Supporting women and communities to mobilise local resources to prepare for health emergencies (such as by establishing community emergency funds), and to establish community led transportation mechanisms for increasing access to health care.
- Orientating health service providers and managers on rights based development and strengthening their interpersonal communication skills to deliver non-discriminatory services and to respond to communities' health needs.
- Building the capacity of local organisations, including health facility management committees and NGO implementing partners, to enable and help sustain the programme and underlying social changes.
- Strengthening linkages between communities and their local health service providers, health facility management committees and local governments to place demands for health resources and to seek greater responsiveness.
- Fostering local change agents and forging coalitions for change at the district level and below, including in district development committees (DDC), reproductive health coordination committees (RHCC), village development committees (VDC), political parties, NGOs, community based organisations (CBO), and women's groups and among female community health volunteers (FCHV).

3.3 THE EAP MODEL

Women's groups and women's empowerment are at the core of the EAP model. Through membership of women's groups and their participation in reflective and action-oriented discussions, women gain access to health information in a supportive environment. They reflect on the challenges they face in accessing care, the underlying social determinants and social norms that undermine their own and their families' health and well-being, and make plans to improve their situation. Through this participatory process, which is facilitated by trained local women, the confidence and capacity of women's group members is built to identify their health problems, share information among family and peers, develop local solutions, and support one other in overcoming barriers to care. The way the model should work is shown in Figure 1.

Figure 1: The EAP model with its goal and linkages



The strength of the model is the multiple layers of the social mobilisation and empowerment process. Women's empowerment is complemented by the mobilisation of men, older women and social leaders, and by establishing community mechanisms such as transport solutions to respond to health emergencies, and the sharing of responsibilities in communities that this entails. This sense of community purpose and solidarity is then linked to institutional structures to leverage local resources. The provision of resources to the women's initiatives, such as VDC contributions to emergency funds, and the collection of information on maternal and new-born health by local leaders, in turn reinforces women's empowerment as women and men see the effectiveness of women's voice and demands.

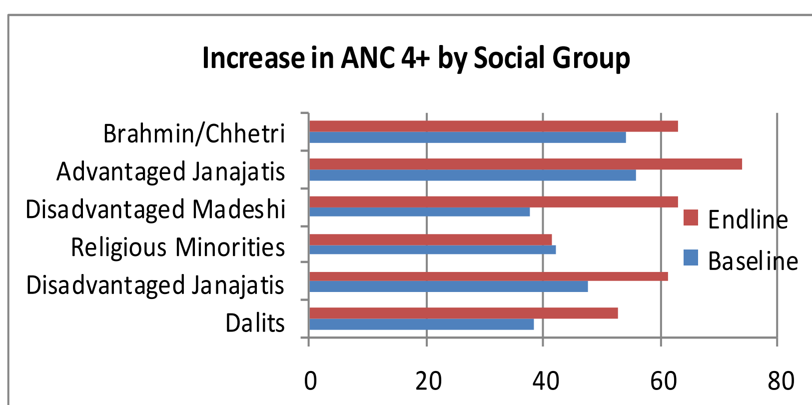
3.4 EVIDENCE OF EAP ACHIEVEMENTS: FINDINGS AND LESSONS UNDER SSMP

Implementation bottlenecks and a paucity of data mean that it is not possible to measure the outcomes from EAP in the 21 districts where DoHS has provided funding. However, drawing from the evidence base collected during the period when EAP was funded by SSMP, including from baseline (2006) and endline (2009) household surveys, service records, and qualitative research, this review found strong evidence that EAP has delivered results when implemented well. Dramatic increases were achieved in maternal and new-born health (MNH) knowledge, attitudes and practices in the EAP programme areas under SSMP. Moreover, while all social groups benefitted from improved maternal and new-born health indicators, social groups that have lagged behind national level health improvements (Dalits and

Disadvantaged Janajatis [disadvantaged ethnic groups], and Disadvantaged Madhesis) benefitted particularly well. Some of the key findings on EAP's achievements are presented below.

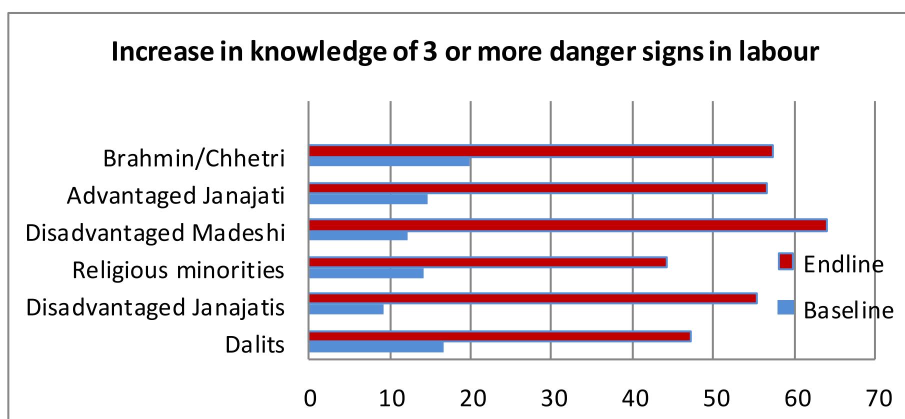
Antenatal care: According to the baseline and endline surveys, the take-up of four or more antenatal care visits increased in EAP areas from 45% in 2006 to 60% in 2009. In this period the equity gap on the use of antenatal care decreased between the generally better-off Brahmin/Chhetri social group and the generally disadvantaged Dalits, Disadvantaged Janajatis and Disadvantaged Madhesi groups (see Figure 2). Notably women exposed to EAP had a significantly higher antenatal care use rate than women who had not been exposed to EAP.

Figure 2: Increase in antenatal care 4+ by social group (%)



Knowledge of dangers: Knowledge of the danger signs in pregnancy, labour and the post-partum period among recently delivered women, their husbands and mothers-in-law more than doubled over the EAP period, with the largest knowledge gain being among Disadvantaged Janajatis and Disadvantaged Madhesis (see Figure 3). Women who had been exposed to EAP had significantly better knowledge than other women.

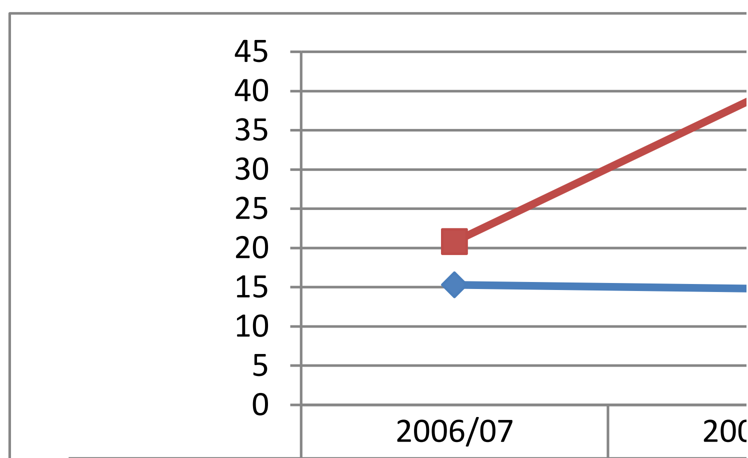
Figure 3: Increase in knowledge of 3 or more danger signs in labour (%)



Facility-based births: The programme mobilised women, their families and communities to reflect and act upon the social norms, traditional practices and cultural beliefs that work against safe motherhood, while policy and service-level improvements synergistically increased access to services. By 2009, an impressive 85% of respondents reported that women should deliver in a facility, including 80% of mothers-in-law. The latter are one of the target groups of EAP and are a key stakeholder group for changing birthing practices.

The endline household survey (2009) found that 40% of recently delivered women had given birth in a health facility, up from 21% at the time of the Baseline survey (2006) and over double the national rate of 15% in 2008/09 (Figure 4). Service records from the programme areas charted the same upward trend in institutional deliveries, with an average increase of 29% during the first two years of EAP.

