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Rural Health Development Project
Phase VII
Project Completion Report
July 2013

Rural Health Development Project (RHDP)
ग्रामिण स्वास्थ्य विकास परियोजना
Government Of Nepal / Swiss Agency For Development And Cooperation

CONTENTS

PAGE

ACKNOWLEDGEMENT

Health is considered a fundamental right of each citizen. The Interim Constitution of Nepal 2007 has also guaranteed health as a fundamental right of every Nepali citizen. Nepal has made tremendous progress in the reduction of health morbidity and mortality rates, especially in maternal and child mortality, which has significantly reduced in line with the MDG targets. Likewise, significant progress can be observed also in the reduction of communicable diseases. However, the progress on the reduction of neonatal death and the increase in non-communicable diseases are becoming a huge challenge in the field of public health.

The Rural Health Development Project (RHDP) has been active since 1990 in Dolakha; in Ramechhap since 1996, and in Okhaldhunga since 2006, with the aim to improve the overall health status, particularly of women, disadvantaged groups and those living in remote areas of these districts. During it's more than two decades presence the project has contributed mainly in strengthening the rural health care system and bringing a positive result in the health status of people through reactivation and mobilization of Health Mothers Groups (MGs); Mothers Groups Networks (MGNs); Health Facility Operation and Management Committees (HFOMCs); Female Community Health Volunteers (FCHVs); adolescent clubs, and disadvantaged groups. Likewise RHDP supported in building the management capacity of the HFOMCs and technical capacity of health workers and the project remained actively engaged for policy reformation through different sub committees and alliances in the areas of Uterine Prolapsed; FCHV fund and FCHV uniform; Adolescent Sexual and Reproductive Health (ASRH); revised strategy of PHC/ ORC, and up scaling of Misoprostol and Birth Preparedness Package (BPP).

Kosheli bhet ; involvement of local bodies for health; initiation of a mothers groups network; provision of *bhoto-topi* to new babies and dhoti / sari to mothers, and *jwanoko jhol* are the best practices that were developed and initiated by the community, which have proven to be an effective way of health promotion.

Lots of progress has been seen over the past 22 years. Mothers Groups, which were inactive before the project came into these areas, are now actively functioning. Similarly, FCHVs and HFOMCs have become more active. As a result, participation of females and disadvantaged groups in health and empowerment has increased remarkably. All Health Posts and even some Sub-Heath Posts have 24 hours birthing centres, have upgraded the skills of health workers and health promoters, and have ensured the essential medicines and equipments are available in the health facility, the result of which has been an increase of quality health services and a resulting increase in overall health indicators in Dolakha, Ramechhap and Okhaldhunga Districts.

I would like to thank all the partners especially the Ministry of Health and Population, DoHS, FHD, NHTC, DHOs and all HFs who took the lead role in project implementation, and all the DDCs, VDCs and Community Groups with whom we had very good collaboration. Finally, I would like to express my gratitude and thanks to SDC/ Embassy of Switzerland in Nepal and the project staff who made this project successful.

Thank you

Dambar Singh Gurung
Project Manager
SDC/RHDP

Celebrating and Sharing Rural Health Development Project's Achievemnt, Best Practices and Lessons Learnt

"RHDP's outcomes have been achieved with the efforts put together by all level partners and stakeholders.I wish these outcome will be sustained in future". I thank to all and particularly Government of Nepat for such wonderful companionship in achieving such impact in the community".

- HE Thomas Gass
Ambassador to Nepal
Embassy of Switzerzland

"I extend my best wishes to all staffs involved in RHDP who served the community in health sector. Thank you to Embassy of Switzerland for such a long partnership in health. I am optimistic that good practices left behind by RHDP in the working districts will be continued and our health system will be able to support community demand".

- Honorable Secretary Dr. Pravin Mishra
Ministry of Health and Population

INTRODUCTION

The Swiss Agency for Development and Cooperation (SDC) has been one of Nepal's longest standing development assistance partners, going back 50 years, with its initial support focused on livelihood-related issues. SDC began its support of the health sector in Nepal in 1991, with a Primary Health Care – Mother and Child Health and Family Planning - Project in Dolakha, an offshoot of the Integrated Hill Development Project, which was later, renamed the Rural Health Development Project (RHDP) and implemented in an additional district, Ramechhap, in 1997. The newly named RHDP focused more on the demand-side of maternal health needs and its link to the supply-side. RHDP has continued to strengthen this linkage by changing the health seeking behaviour of people and building the capacity of health service providers in collaboration with local authorities. In 2006, RHDP extended the implementation of its programmes to another district, Okhaldhunga.

Phase VII of RHD, a bilateral project between the Government of Nepal and SDC, like the preceding phases, "aimed at achieving the overall strategic objective of enhancing the status of disadvantaged groups by empowering them to exercise their rights and improve their capacity to claim better access to, and enjoy their rightful share of, national health services" in the remote areas of Dolakha, Ramechhap and Okhaldhunga Districts. The seventh and final phase of RHDP ran from July 2009 to July 2013 and, in collaboration with the Ministry of Health and Population (MOHP), aimed to reach the Millennium Development Goals (MDGs) – primarily numbers 4 and 5, but also worked towards 3 and 6 – during the four years of its project phase.