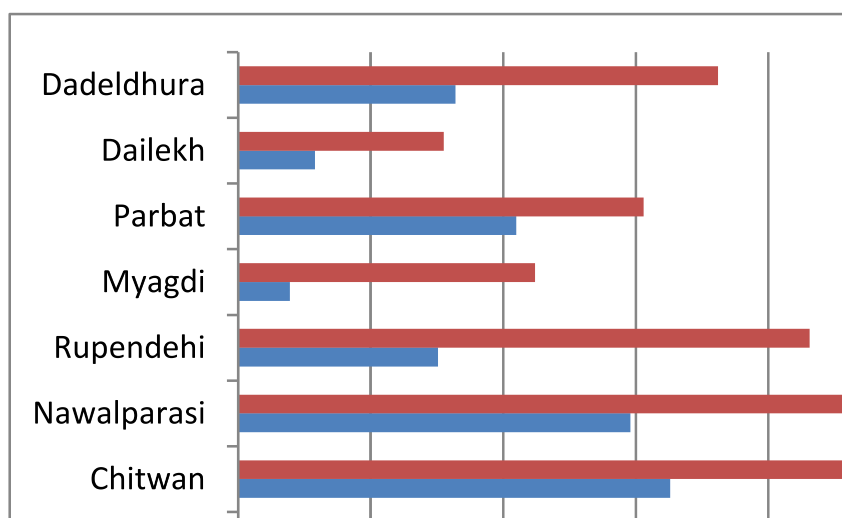
Figure 4: Institutional delivery rate for EAP areas and nationally (%)



Note: HMIS stands for the national Health Management Information System and reflects the national figures

The proportion of deliveries occurring in health facilities increased over the course of the programme across all EAP districts — and all EAP districts had higher rates than the national average of 14.8% for 2008/09. Within this trend there were much higher rates of institutional deliveries in the Terai districts than in hill districts — for example see Figure 5 where Rupandehi, Nawalparasi, Chitwan and Morang are Terai districts and Baitadi, Dailekh, Parbat, and Rukum are hill districts. Various factors appear to have contributed to this situation including the better availability and physical accessibility of obstetric services in the Terai. Another trend was the lower levels of institutional deliveries in the Far Western and Mid-Western regions (e.g. Dadeldhura and Dailekh districts respectively in Figure 5) with this probably related to the lower levels of human development in these regions and the stronger traditional and religious beliefs and practices surrounding pregnancy and birthing.

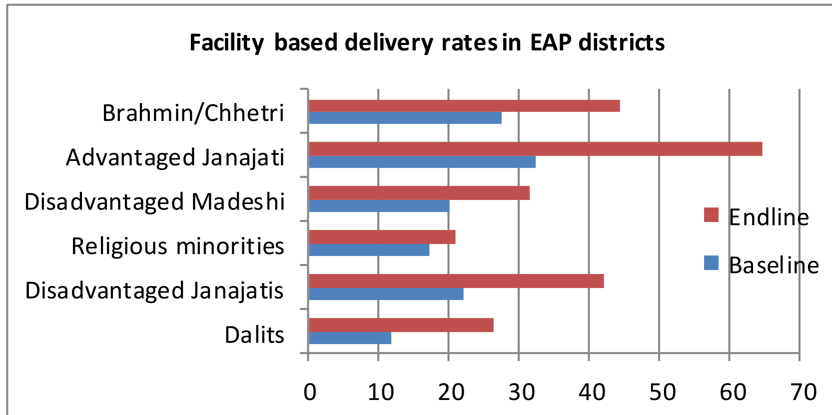
Figure 5: Facility-based delivery rates in eight EAP districts (%)



Broken down by social group, the rise in facility-based deliveries was greatest among Dalits (with a 123% increase) (see Figure 6). Rapid gains were also made by Advantaged Janajatis (99%) and

Disadvantaged Janajatis (91%), with lesser improvements among Brahmin/Chhetris (62%), and Disadvantaged Madhesis (57%), with the lowest gains among Muslims and other religious minorities (only 21%).

Figure 6: Facility-based delivery rates in EAP areas (%)



During the 2006–2009 period, EAP, as implemented by Action Aid Nepal under SSMP contributed to significant health gains in its programme areas. EAP showed how disadvantaged groups could be empowered to access health services. It was particularly successful in increasing the access to health of Dalits and Disadvantaged Janajatis, but less so for Disadvantaged Madhesis and Muslims. One of the lessons from this period is that communication and mobilisation approaches need to be better tailored to the cultural and social norms of Disadvantaged Madhesis and Muslims if their health behaviours and use of services is to catch up.

4. *EAP MOVES INTO GOVERNMENT*

4.1 TIMELINE AND COVERAGE

Based on the promising results achieved by EAP under SSMP, the Family Health Division (FHD) of DoHS included the roll-out of EAP to VDCs in Gorkha and Kanchanpur districts in its annual work plan and budgets (AWPB) for 2008/09. This initiated the absorption of EAP into the regular programme and budget of DoHS. The following year, 2009/10, when donor funding for EAP ended, FHD added support to focal VDCs in an additional seven districts in its AWPB, in effect absorbing seven out of the original eight EAP districts plus the two new districts of Gorkha and Kanchanpur. In 2010/11, FHD extended EAP to another seven new districts and continued activities in the existing nine districts, bringing the total number of EAP districts to 16. Focal VDCs were selected in all districts. In 2011/12, EAP moved across to Primary Health Care Revitalisation Division (PHCRD) stewardship and four new districts were added, bringing the total to 21 EAP districts. Table 3 details the scaling-up of EAP since 2008/09.

Table 3: District and VDC coverage of EAP (2008/09 to 2011/12)

	2008/09 District and no. EAP VDCs in last year of Action Aid Nepal implementation	**2009/10 District and number of VDCs (old + new)**	**2010/11 District and number of VDCs (old + new)**	**2011/12 District and number of VDCs (old + new)**
Districts during implementation by Action Aid Nepal	Baglung (only mass communication activities) Chitwan (24 VDCs) Dadeldhura (14) Dailekh (21) Morang (21) Myagdi (29) Nawalparasi (20) Parbat (26) Rupandehi (22) Surkhet (only mass communication activities)			
Districts under DoHS stewardship (old + new)	Gorkha (8) Kanchanpur (8)	Chitwan (whole district) Dailekh (3+7) Gorkha (8+8) Kanchanpur (8+5) Morang (2+6) Myagdi (9) Nawalparasi (3+6) Parbat (4+4) Rupandehi (11)	Baitadi (8) Chitwan (advocacy in whole district; range of activities in 10 VDCs) Dailekh (did not implement) Doti (whole district) Gorkha (8+5) Gulmi (10) Jajarkot (9) Kanchanpur (13+6) Morang, (8+8) Myagdi (9+0) Nawalparasi (1+5) Parbat (8+4) Parsa (but did not implement) Rukum (10) Rupandehi (9+5) Taplejung (10)	Baitadi (8 old, 2 new) Chitwan (10 old) Dailekh (10 old, 10 new) Darchula (8 new) Doti (10 new) Gorkha (5 old, 3 new) Gulmi (10 old, 4 new) Jajarkot (2 old, 6 new) Kanchanpur (whole district) Khotang (4 old, 4 new) Morang, (16 old, 6 new) Myagdi (9 old, 5 new) Nawalparasi (31 old, 1 new) Palpa (8 new) Parbat (4 new) Parsa (10 new) Rasuwa (9 new) Rukum (10 old) Rupandehi (6 old, 6 new) Salyan (10 new) Taplejung (3 old, 7 new)

4.2 FHD TO PHCRD

The government decided to move EAP to the Primary Health Care Revitalisation Division (PHCRD) in 2011 given PHCRD's management of social protection programmes and its focus on reaching unreached populations. As a social mobilisation programme, the potential for EAP to generate demand for a full range of essential health services and move beyond the original maternal and new-born health focus also aligned with PHCRD's mandate. In 2011/12, the focus of EAP was broadened to include the promotion of free care and advocacy against gender-based violence. Further expansion was not attempted due to the implementation constraints being experienced (see section 5 of this report).

4.3 DISTRICT LEVEL MANAGEMENT

The transfer of EAP into the regular government programme saw the management and technical role of Action Aid Nepal removed at central and district level. This led to a considerable increase in the management load on government officers at central and district levels, which was exacerbated by the practice of the annual procurement of the district implementing NGOs. Only a minimal amount of strengthening has taken place at central and district levels of the government's capacity to manage EAP. Under the stewardship of both FHD and PHCRD, no full-time, dedicated central level focal person has been assigned to manage EAP, and both divisions have heavily relied on technical assistance from NHSSP to provide technical and management support to the programme.

At the district level, the responsibilities for programme and financial management, the selection of NGO partners, and technical support shifted from full-time EAP district coordinators hired by Action Aid Nepal to the district health offices and district public health offices (DHOs/DPHOs).[1] In each district an EAP focal person was assigned from the district health team to support programme rollout. Initially this was the public health nurse or family planning supervisor, and then the PHCRD focal point when EAP moved to PHCRD. This transfer of responsibility among district officers reportedly set back the district management of the programme and caused administrative tensions in some districts. The lack of capacity of district health teams to manage EAP and partnerships with district implementing NGOs has been a key constraint to the implementation of the programme.

NGO internal management has tended to follow the same pattern of each implementing NGO employing a designated EAP coordinator and accountant.

4.4 CAPACITY BUILDING AND TECHNICAL SUPPORT

The shift of EAP into government has been accompanied by a considerable reduction in the level of capacity building and technical support provided to the district NGO implementing agencies of EAP. Under Action Aid Nepal's management, on-going training was provided across a spectrum of thematic areas to NGO partners and staff. This included training on rights based approaches, gender, social inclusion, social mobilisation, maternal and new-born health, behaviour change communication, facilitation skills and planning, budgeting and monitoring. In addition to training, Action Aid Nepal's EAP district coordinators and centrally-based technical staff provided regular on-site coaching and follow-up in the field.

Since EAP moved into government, and NGOs have been selected annually, there has been an increased need for orientation and capacity building training to prepare new NGO partners. However, the amount of training has reduced. In 2008/09 and 2009/10, five days initial training was provided to NGO

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[1] Note that a district has either a DHO or a DPHO as the district health line agency.

partners, which was reduced to only three days orientation training in 2010/11 and 2011/12. In the past two years, with only three days for orientation, there has been only limited training of the NGOs on rights-based approaches, behaviour change communication and facilitation skills.

4.5 CHANGING BUDGETARY SUPPORT TO EAP

Since EAP moved into government in 2008/09 the AWPB allocation for EAP activities per district has almost halved declining declined from an average of NPR 2 million in 2008/9 and 2009/10 (£15,385 at £1:NPR 130) to an average of NPR 1.1 million in 2011/12 (£8,231), (see Annex 3). At the same time some districts increased the number of VDCs covered. This seems to have been in part a pragmatic response to the short implementation period per year, and more broadly, a possible reflection of the Ministry of Finance's reluctance to invest in social mobilisation. The implications of the reducing budget for EAP are discussed later in this report.

5. *KEY FINDINGS OF THE REVIEW*

Note that a brief account of the performance by each of the seven sample districts is given in Table 2 in section 2 of this report.

5.1 PROGRAMME MANAGEMENT

The biggest constraint faced by EAP since it has been funded through the DoHS/PHCRD's AWPB is the reduction of the implementation period to only two to four months per year. Such a short implementation period jeopardises the empowerment process that lies at the heart of the programme, affects the credibility and influence of local NGO partners among the communities they serve, and undermines the programme's health impacts. National, district and local level stakeholders agree that effective empowerment and social mobilisation cannot be squeezed into a two to four month window.

Feedback from a range of stakeholders revealed that the short implementation period is a result of:

- the practice of the annual contracting of NGOs;
- the slow selection process, taking on average 3–4 months;
- delays in budget approval and the issuing of authority letters from the centre; and
- the inclusion of EAP in the AWPB budget only from the second four-month-period of the fiscal year.

Annual contracting: The current practice of contracting district NGOs for only a year at a time has reduced the implementation period and added a considerable administrative burden and political pressures to the busy DHOs and DPHOs. The process is often futile given that in many areas the same NGO partners are selected year after year. The annual contracting process has led to NGOs losing capacitated staff at the end of their EAP contracts and then having to use vital resources to build the capacity of new staff.

The overwhelming view of all stakeholders was that EAP needs to move to multi-year contracting on efficiency and effectiveness grounds. Multi-year contracting, as implemented by the Ministry of Federal Affairs and Local Development (MoFALD)[2] for its Local Governance and Community Development Programme (LGCDP), would reduce the administrative burden on DHOs/DPHOs, better sustain the capacities built in local partners, and enable the programme to return to its empowerment and social mobilisation approach, which is critical to addressing the social determinants of health.

NGO selection process: The DHOs/DPHOs and NGO partners reported that the NGO selection process is slow — usually taking three to four months to complete from the time the DHO/DPHO receives the authorisation letter (see Annex 2 for the times taken in the different districts). In an environment of scarce resources and increasing politicisation, with many NGOs aligned to political parties, it is inevitable that the NGO selection process is open to political influence. How political pressure manifested itself in each district, and was managed, was found to vary by district and by year. The partner selection guidelines introduced for fiscal year 2068/69 (2011/12) by PHCRD were perceived to be useful in helping manage political influence, although they were viewed as alone being inadequate to avoid political pressure for selecting certain NGOs.

Kanchanpur, Gorkha and Baitadi DHOs/DPHOs reported stronger confidence in managing political influence at the local level. In Kanchanpur and Gorkha the DHO/DPHO teams reported that the

[2] Previously the Ministry of Local Development (MoLD)

involvement of the chief district officer (CDO) and treasury office in the NGO selection process had been sufficient to offset local influence in 2011/12. In previous years this was said to have not always been the case. In 2010/11, political interference in Gorkha district was reported to have led to the selection of an NGO from outside the district[3], which subsequently didn't perform, and was dropped. In Baitadi district, the DPHO staff reported that the involvement of the regional health directorate and civil society organisations such as the journalists' federation had increased the transparency of the process and its manageability.

In contrast, in Morang district, the close working relationship between the district public health office and local NGOs and severe political pressure in 2011/12 led to the district public health officer delegating NGO selection to the centre. In previous years (2008/09 to 2010/11), selection had been possible at the district level. The district public health officer reported that participation by the regional health directorate had been insufficient to manage the political pressure; and the participation of central level representatives was needed to counter this kind of pressure.

It was reported in Myagdi and Kanchanpur districts that the DDC's involvement in selection had been primarily to formalise the process and that selection was ultimately the choice of the district public health officer, although it was said that it would have been better to have had an external body undertake selection. In Rukum, the pressure and influence was reportedly from among the DPHO staff, and in the past year selection was stalled so long that by the time NGOs were contracted only 1.5 months of implementation time remained.

In the current governance environment, political pressure comes from multiple directions, principally from political parties at central and local levels, trade unions and associations, and from central and local level administration. This pressure was said to be increasing. In such an environment, as seen from the seven district case studies, it is not always feasible for the selection of NGOs to happen at the district level, as much depends on the personal and political standing of the officer-in-charge and the district team as to how well and fairly they are able to manage the selection process.

Budget approval and issuing of letter of authority: Delays in approving the budget and issuing the authority letter frequently delays NGO selection. DHO/DPHO staff reported that preparatory work, such as advertising expressions of interest, could not proceed as this incurred costs, and it was generally felt that the legal and financial risks were too high to spend money on this sort of thing without a letter authorising expenditure.