Despite continual political instability, Nepal has made tremendous progress in its health indicators and is on track to meet the MDGs, especially those on reducing child mortality and improving maternal health. The most recent Nepal Demographic and Health Survey 2011[1] shows that infant and under-five mortality have declined and currently stand at 46 and 54 per 1,000 live births, respectively. According to the Nepal Maternal Mortality and Morbidity Study 2008-2009[2], the maternal mortality ratio stands at 229 per 100,000 live births, a dramatic decline from 539 in 1996.

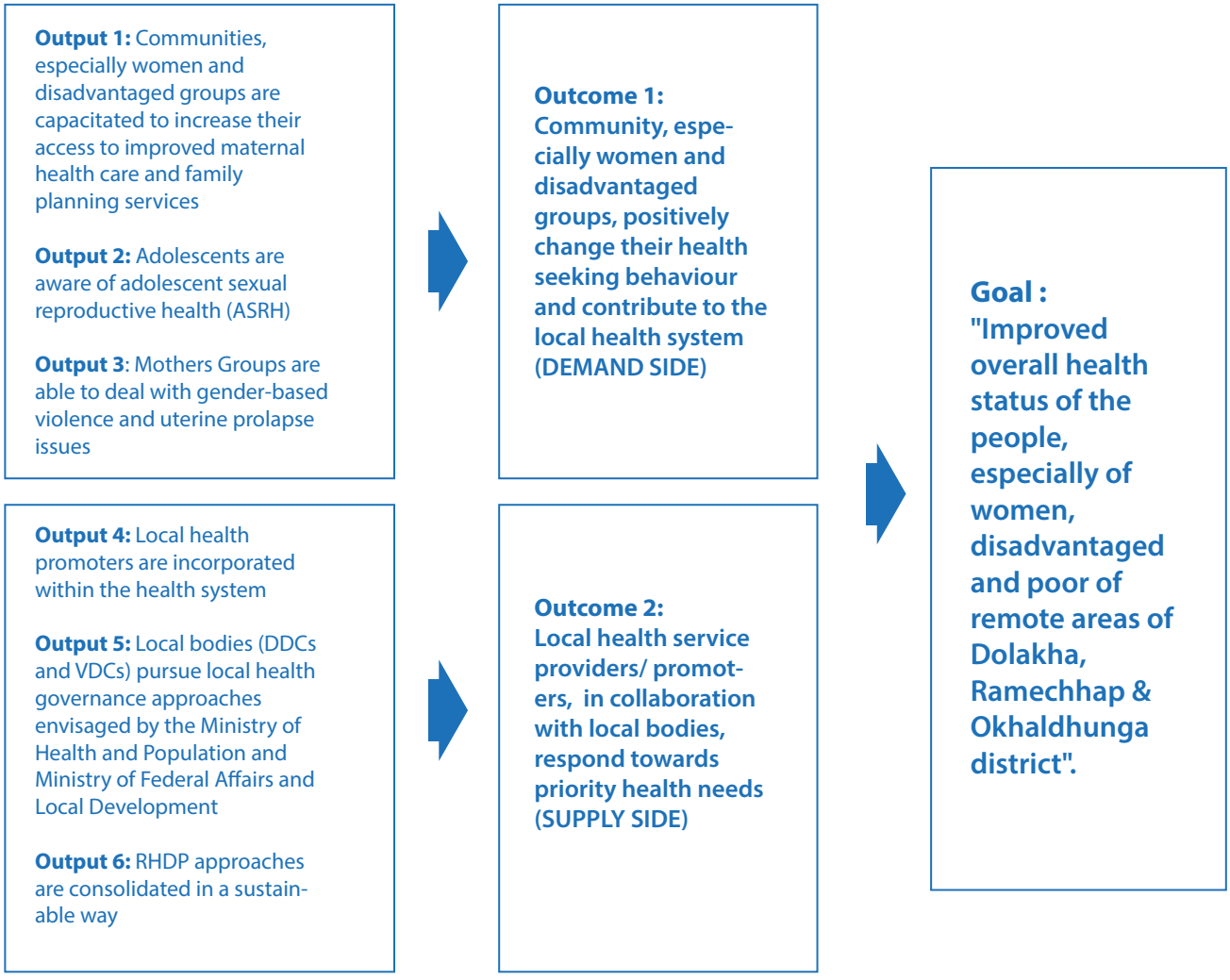
[1] Ministry of Health and Population (MOHP) [Nepal], New ERA and ICF International Inc. 2012. Nepal Demographic and Health Survey 2011. Kathmandu, Nepal: Ministry of Health and Population, New ERA and ICF International, Calverton, Maryland.

[2] Suvedi, Bal Krishna, Ajit Pradhan, Sarah Barnett, Mahesh Puri, Shovana Rai Chitrakar, Pradeep Poudel, Sharad Sharma and Louise Hulton. 2009. Nepal Maternal Mortality and Morbidity Study 2008/2009: Summary of Preliminary Findings. Kathmandu, Nepal. Family Health division, Department of Health Services, Ministry of Health, Government of Nepal.