Implementation only from second four-month-period: The implementation of EAP tends to be only scheduled in AWPBs from the second four-month-period[4] of the fiscal year onwards. This in effect only leaves the final four-month-period for implementation, as the second four-month-period is usually taken up with selecting and contracting NGO partners. The result is that in the third four-month-period once NGOs have been selected, activity plans are typically re-designed to soak up the full budget by the end of the fiscal year with quality and impact compromised.

The executive director of a NGO pointed out the drawback of the short period of engagement of EAP NGOs thus:

> *Some communities perceive that the EAP implementing NGOs are only present because of the money. Without longer and deeper relationships their influence is limited and*

[3] Although this contravened the criteria set out in the selection guidelines.

[4] Note that these periods are also commonly referred to as 'quarters' or 'trimesters'

empowerment is not possible. NGOs lose credibility in communities if they are only present for 3 months.

5.2 EAP IMPLEMENTATION

The approach: The short implementation period within each of the past four years has affected programme coverage within each district, choices over which populations to target, and the effectiveness of activities undertaken. Faced with only 2–4 months of implementation time, NGO partners have pragmatically focused their efforts on events that could be implemented quickly, often by building on existing community groups and networks. The timing of when EAP funds have been mostly available (April to June) has further hampered activities as this is the time when many rural people are busy in the fields. This is also the end of the fiscal year with the pressure to spend budgets often in ways that result in the rushed and lower quality implementation of activities.

A representative of an EAP implementing NGO pointed out how the delays meant that the planned five months of activities were hurriedly implemented in two months resulting in less of an impact:

> *In Morang in 2011/12, each NGO developed a 5 month plan initially with 1 social mobiliser covering 2 VDCs. Due to delayed decision-making, the budgets were revised during training to allow for only 1 mobiliser per VDC. In addition, a programme coordinator post was added and the NGOs used extra staff to implement activities. This way, the full list of activities was implemented as per the 5 month budget in 2 months, but the result was much less.*

The programming responses varied by district. In Rukum, the NGOs focused on delivering event-based orientations, such as street dramas and community gatherings, and not on group mobilisation. In other districts, such as Myagdi and Gorkha, the NGOs have worked with existing women's groups to deliver information, establish emergency funds, and provide stretchers and torches. Mother's groups were particularly targeted in some districts as they were established, on-going, and anchored via the FCHVs to the DoHS.

In the best case, NGOs mobilised through groups they had previously worked with; but in all districts where NGOs pursued group mobilisation, the quality of interaction was marred by the short timeframe they had to build and sustain credibility and trust.

Several NGOs reported how communities questioned their integrity given their transient presence and community people reportedly often asked for money to attend meetings. Lacking human resources and funds to continue activities once EAP funds expire, NGOs reported that they generally had to exit the community at the end of the financial year, often after only a short spell of interaction. As expected, the sustainability of the women's groups varied by a range of local factors including the strength of leadership of the group, the maturity of the group itself, and linkages with other programmes. In this context, mobilising women through mother's groups makes sense in areas where FHCVs are active.

Coverage and reach: The VDC coverage of EAP has generally been decided year-by-year, and has been open to political influence. The absence of long-term district EAP plans has hindered the programme's effectiveness to reach the unreached, and improve health. In some cases, due to political and other factors, there has been a less than optimal selection of VDCs, with VDCs with less access to and use of health services not being chosen. This appears to have been in part due to a lack of appreciation by district stakeholders of the theory of change underpinning EAP and the political realities of local level decision-making. In most districts, officials tended to target EAP to the VDCs where UNICEF's

Decentralized Action for Children and Women programme (DACAW) was being implemented, and specifically to Dalit and Janajati groups. But the rationale for selecting DACAW VDCs was at times unclear. The need to retain a balanced presence in each of the electoral areas within a district was reported in Gorkha and Rukum districts. Other strategies were to shift EAP VDCs each year, and sometimes to switch the district NGO covering specific VDCs. The resulting thin spread of limited inputs, and disrupted relationships between NGOs and target communities, has undermined impact.

Most implementing NGOs felt that EAP needed to be operational for a minimum of 2–3 years in a VDC in order to achieve a significant impact on health utilisation and to mobilise communities sufficiently to allow resources to be shifted on to other underserved areas. The international literature endorses this benchmark, with 2–3 years generally seen as a reasonable timeframe to achieve outcomes from community mobilisation (Howard-Grabman 2007).

Within a VDC, the EAP resources are generally insufficient to achieve full coverage of the nine wards, especially as many NGOs operate on the basis of one social mobiliser per two VDCs, thus requiring the targeting of resources. However, the reluctance of many VDC secretaries to target resources has meant that NGOs have often been under pressure to cover all wards. This has served to further dilute the efforts of the NGOs (see example in Box 1).

Box 1: The drawbacks of covering all wards with EAP's limited resources

In Gorkha, EAP resources were budgeted for one group per ward, including one torch and stretcher per group. One mobilised group had more than 70 members and so it was difficult to manage because of its size and geographical spread; but with only one torch and stretcher available it was difficult to split the group. Such arrangements not only affect the quality of mobilisation activities but act against the inclusion of Dalits, which may need a Dalit specific group to encourage their participation.

Reaching the most poor and excluded: Hurried implementation to utilise budget allocations by the end of the fiscal year acts against reaching the most difficult to reach populations. Although all districts reported that EAP was directed to underserved geographical VDCs, within those areas time and resources were too scarce to allow for context-specific strategies to be used to reach the most excluded. In Baitaidi, Kanchanpur, Morang and Rukum districts, more home visits were said to have been needed to adequately reach excluded groups, including Muslim women in the Terai.

During the SSMP period, EAP struggled to reach the ultra-poor in its focal VDCs, and within the current operating environment this challenge continues. Several stakeholders felt that reaching the most excluded needed a broader bottom-up, multisectoral approach that came under VDC planning processes. Now that community action centres, ward citizen forums, and poverty alleviation funds are functional in many VDCs, these serve as more appropriate vehicles to empower the most excluded for health.

Reaching remote areas: It remains a large challenge to attract and retain health personnel in remote areas resulting in health services often remaining very limited in these areas. Discussions on how to improve access to health in northern Gorkha found that government health personnel were reluctant to work in such areas, even with remote area allowances, because of the high cost of living, difficult living conditions, and lack of opportunities for professional advancement. In such places, a more comprehensive demand-supply side model is needed to fill the basic gaps in community health services

possibly on an intermittent basis alongside community mobilisation to improve health awareness and empowerment. There is a need to develop and test such an EAP+ model that builds on the lessons of EAP and of NGOs providing services in remote regions, and by forging partnerships between NGOs, private providers and the government.

District ownership of EAP: One of the strengths of shifting EAP into government has been the increased ownership of the programme by DHOs/DPHOs, and strengthened links between social mobilisers and district health staff. For example, in Bakrang VDC, Gorkha district, a sub-health post in-charge reported that he had asked the social mobiliser to monitor the outreach clinics and through her had heard of a shortage of drugs. Locating EAP around birthing centres has been a standard practice to increase utilisation and supplement government services. In Kanchanpur it was felt that EAP's provision of a baby wrapper to new-borns at birthing centres had encouraged institutional deliveries and helped prevent new-born deaths. The involvement of health workers in EAP orientation sessions was felt to be valuable in forging closer working between government and NGOs, and the practice of social mobilisers working alongside and supporting FCHVs was endorsed.

In most of the seven study districts government staff appeared to respect and value the contribution of the implementing NGOs, and recognised that they were filling a role that government service providers were poorly equipped for. In only one district was the view presented that NGOs were redundant and that the district office could implement EAP directly. In Morang, DPHO staff said that too many NGO implementing partners had reduced the quality and functioning of the programme. The difficult political situation in Morang had resulted in six NGO partners being selected in 2010/11.