PROJECT STRATEGY AND OBJECTIVES

RHDP was designed in line with the Government of Nepal's health policies, strategies and plans[3] and was aligned with the priorities of the Family Health Division/ Department of Health Services, MOHP. It contributed directly to the Three-Year Interim Plan and the Nepal Health Sector Programme – Implementation Plan. In addition to the direct health objective of ensuring citizens' fundamental right to health services and health care emphasised in these documents, RHDP kept in focus issues of empowerment, social inclusion, gender equality and governance, bearing in mind that addressing health needs, particularly those of the disadvantaged and poor, requires multi-sectoral interventions.

The diagram below displays the outcomes and outputs of the Project. Outputs 1-3 falls under Outcome 1, which involves empowering the community and changing their health seeking behaviour, while outputs 4-6 deals with capacity building of local bodies and health promoters, and governance.



[3] National Health Plan 1991, the Second Long-Term Health Plan 1997-2017, Three-Year Interim Plan, Nepal Health Sector Program – Implementation Plan and Health Sector Reform Strategy Reform Strategy: An Agenda for Change.

PROJECT APPROACHES

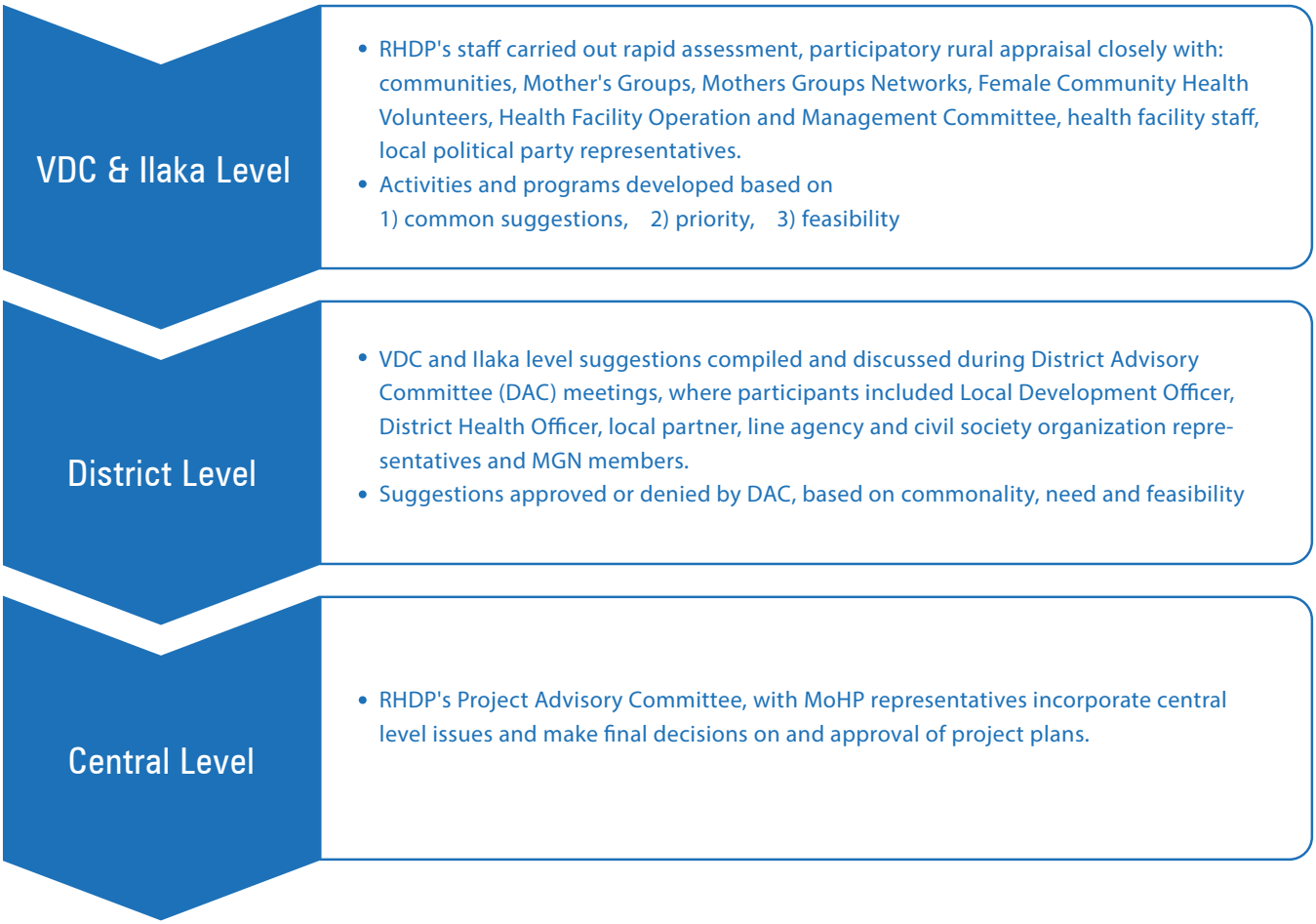
One of the successes of RHDP has been its focus on strengthening not only the supply but also the demand side of health services, thus having optimal impact on overall health systems strengthening. Another noteworthy characteristic has been its effort to work in conjunction with, and not parallel to, the MOHP's programmes and activities, thus strengthening the public health sector and ultimately ensuring sustainability of the programmes, even after the closure of the Project.