Achieving the balance of government ownership and NGO independence is an on-going tension. One complaint by several NGOs was the pressure placed on them by the DHO/DPHO to hire health-trained persons as social mobilisers. Health officers tended to be of the opinion that auxiliary nurse-midwives (ANMs) and community medicine assistant (CMAs) were better placed to carry out the work than non-technical social mobilisers. The NGOs held the reverse view. This difference of opinion reflects the somewhat different expectations government health staff and NGO partners have of the function of social mobilisers specifically, and of the EAP process more broadly.

5.3 TECHNICAL SUPERVISION AND MONITORING

District government and NGO stakeholders reported that the technical supervision and monitoring of EAP activities was insufficient and needed strengthening. For example, an NGO representative in Morang said: "No-one monitors from the district and no-one from the district asks the in-charge what EAP is doing." With the transfer of EAP to government, third party technical and monitoring was lost, and neither the centre nor regional health offices had, nor have, the capacity and resources to take this on. The EAP NGOs in most districts reported that monitoring was left to the local facility in-charges with few if any field visits by district health office staff. Only limited funds are assigned for monitoring and are included in the NGO budget, while the district and regional offices have no dedicated budgets for monitoring EAP.

Furthermore:

- reporting was not felt to be systematic, and primarily consisted of monthly review meetings and final reporting;
- district officers tended not to discuss EAP at quarterly or annual review meetings when this would have been a good opportunity to share learning and challenges;

- district health officers were not bringing NGOs, VDCs and facility in-charges together to discuss how to develop the programme, with the lack of a forum to discuss EAP progress and challenges at the district level being raised as an issue by implementing agencies and being part of the broader lack of coordination among social mobilisation programmes in districts; and
- the short implementation periods undermining the scope for monitoring findings to be fed back into programme implementation, thus weakening efforts to promote quality.

5.4 Capacity of EAP NGOS

The relatively fast expansion of EAP from 2 to 21 districts under the government in four years without a dedicated source of technical support for capacity building has resulted in insufficient support for NGO and district level capacity building. NHSSP has provided essential orientation training to new NGOs, which has been highly appreciated. But this support has been hampered by delays in contracting and the window to provide this training has often been very short.

The commonplace absence of any request or the late request from DHOs/DPHOs for orientation training for selected NGOs has also been an issue. Also, the annual contracting of NGOs has undermined capacity building efforts, as trained NGO staff have often left to take on other more secure jobs, while capacity building resources have mostly had to be directed at orientating new partners rather than building up the capacities of on-going NGO partners.

As expected, NGO partners have varied widely in their abilities and preparedness to implement EAP. The emphasis on selecting local district NGOs has also meant that in districts where NGO capacity is weak, partners have needed substantial support to enable them to deliver the programme. Unfortunately the capacity building support necessary to make such a trade-off worthwhile has not been available. In several districts, NGOs have received only three days' orientation.

Some NGOs expressed the need for training on rights, social mobilisation, gender and social inclusion, and group facilitation — topics at the heart of EAP. Management training was also desired. The depth of capacity building required is linked to both the availability and selection of NGO partners with the requisite skills and experience, and accepted standards of quality for EAP implementation. A politically acceptable balance of capacity building for quality outcomes has yet to be achieved.

5.5 FINANCIAL ISSUES

The inclusion of EAP in only the second and third four-month-periods of AWPBs as a major bottleneck to programme implementation has already been discussed. In addition, DHOs/DPHOs have varied in their willingness to provide advance funding to NGOs. In Kanchanpur, Gorkha and Morang the current practice is that DHOs/DPHOs require a bank guarantee from the selected NGOs before they can release advance funds. Thus, many NGOs have had to fund activities upfront themselves, although in previous years advance funding was provided in Gorkha district. Also, there has been confusion as to whether DHOs/DPHOs have the authority to offer advance funding. Official clarification is needed on whether advance funding can be provided to NGOs without a bank guarantee. Without upfront funding, many NGOs struggle to cover the cost of inputs, again negatively affecting quality. NGOs in Kanchanpur suggested that budget releases from the centre directly to NGOs would unblock delays and reduce the influence of local politics in transferring funds to NGOs.

Another important factor is that EAP activity allowances have remained the same over the past four years and are felt by many to be inadequate. The low budget allocations for social mobilisers are a case in point and impact the quality of staff attracted to the programme. The reduction in EAP budgets per

district (see Annex 3), has encouraged a move from group mobilisation to one-off events that tend to have less impact. The move to one social mobiliser per two VDCs has been particularly regressive and reduced the scope for household visits, which are crucial for reaching the most excluded. There is a need to realign EAP allowances to reflect current prices and to build in flexibility to allow NGO partners to adapt activities to the local context and target the most underserved.

5.6 DISTRICT COORDINATION OF SOCIAL MOBILISATION PROGRAMMES

EAP is one of several social mobilisation programmes operational in Nepal. MoFALD's Local Governance and Community Development Programme (LGCDP) is the country's flagship local governance programme. It is implemented by DDCs in partnership with implementing NGOs hired on multi-year contracts. The LGCDP model is particularly interesting both as a possible contracting model and as a potential future host for EAP.

Interviews with DDC staff involved in managing LGCDP and with staff of its Programme Coordination Unit at MoFALD suggest that LGCDP has made good progress over the past four years in establishing ward level vehicles for inclusive social mobilisation — community action centres (CAC) at the VDC level and ward citizen forums (WCF) at the ward level. Ward citizen forums are planning and advocacy forums, with community action centres bringing together 20–25 people in a ward from poor and excluded backgrounds to work through a reflective cycle of empowerment. (Note that community action centres are located in one of the most disadvantaged wards of each VDC). The penetration of ward citizen forums into communities is mixed, and during our field visits several of the women's groups consulted were not aware of their local ward citizen forums or community action centres. LGCDP staff also reported the challenge of moving beyond ward citizen forums to mobilising and informing wider communities about governance issues.

Also, the functioning of local government structures remains relatively weak. Lack of skills and human resources to undertake monitoring and coordination, particularly in remote VDCs was raised as an issue by some DDC staff. In Rukum it was reported that the use of VDC funds allocated to health was not being monitored.

NGOs from across the districts reported that, despite the existence of district social mobilisation committees under LGCDP, there was effectively no functional coordination between social mobilisation programmes. DHOs/DPHOs are not involved in LGCDP planning and monitoring. There are typically several social mobilisers present in a VDC — with one each from LGCDP, DACAW, the Poverty Alleviation Fund (PAF), the women's development office (WDO), EAP, and other civil society programmes; but there is typically very little if any coordination between them or any mechanism for joint working. VDCs usually lack the initiative and/or influence to forge this kind of coordination themselves.

Ward citizen forums and community action centres have the potential to advocate on and include health agendas. More needs to be done to support these centres and forums to promote health issues by forming linkages with EAP social mobilisers, and through district level influencing by NGOs and DHOs/DPHOs. The nature and purpose of ward citizen forums and community action centres does not however counter the need for the sort of group based community processes that EAP incorporates and, in its current form, LGCDP does not provide a natural home for EAP.

LGCDP's model of the multi-year contracting of NGOs to run the centres and forums does however provide a template that can be adapted for EAP. Central to this is the development of clear and measurable indicators of what NGOs need to deliver, and a strong monitoring framework and the

capacity for government to monitor their performance and determine whether to continue funding into the next fiscal year. Multi-year contracting would bring with it a higher level of accountability of NGOs than currently achieved through annual contracting.

5.7 MOST SIGNIFICANT CHANGES

A considerable part of the review focused on the constraints and challenges of implementing EAP through the DoHS/PHCRD AWPBs. Despite this, national, district, government and NGO stakeholders were all of the view that EAP has value and could be effective if adequate the space for implementation was made available. Several participants reflected on how group mobilisation and household visits had changed the attitudes and confidence of women to seek services. The power of mobilised communities to leverage VDC resources was also high on the list of achievements. Table 4 gives examples of what respondents felt had been the most significant changes resulting from EAP.

Table 4: Examples of reported most significant changes

	Changes	District(s)
1	In more than 5 VDCs, women's groups have leveraged VDC funds for building a birthing centre.	Gorkha
2	The locating of green flags on houses where pregnant woman live is widely recognised and appreciated. This system facilitates more respect and care for pregnant women.	Gorkha
3	Muslim women were previously very shy but many are now coming for antenatal check-ups at health facilities and have started using family planning.	Gorkha, Morang
4	Primary health care outreach clinics have been added in remote wards.	Myagdi, Baitadi
5	The DDC allocated NPR 500,000 for building a birthing centre.	Morang
6	Emergency funds have been established and provide a feeling of security and strength. In contrast to FCHV funds, these funds are owned by local women and their use is flexible.	Gorkha, Morang
7	FCHVs have been made more accountable and communicative and are working more closely with NGOs.	Morang
8	Jhurkia Primary Health Care Centre was on the verge of closure due to low utilisation; but utilisation has increased since EAP has been active in the surrounding VDCs. Through EAP, local stakeholders have been empowered and have become more active by, for example, being more ready to complain to the DPHO when services or supplies have been insufficient.	Morang

6. *HOW TO REIGNITE THE IMPACT OF EAP?*

6.1 FIRST: THREE STRATEGIC QUESTIONS TO ADDRESS

Evidence from the achievements of EAP under SSMP, and the international literature on the impact of community mobilisation through women's groups in Nepal (see Manandhar et al. 2004 and Morrison et al 2010) endorses the validity of EAP's design and its potential to raise access to health services and the well-being of targeted communities. However, this review has found that the current implementation bottlenecks of EAP are strangling its effectiveness, incurring the inefficient use of resources and undermining its reach to the poor and excluded. The findings of this review raise serious questions as to the value of continuing the programme.

To support the government in deciding how to move forward from this point, this report first poses and answers the following three strategic questions:

i. *Does EAP fit in the current policy environment?* — The Interim Constitution (2007), the Second Long Term Health Plan (1997–2017), and the second Nepal Health Sector Programme (2010-2015) set strong policy directives for the pursuit of gender equality and social inclusion in health care access and provision. Various programmes such as the free essential health care programme (up to district hospital level) and the provision of free delivery care respond to the country's commitment to health as a fundamental right. In this policy context, a rights-based social mobilisation programme, such as EAP, which aims to increase access to health services of the poor and excluded, has strong currency. EAP offers a platform for empowering women, reaching the unreached and achieving greater health equity.

ii. *Is there still a need for a targeted health social mobilisation programme?* — Continuing inequalities in health awareness and the use of services by caste, ethnicity, topography and region reflect the fact that some populations have significantly poorer access to health information and services (Bohra et al. 2012). Women's lack of empowerment is an underlying determinant of continuing poor health outcomes, as are the cultural and social barriers that impede some caste and ethnic groups from using health services. As long as the equity gap in health utilisation and outcomes remains high for disadvantaged population groups and standard government services and programmes — such as FCHVs and IEC/BCC — are unable to reach the unreached and raise their access to services, there is a strong justification for targeted-side programming to try and close the gap.

   With many social mobilisation programmes operational in Nepal, it is legitimate to ask whether there is a need for a specific health one. In an ideal situation health would be integrated into broad, multi-sectoral community mobilisation processes; but until there is a strong social mobilisation platform with the capacity and the political commitment to absorb sector needs, it would be a high risk strategy to attempt integration.

iii. *Where is the best institutional home for EAP?* — Synergising the supply-demand nexus is of key importance when mobilising for health. Over the past four years, with MoHP stewarding EAP, beneficial linkages have been forged at the local level between NGO activities and health providers. While MoFALD is the natural institutional home for future social mobilisation programmes, currently LGCDP lacks the maturity or structures to absorb the community-based package of activities that make up EAP. Integration into MoFALD-led social mobilisation should be an objective for the medium to long term, and strengthening coordination of LGCDP with the health system would be a step towards this.

6.2 MANAGEMENT AND COORDINATION MUST BE IMPROVED

We believe EAP remains a strategically valuable programme as it speaks to policy priorities, it addresses continuing social inequities in access to and the use of services, and there is merit in it remaining under the stewardship of MoHP.

However, the following four strategic management conditions need to be met to enable the programme to deliver results, and provide good value-for-money. If these conditions cannot be met then we recommend that the government should consider terminating the programme or relocating management fully outside of government to a third party agency where these conditions can be met.

i. *The multi-year contracting of NGO partners with annual incremental budgets* — Without multi-year contracting it is not viable to implement an empowerment-oriented social mobilisation programme. LGCDP has shown that multi-year contracting can work in the Nepalese context and has administrative and governance benefits. It reduces administrative costs and introduces stronger accountability. With inflation likely to continue rising, incremental budget increases will be needed to prevent activities being underfunded.

ii. *Increased central-level involvement in the district NGO selection process* — The NGO selection process needs to be better mediated to reduce political influence, raise transparency, and to make more efficient use of the time and resources of DHO/DPHO staff and NGOs. We recommend this is achieved through greater central-level involvement. Given the capacity constraints of PHCRD to play a major role in NGO selection, this calls for a third party agency to be engaged to support this process.

iii. *The strengthened supervision and monitoring of programme implementation* — The level of technical supervision and programme monitoring needs elevating to improve the quality and relevance of activities and to leverage health services and local government resources. Monitoring also needs to be significantly strengthened to raise the accountability of NGO implementers and the accountability of health providers as key agents of change.

iv. *Better coordination with MoFALD/LGCDP and other social mobilisation programmes* — Improved coordination is needed at the policy and implementation level and EAP, LGCDP and other social mobilisation programmes need to work more closely. At the VDC level, opportunities for wider coverage and impact need to be grasped through more coordination between social mobilisers from EAP, LGCDP and other programmes, and the integration of health into other programme agendas and activities. In addition, policy dialogues are needed to enable the longer term integration of health, and EAP specifically, into MoFALD's social mobilisation programmes.

6.3 RESHAPING THE PROGRAMME

If government can address the above strategic management issues and EAP is continued, we recommend the reshaping of the following four areas to reignite and re-position EAP to deliver the results that it has demonstrated in the past.

i. *Coverage: Strengthen targeting of the unreached* — EAP is not a universal programme. Its merit and value lie in reaching unreached and excluded populations. Due to implementation bottlenecks over the past four years, the practicality of targeting the most vulnerable in focal districts has been compromised. And some districts have continued receiving EAP when arguably they were ready to exit the programme. There is a need now to develop a clear strategic plan for the programme that clearly defines its purpose and specifies how it should be rolled to selected low-performing and

underserved districts. Such districts should be identified by a composite index that scores districts against indicators that record the relatively low utilisation of essential health services, a high incidence of outbreaks, a high prevalence of social and cultural barriers to accessing services and limiting geographical factors. This would set the pace of expansion and help identify the target number of districts to be covered in total. We believe that a maximum of 30 districts would be the right order of magnitude. In addition to defining districts, the strategy needs to define criteria to be used in selecting VDCs and to reintroduce a strong focus on poor and excluded groups. The strategy also needs to map out an exit strategy from VDCs and districts where the programme's objectives have been achieved, and mechanisms for learning and dissemination.

We suggest that the programme is reshaped in fiscal year 2012/13 (Nepali fiscal year 2069/70). This will involve reviewing the current portfolio of districts to determine and develop exit plans for districts that no longer meet the criteria, and sharpening the focus of VDC activities in districts which are kept on. An important focus should be on gathering experiences and learning from the districts that are due to leave the programme.

Given the difficulties of involving the ultra-poor in group mobilisation the current EAP model seems inadequate for reaching them. We therefore recommend that MoHP seeks collaboration with LGCDP and the Poverty Alleviation Fund to develop ways of improving access of the ultra-poor to health information, and to integrate health into their respective empowerment models that target the ultra-poor.

ii. *Extend the focus of the EAP package* — The shift to broaden the scope of work to include essential health care, gender based violence and related rights and entitlements has already started. This needs to be further developed and strengthened to address other key social determinants including nutrition, water, sanitation and hygiene. The subjects of rights and accountability are at the heart of EAP but attention to them has been weakened due to implementation bottlenecks. As the programme is reshaped, a stronger focus needs to be developed on rights and accountability in tune with the emerging accountability landscape. Linkages between women's groups and voice mechanisms, such as social auditing and the ward citizen forums, provide opportunities for women's empowerment and increasing the responsiveness of government to citizens.