RHDP used certain unique approaches in its implementation that have been well appreciated by the government, communities and stakeholders and are worth noting.

Community Participation

RHDP very actively used the participatory planning process to ensure that the targeted communities were involved in all processes, from the identification and design of activities/ programmes to its implementation and monitoring (Figure 1).

Figure 1 : Participation in Project Planning



RHDP played a more facilitative role during the planning process, with other stakeholders and the community being more actively involved in the actual planning, implementation and monitoring of programmes and activities, thus being truly participatory in its approach at all phases of the project cycle. When local health promoters, i.e. MGs, MGNs, and HFOMCs, and political party representatives decided, for example, that a placenta pit was needed in a particular health facility, they came to a consensus and sent a proposal requesting RDHP to contribute a certain amount for its construction, with the rest mobilized through local resources.

This manner of community mobilization and participation has meant that each ward, community and household has been involved and have had their needs voiced in the planning process, thus resulting in true ownership over programmes that are targeted at them. Indeed, because of their participation, RHDP has not had significant problems implementing its activities. In addition, encouraging their involvement in the planning process has resulted in strengthening of their management and organisational development skills - for example, they developed proposal writing skills/ organisation and leadership development skills and became knowledgeable on how to run health facilities efficiently and effectively. This participatory approach has contributed tremendously to strengthening local health governance and has made a big difference in empowering and mobilizing communities by ensuring that the community, particularly women and disadvantaged groups, had a voice in decisions relevant and that mattered to them, at each stage of the project cycle.

Social Inclusion and Gender Equality

Nepal has historically been deeply divided along caste, ethnic and gender lines, and discrimination based on these identities is still rampant, despite measures to mitigate it. The Interim Constitution of Nepal guarantees social justice and affirmative action for women and disadvantaged communities and RHDP worked directly to ensure this was highlighted in its interventions and activities. The project :

- Encouraged Mothers Groups (MGs), Mothers Groups Networks (MGNs), Female Community Health Volunteers (FCHVs) and Health Facility Operations and Management Committees (HFOMCs) to ensure inclusive composition in the formation of their respective committees/ groups.
- Ensured people from disadvantaged groups increased health service utilization through awareness raising efforts specifically targeting the said group, and enhancing their participation in community groups (MGs, MGNs, FCHVs, HFOMCs) at the local level.
- Gave preference to the discriminated and poor with regards to utilization of the Emergency Health Fund.
- Ensured representation of participants from disadvantaged and poor groups during training, meetings, interactions, and workshops.

The External Review of Phase VII carried out in February/March 2013 shows that the composition of 57 percent of MGs in Ramechhap and 100 percent of MGs in Okhaldhunga reflected the socio-demographic profile of the districts, indicating a majority of MGs did think about inclusive composition during their formation. In addition, the Review also reported that 61 percent of sampled HFOMCs complied with the policy regarding the representation of at least one Dalit and four women in their committees.

> " Earlier we were not allowed to touch the water tap, but not anymore. All of us are like family members, without discrimination, in the Mothers Group. All members come forward to help if there is a need to take a Dalit women to the health facility " *~ Dalit MG member*

Appreciative Inquiry

Although not exclusive to RHDP, the Appreciative Inquiry (AI) approach used during training of, for example, health workers, HFOMC members and District Health Officers (DHOs), had significant impact on results in project districts. RHDP was involved in facilitating trainings and workshops using the AI approach, which emphasises heavily on using positive motivation and analysis to bring about organisational change. To have the greatest impact, RHDP began first by giving AI training to its staff, through which they were able to internalise the approach.

As a result of the AI approach, all participants that received AI training - from DHOs to health HFOMC members - were motivated to provide quality health care and hold themselves responsible and accountable to their communities. HFOMCs for example, were sensitised and made aware that it is not solely the government's responsibility to provide health care, but also theirs to demand for it, and to create an enabling environment to take on and share this responsibility. As such, one of the biggest changes brought about by the AI approach has been the influence it has had on HFOMCs to become proactive decision-makers in health programme planning. HFOMCs at most health facilities and at all birthing centres have now formed five-year long term health plans that are based on their communities' needs and consist of comprehensive visions, missions, goals, objectives and activities. In addition, HFOMCs have demanded the allocation of specified government budgets towards health, by incorporating these plans in district and VDC periodic planning.

Connected Development

One of SDC's most valued characteristics is that, although it carries out diverse projects - ranging from agriculture, rural infrastructure development, governance, sustainable resource management, to occupational skills development - it focuses on several cluster districts, and ensures synergy between the many projects, as well as among the difference line agencies, government bodies, and stakeholders, thus enhancing aid effectiveness and achieving very tangible results.