EAP's demand side focus fits many geographical and service contexts across the country where basic services are available. However, the specific challenges faced by populations in remote areas where service availability tends to be particularly weak, suggests that an expanded EAP package incorporating supply and demand side inputs would be more appropriate for such areas. This is an area for further innovation and testing. We recommend that the government builds on the learning of EAP and lessons from service provision in remote mountain areas to design an EAP+ package that can be tested for use in such areas.

iii. *Ensure quality* — In the transfer of EAP from SSMP to the government, technical support and monitoring provided by technical specialists in Kathmandu and district coordinators was eroded. Implementation bottlenecks have further undermined the quality of EAP efforts. NGO partners have at times received insufficient technical support, training, supervision and monitoring. Capacity building has been compromised. This situation needs to be corrected by investing more resources for technical support, capacity building and monitoring.

How to achieve this? PHCRD at the centre, regional directorates and DPHO staff lack the technical know-how and experience to guide social mobilisation processes, although they can and do provide

valuable guidance on health issues. These institutions also currently lack the resources (time and funds) and incentives to undertake the regular quality field supervision of community mobilisation processes. In view of the capacity constraints within government, we recommend that a third party agency be engaged to ensure the quality of EAP implementation by providing technical support, field supervision, training and by carrying out programme monitoring. Such an agency should be contracted centrally and be accountable to PHCRD to work in close coordination with DHOs/DPHOs and NGO partners. This agency would also assist district health teams to build their capacity in the areas of social inclusion, gender, access and accountability. It is recommended that this agency be hired on multi-year contracts based on milestone deliverables. In addition (as discussed earlier), the agency could be tasked with supporting the district NGO selection process.

The third party technical support agency's role could also entail supporting PHCRD to address the following design and implementation issues that have been identified by the review:

- The targeting of needy VDCs.
- Packaging activities for impact and sustainability.
- Criteria for selecting social mobilisers.
- The scope of work of social mobilisers.
- The size of women's groups.
- The appropriateness of non-local NGO implementing partners.
- Coordination with LGCDP.
- Incentivising health workers.

iv. *Financing for an effective package of inputs* —The often delayed release of the annual health budget to DHOs/DPHOs has already been discussed. Here we draw attention to the fact that the budget for EAP implementation per district has been declining while VDC coverage has remained the same or increased. This has resulted in activities being scattered more thinly. A shift to multi-year contracting would require stronger costing frameworks and analysis, and strict definitions of how much can be spent on various activities from within the EAP package. This costing analysis has already started. Our expectation is that the financial management discipline that multi-year contracting will bring will guard against shrinking budgets being spread ever more thinly. In future, if budgets shrink then coverage needs to reduce concomitantly. Spreading EAP inputs thinly to a large population negates its impact.

The development of a strategic plan will also make explicit the government's long term commitment to the programme. This will send positive signals to DHOs/DPHOs and encourage greater prioritisation of EAP amongst the many other district health programmes.

7. *NEXT STEPS*

The initial presentation of the findings and recommendations of this review have been made to the Director of PHCRD, the Director General of the Department of Health Services, and the Chief of the Policy, Planning and International Cooperation Division (MoHP). From their initial feedback we believe that the steps outlined above will be endorsed by MoHP and their will be no need to explore the alternative arrangement of contracting the entire management of EAP out to a third party. Based on this assumption, it is proposed that PHCRD takes the lead on implementing the following next steps:

I. The government health authorities to review the findings and recommendations of this strategic review and then agree with the major stakeholders on how to shape EAP for the future.

II. Undertake the necessary administrative procedures for securing the multi-year contracting of NGOs to implement EAP from 2012/13 onwards.

III. Undertake a comprehensive costing exercise and develop performance criteria for the multi-year contracting of NGOs.

IV. Develop a work-plan for 2012/13 to undertake the reshaping of EAP in line with the recommendations of this review.

V. Develop a five year strategy for EAP implementation in consultation with other stakeholders in MoHP and MoFALD and among external development partners.

VI. Develop a terms of reference for hiring a third party technical support and programme monitoring agency.

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ANNEX 1: PARTICIPANTS IN THE STRATEGIC REVIEW

1. MoHP and DoHS

	Name	Position
a.	Dr Padam Bahadur Chand	Chief, PPICD, MoHP
b.	Dr Mingmar Gyalgang Sherpa	Director General, DoHS
c.	Dr Gunaraj Lohani	Deputy Director General, DoHS
d.	Mr Ramchandra Khanal	Senior Public Health Administrator, MoHP
e.	Mr Madan Shrestha	Senior Public Health Administrator, PHCRD, DoHS
f.	Dr Shilu Aryal	Safe Motherhood Coordinator, FHD, DoHS

2. External development partners

	Name	Position
a.	Ms Natasha Mesko	Health Adviser, DFID
b.	Ms Latika Pradhan	Australian-Aid
c.	Mr Gopi Khanal	National Coordinator, LGDCP
d.	Mr Mahesh Pokhrel	Procurement Officer, LGCDP

3. Gorkha district

	Name	Position
a.	Mr Bishow Ram Shrestha	DPHO
b.	Mr Basudev Adhikari	Family Planning Supervisor (EAP focal person) DPHO
c.	Mr Sushil Dhakal	Accountant
d.	Mr Bhes Bahadur Khadka	President of SODESI
e.	Mr Dinesh Pant	Planning Office, DDC
f.	Mr Bir Bahadur Chhetri	Health facility in-charge, Bakrang VDC
g.	Ms Maya Shrestha	Maternal child health worker, Bakrang SHP
h.	Community Group (around 60 women)	Bakrang VDC, ward 5

4. Kanchanpur District

	Name	Position
a.	Mr Bhava Raj Regmi	Director – NEEDS
b.	Ms Sarita Bhatta	Coordinator – NEEDS
c.	Mr Shiva Dutta Bhatta	DPHO
d.	Mr Khem Bhatta	Statistician (EAP focal person) DPHO
e.	Mr Bhandev Bhatta	Social Development Officer, DDC
f.	Mr Prem Bokati	Executive Secretary – LDF/DDC
g.	Mr Gokarna Upadhaya	LGCDP social mobilizer – NEEDS
h.	Mr Yogendra Bhatta	Public Health Inspector – Belauri PHCC, Shreepur VDC
i.	Mr Kabindra Ojha	VDC Secretary – Shreepur VDC
j.	Community Group (Around 18 women)	Shreepur VDC ward 1 Udayapur

5. Baitadi District

	Name	Position
a.	Dr Guna Raj Awasthi	district health officer
b.	Mr Dhan Singh Bhat	President – SSSSM
c.	Mr Lokendra Pant	Coordinator – SSSSM

d. Mr Man Bahadur Chand — Health facility in-charge – Pancheswar SHP
e. Mr Dilli Ram Joshi — Family Planning Supervisor (EAP focal person) – DPHO
f. Mr Nabin Pandey — Social Development Officer – DDC
g. Mr Bikram Pandey — Programme Officer – DDC
h. Mr Khem Raj Bhatta — Executive Secretary – LDF/DDC

6. Myagdi district

a. Dr Jhalak Sharma Gautam — DHO
b. Ms Ratna Khadka — Public health nurse
c. Mr Hari Krishna Acharya — Social Development Officer – DDC
d. Mr Hari Prasad Paudel — President – KADAM
e. Community Group (Around 10 women) — Baranja VDC ward 2 Pakher

7. Morang district

a. Mr Nabaraj Subba — DPHO
b. Mr Dharani Khatiwada — Family Planning Supervisor (previous focal person)
c. Mr Utsav Pokharel — Health Assistant (EAP focal person)
d. Mr Sitaram Thapa — Secretary, Social Action for Rural Health Development of Nepal (SARHDON), Biratnagar
e. Mr Mukesh Basnet — Chairperson, Sagarmatha Community Development Centre (SEDC), Biratnagar
f. Mr Ambu Bista — Programme Coordinator
g. Ms Sushila Luitel — Social Mobiliser
h. Mr Chandra Kandel — VDC secretary – Lakhantari VDC
i. Mr Santosh Gautam — Health Facility In-charge – Lakhantari Health Post
j. Community group (around 12 women) — Lakhantari VDC ward 5
k. Mr Sampatti Lal Yadav — Health Facility In-charge, Bhaudaha Health Post
l. Community Group (Around 15 women) — Bhaudaha VDC ward 1

8. Rukum District

a. Dr Yedu Chandra Ghimire — DHO
b. Mr Bishnu Bahadur Budhathoki — Family Planning Supervisor, DHO
c. Ms Hridayakali Paudel — Staff Nurse, DHO
d. Mr Himprasad Shrestha — Accountant, DHO
e. Mr Dilli Bahadur Khadka — Administrative Assistant, DHO
f. Ms Krishna Khadka — Expanded programme on immunisation (EPI) supervisor
g. Mr Liladhar Adhikari — Planning Officer, DDC
h. Mr Rajan Gautam — District Coordinator, MEDEP Nepal (based in DDC)
i. Mr Lalit Budha — Focal Point LGCDP, DDC
j. Mr Viyuman Gharti — Chairperson, MiK Nepal
k. Mr Mukunda Pun Magar — MiK Nepal

l.	Mr Shambhu BC	Chair, Nepal Public Awakening Forum
m.	Mr Ramesh Nepal	Secretary, Nepal Public Awakening Forum
n.	Mr Dhurba Bikram Budhathoki	Vice Chair, Sisne Multipurpose Janasewa Kendra
o.	Mr Karna Bahadur Nepali	General Secretary, Sisne Multipurpose Janasewa Kendra

9. Parsa District

a.	Mr Indra Prasad Yadav	DPHO
b.	Mr Arjun Bikram Hamal	Accountant, DHO
c.	Mr Kameshowr Chourasiya	EAP focal person
d.	Ms Debaki Timilsina	Subhalaxmi Nari Utthan Samaj, Birgunj
e.	Mr Bijaya Kumar Patel	Jeevan Jyoti Youth Club

ANNEX 2: EAP CONTRACTING AND IMPLEMENTATION TIMELINES

Year 1 (2008/09)

District	Events							
	Authority received	**EoI published**	**NGO short listing**	**Proposal submission**	**Final selection**	**Contract award**	**Training**	**Implementation (months)**
Baitadi	-	-	-	-	-	-	-	
Kanchanpur	NA	Last week of Feb.	Last week Mar.	April week 2	April week 2	April week 23	Last week April	2.5
Rukum	-	-	-	-	-	-	-	-
Myagdi	-	-	-	-	-	-	-	-
Gorkha	March	March	March	April	April	April	May	3
Parsa	-	-	-	-	-	-	-	
Morang	-	-	-	-	-	-	-	-

Year 2 (2009/10)

District	Events							
	Authority received	**EoI published**	**NGO short listing**	**Proposal submission**	**Final selection**	**Contract award**	**Training**	**Implementation (months)**
Baitadi	-	-	-	-	-	-	-	-
Kanchanpur	NA	Feb. last week	March last week	April week 2		April week 3	April last week	2.5
Rukum	-	-	-	-	-	-	-	-
Myagdi	NA	Dec. week 1	Jan week 3	Jan. last week	Feb. week 1	Feb. last week	March week 2	4
Gorkha	-	February	March	March	March	March	March	4
Parsa	-	-	-	-	-	-	-	-
Morang							Feb. week 3	4.5

Year 3 (2010/11)

District	Events							
	Authority received	EoI published	NGO short listing	Proposal submission	Final selection	Contract award	Training	Implementation (months)
Baitadi	End of March	April week 1	-	Asked proposal along with EoI	May week 1	May week 1	May week 2	2
Kanchanpur	NA	Feb. last week	March last week	April week 2	April week 2	April week 3	April last week	2.5
Rukum	NA	January	February	February	March	April	-	
Myagdi	NA	Feb. week 2	March week 1	March week 3	March week 3	March last week	April week 2	3
Gorkha	-	February	March	March	March	March	March	4
Parsa	NA	NA	NA	NA	NA	NA	NA	
Morang							April last week	2.5

Year 4 (2011/12)

District	Events							
	Authority received	EoI published	NGO short listing	Proposal submission	Final selection	Contract award	Training	Implementation (months)
Baitadi	Last week of Sept.	Dec. week 1	Dec. last week	Jan week 1	Jan. week 2	Jan. week 2	April week 2 (started some work before the training)	3
Kanchanpur	NA	Nov. last week	Dec. last week	Jan. week 2	Jan. week 2	Jan. last week	Feb. week 1 (just one day orientation)	5
Rukum	NA	March	March	March	May	Early June	-	1.5
Myagdi	NA	Nov. last week	Dec. week 2	Dec. last week	Dec. last week	Jan. week 1	Feb. week 2	4
Gorkha	October	November	December	January	February	February	February	4
Parsa		December	February	March	March	June	½ day orientation by GESI advisor on 4 July	About a month
Morang							May week 3	2

ANNEX 3: DISTRICT-WISE EAP BUDGETS UNDER DHO/DPHO ANNUAL WORK PLAN AND BUDGETS

	District	Budget allocated in each district				*Total (NPR)*	Total (GBP)
		2008/09	2009/010	2010/011	2011/2012		
1.	Kanchanpur	2,000,000	2,500,000	1,500,000	1,200,000	***7,200,000***	**£55,385**
2.	Gorkha	2,000,000	2,500,000	1,600,000	1,500,000	***7,600,000***	**£58,462**
3.	Dailekh		2,000,000	1,500,000	1,000,000	***4,500,000***	**£34,615**
4.	Parbat		2,000,000	1,500,000	1,000,000	***4,500,000***	**£34,615**
5.	Myagdi		2,000,000	1,400,000	1,000,000	***4,400,000***	**£33,846**
6.	Nawalparasi		2,000,000	1,500,000	1,100,000	***4,600,000***	**£35,385**
7.	Rupandehi		2,000,000	1,600,000	1,200,000	***4,800,000***	**£36,923**
8.	Chitwan		2,000,000	1,500,000	1,200,000	***4,700,000***	**£36,154**
9.	Morang		2,000,000	1,500,000	1,200,000	***4,700,000***	**£36,154**
10	Doti		1,000,000	1,500,000	1,000,000	***3,500,000***	**£26,923**
11.	Baitadi			1,000,000	1,000,000	***2,000,000***	**£15,385**
12.	Jajarkot			1,000,000	1,000,000	***2,000,000***	**£15,385**
13.	Rukum			1,100,000	1,000,000	***2,100,000***	**£16,154**
14.	Gulmi			1,500,000	1,100,000	***2,600,000***	**£20,000**
15.	Parsa			1,500,000	1,000,000	***2,500,000***	**£19,231**
16.	Taplejung			1,000,000	1,000,000	***2,000,000***	**£15,385**
17.	Darchula				1,000,000	***1,000,000***	**£7,692**
18	Salyan				1,000,000	***1,000,000***	**£7,692**
19.	Palpa				1,000,000	***1,000,000***	**£7,692**
20.	Rasuwa				1,000,000	***1,000,000***	**£7,692**
21.	Khotang				1,000,000	***1,000,000***	**£7,692**
	Total	**4,000,000**	**20,000,000**	**22,200,000**	**22,500,000**	***68,700,000***	**£528,462**
	Average per district	**2,000,000**	**2,000,000**	**1,387,500**	**1,071,428**		