For example, within the three RHDP districts, certain VDCs are targeted by SDC to implement RHDP along with other projects to provide multiple livelihood options and therefore have maximum impact on the lives of disadvantaged population groups. RHDP also ensured that this connectedness existed beyond SDC projects and was apparent between line agencies such as the District Health Office and District Education Office to implement, for example, the Adolescent Sexual Reproductive Health intervention and between government bodies such as the Women's Development Office and the VDC and women and political party representatives, to ensure women's health rights are focused on and joint planning occurs during periodic planning.

As such, because of this holistic approach where thematic projects are interlinked and supported by cross-cutting principles and themes, and because of the synergy between the different stakeholders, impact has been visible and will continue to be, not only on the targeted groups, but also on society at large.

IMPROVED SAFE MOTHERHOOD PRACTICES

Key achievements

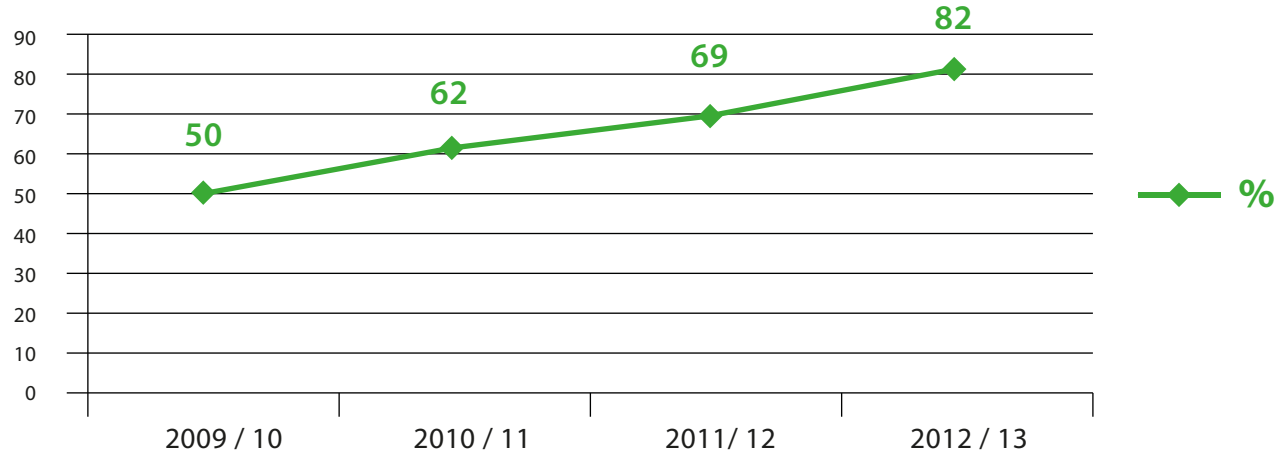
- Institutional deliveries increased from **38%** at baseline to **82%** at endline.
- Of the total number of people that went for institutional deliveries, **70%** came from disadvantaged groups.
- ANC and PNC visits both increased from **50%** to **89%** and **49%** to **82%**, respectively.
- The number of **24-hour birthing centers** rose from **19** at the start of the project period to **64** at the end.
- The percentage of discriminated service recipients rose to **87%** from **76%**.
- A total of **2,254 people benefitted** from the Emergency Health Fund since it was established, out of which **95% came from disadvantaged communities**. In addition, around **75%** of female recipients utilised the fund for safe motherhood services.

RHDP supported stakeholders and local health promoters, i.e. MGs, MGNs, FCHVs and HFOMCs in project districts to improve the communities' health seeking behaviour and practices and, ultimately, increase access to and utilization of safe motherhood and related services.

SAFER DELIVERY PRACTICES

Institutional deliveries increased significantly from 50 percent at the start of Phase VII to 82 percent at the end, indicating improvements on both the demand and supply sides (Figure 2). This included availability of skilled birth attendants (SBAs) at all birthing centres at the Village Development Committee (VDC) level, which not only had the required equipment needed for safer delivery - much of which was provided by RHDP - but services were available 24-hours a day. On the demand side, improved awareness and knowledge about the importance of institutional delivery, and the Maternity Incentive Scheme implemented by the government resulted in target population increases in delivering at health facilities/ through the assistance of health workers. The couples training approach also made a clear difference in both increasing the number of those who took advantage of, and changing the attitude of the community towards institutional delivery (for more information on couples training please refer to the chapter on Capacity Building).

Figure 2 : Institutional Delivery



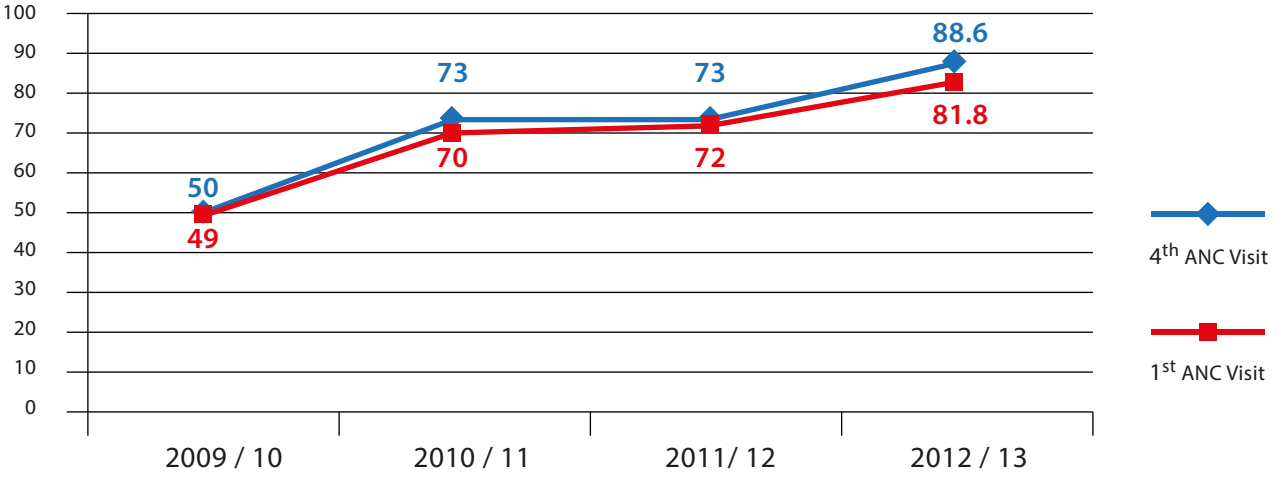
In addition to the steady increase over the four years, the Project results demonstrate that of the total number of women that went for institutional deliveries, 70 percent came from disadvantaged groups [4] , indicating that RHDP's objective to improve access to health care by disadvantaged people has been met.

Of the total number of beneficiaries that delivered with the assistance of a health worker/ at a health facility, 70 percent came from disadvantaged groups.

ANC AND PNC VISITS

Through constant mobilization of MGs, MGNs, FCHVs, and HFOMCs, trends in the number of visits to health facilities for antenatal (ANC) and postnatal (PNC) check-ups also increased over the project cycle. Although the percentage of both ANC and PNC visits remained constant between 2010 and 2012, overall, they rose from baseline to endline from 50 percent to 89 percent for the former and from 49 percent to 82 percent for the latter (Figure 3).

Figure 3 : 4th ANC and 1st PNC Visit



[4] Disadvantaged groups are groups of economically poor people (living on less than one dollar a day or having less than six months food security) that also suffer from social discrimination based on gender, caste/ethnicity and regional identity (regional identity denotes people's origin, i.e. 'mountain-people', 'hill-people' or "Terai/Madhesh-people')

In addition to the dissemination of safe motherhood information through print media, information education and communication (IEC) materials and local radio stations, MGs, MGNs, FCHVs and HFOMCs, through RHDP's facilitation, played a tremendous role in awareness-raising and carrying out health promotional activities to enhance the communities' knowledge, and inform and counsel them vis-à-vis safer delivery practices, ANC and PNC visits and other important health information, including the government's maternity incentive scheme and free health care at health facilities.

These health promoters were able to accomplish this through the creation and implementation of programmes such as Kosheli Bhet, Bhoto Topi and Juwanoko Jhol, which focussed on improving overall safe motherhood practices (please refer to the chapter on Best Practices for more information). Other examples of innovative activities initiated by MGs, MGNs and HFOMCs, which have proven to be excellent incentives for expecting mothers to receive safe motherhood services, include:

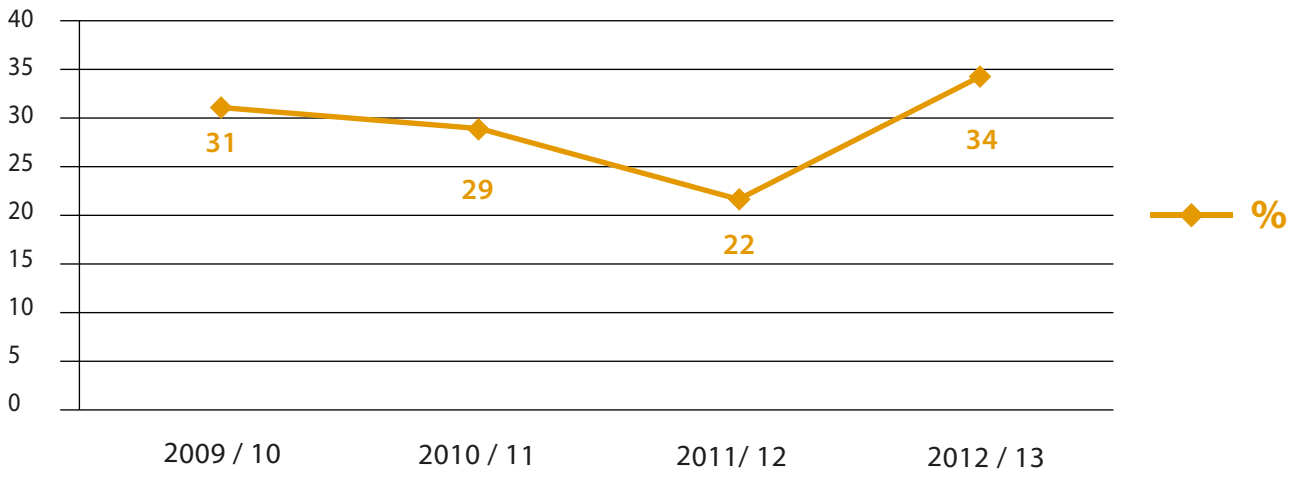
- **Greetings Cards** - pregnant women from the community received greeting cards that, in addition to sending a congratulatory message, also reminded and encouraged them to receive ANC and deliver at health facilities.
- **Green Flags** – hung from the houses of pregnant women, these flags provided for easy identification by the community and more importantly, FCHVs and health workers, thus allowing for counselling about ANC, PNC and dissemination of other relevant health information, education and knowledge.
- **Egg Distribution** – in a few VDCs in Ramechhap, to promote ANC check-ups, pregnant women were given an egg at each ANC visit, which served as an incentive and encouraged them to visit health facilities and obtain the required services.
- **Cash Incentive** - HFOMCs provided cash incentives between Rs 200 to 500 in different health facilities to motivate caretakers to bring pregnant mothers in for institutional delivery.

FAMILY PLANNING SERVICES

Another area of intervention RHDP worked on was to improve awareness on and increase use of family planning services. The Project gave local health promoters information on family planning during their respective training/ orientation sessions in addition to highlighting family planning issues during other standard trainings, such as BPP training. The local health promoters were then informed and able to disseminate this information to their communities. On the service strengthening side, RHDP also supported training of health workers on the intra-uterine contraceptive device, implants and voluntary surgical contraception, and also provided health facilities with these devices and related equipment. All of this contributed to increasing the utilisation of family planning services and played a role in increasing the contraceptive prevalence rate (CPR) in the project districts. The progress in CPR in Nepal, observed until 2006, has stagnated, primarily as a direct result of out-migration, a trend that has become increasingly prevalent throughout the country and has tremendous implications on the national family planning programme. Indeed, this trend along with under-reporting of contraceptive use is also reflected in RHDP's project districts.

According to the District Health Offices in Ramechhap and Okhaldhunga, a total of 22,323 youths migrated in 2012-2013. In addition, a rapid assessment showed that almost 60 percent of respondents claimed not to need contraception because their partner was abroad. RHDP used CPR data from the national health management information system, which show that, despite not reaching the project target of 42 percent, there was a slight increase from 31 percent in 2009 to 34 percent in 2013 (Figure 4). Results show that when used, the most preferred method of contraception was Depo-Provera, followed by oral contraceptive pills, male condoms, intra-uterine contraceptive devices and implants.

Figure 4 : Contraceptive Prevalence Rate



PROVISION OF QUALITY HEALTH SERVICES

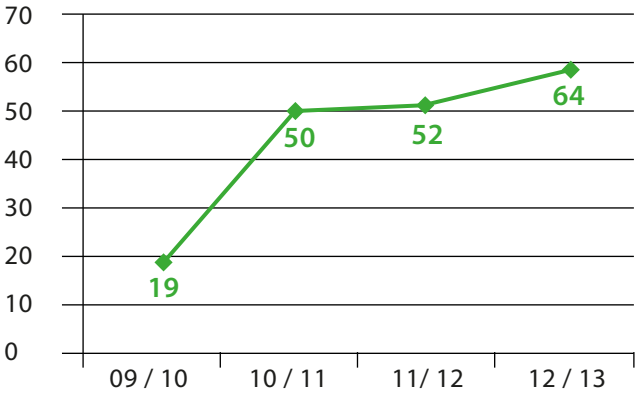
Local health facilities in all three districts increased their capacity to deliver quality health services, particularly those related to maternal health. Sixty-four health facilities established 24-hour birthing centres and are currently furnished with basic equipment along with the availability of SBAs. There was a substantial increase in the number of 24-hour birthing centres from baseline to endline – with only 19 being established at the start of the project period to 64 at the end (Figure 5).

Local health facilities in all three districts increased their capacity to deliver quality health services, particularly those related to maternal health. Sixty-four health facilities established 24-hour birthing centers and are currently furnished with basic equipment along with the availability of mid-level skilled birth attendants. There was a substantial increase in the number of 24-hour birthing centres from baseline to endline – with only 19 being established at the start of the project period to 64 at the end (Figure 5).

Based on the guidelines of the Aama Surakshya Karyakram (Safe Motherhood Programme) of the Department of Health Services, RHDP also provided essential equipment and material to Ilaka-level Health Posts and Sub-Health Posts to establish 24-hour birthing centres.

The quality of health services and care at health facilities has also been enhanced as a result of the "micro health project" (MHP) intervention. Capacitating and strengthening MGs, MGNs and HFOMCs enabled them to play a significant role in designing and implementing health initiatives as part of the MHP activity. Over the course of RHDP Phase VII, 288 micro health projects were implemented in the three districts by these community groups in coordination with VDCs and other development agencies, for which RHDP provided matching grants of up to 50 percent. These micro-health projects included improving delivery/ ANC rooms at health facilities through the construction of attached toilets and providing them with furniture; constructing waiting rooms for expecting mothers and caretakers; repairing drinking water systems; maintaining health facility premises, and ensuring proper waste management through the construction of placenta pits and incinerators.

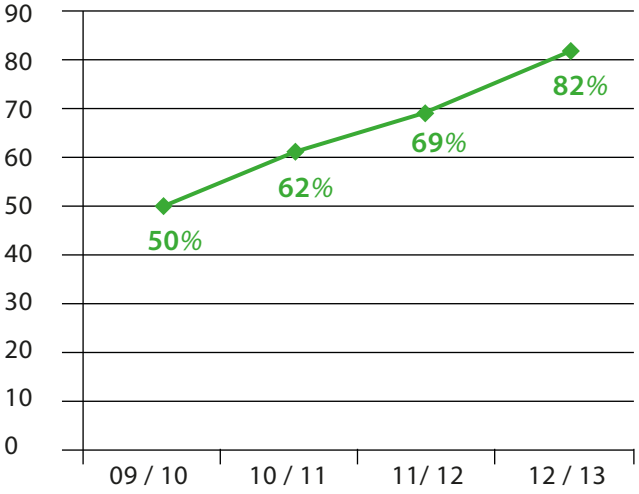
Figure 5 : 24-Hour Birthing Centres



HEALTH SERVICE UTILIZATION BY DISADVANTAGED GROUP (DAG)

Despite provisions by the government to target discriminated groups, in reality, people from this category face tremendous obstacles to access health services, primarily due to their poverty and status in the discriminatory social system. To address this challenge, RHDP carried out awareness raising activities targeting people from this group, as a result of which at endline, health service utilization by discriminated populations rose to 87 percent from 76 percent at baseline (Figure 6).

Figure 6 : Health Service Utilisation by Discriminated Population



EMERGENCY HEALTH FUNDS

Another way in which the Project worked to improve the status of the disadvantaged was through the creation of the Emergency Health Fund (EHF). Specifically, the EHF was established to support poor and disadvantaged people who are in need of emergency health services, but unable to afford them. At endline, EHFs were established and functional in 99 percent of VDCs in Ramechhap and Okhaldhunga, with substantial financial and technical support by RHDP.

Regarding technical support, RHDP facilitated the development of the EHF Operation Guidelines. Although the EHF may be used in any kind of medical or health emergency, the Fund has been linked to the Government's Emergency Obstetric Fund and thus preference is given primarily to those requiring safe motherhood services.

Analysis of data shows an increase in the utilisation of the EHF, mostly as a result of the dissemination of information through the radio, print media and by targeting disadvantaged groups, the poor and those needing safe motherhood services. As a result, of the total of 2,254 people who benefitted from EHF since it was established, 95 percent of them came from disadvantaged communities. In addition, around 75 percent of female recipients utilised the fund for safe motherhood services.

A total of 288 micro health projects were implemented by MGs and HFOMCs during the four-year project cycle.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Key achievements

- A total of 109 adolescent clubs were set up in Ramechhap and Okhaldhunga.
- RHDP helped create 52 youth corners at health facilities; availing adolescents to ASRH related IEC materials and services.
- At endline, 86 percent of adolescents were able to identify symptoms of sexually transmitted infections, and 95 percent and 93 percent understood the modes and prevention of STI transmission, respectively.

The Project played a big role in establishing adolescent clubs in higher secondary schools in the districts, which were integral for disseminating and raising awareness on essential Adolescent Sexual and Reproductive Health (ASRH) skills, knowledge and information to the youth in the targeted communities. In total, 109 clubs were set up in Ramechhap and Okhaldhunga. To ensure students received appropriate information and knowledge, RHDP provided training of trainers to teachers at the schools, Health Facility In-Charges and Health Workers at the district level, who in turn taught appropriate ASRH and other life skills-related lessons to the adolescent club members. This included information on HIV and AIDS, and the mental, physical and psychological changes that take place during puberty. RHDP also helped create 52 'youth corners' at health facilities, where interested youths were able to receive ASRH-related IEC materials as well as counselling services. The Project also supported the adolescent clubs to observe Condom Day, and World AIDS Day.

To spread ASRH messages to an even wider audience, and create further awareness in the community, and simultaneously empower and enhance their leadership skills, club members were taught how to organise street dramas, quiz contests, speech competitions, etc on related topics.

As a result of these efforts, significant changes were observed in the youth's understanding and knowledge of sexual and reproductive health. Endline aggregate data from Okhaldhunga and Ramechhap shows that 86 percent of adolescents were able to identify symptoms of sexually transmitted infections, 95 percent understood the modes of STI transmission and 93 percent understood the ways of STI prevention.

GENDER BASED VIOLENCE AND UTERINE PROLAPSE

Key achievements

- Only **15** percent and **22** percent of Mothers Groups members in Okhaldhunga and Ramechhap, respectively, understood the negative effects of domestic violence on women and children's health at baseline, increasing substantially to **97** percent and **75** percent at endline.
- A total of **5,902** women were screened for uterine prolapse, out of which **1,658** were found to have it and **828** received surgery.

Raising awareness on gender based violence, in particular domestic violence (DV), and uterine prolapse (UP) was a key area of focus for RHDP. Apart from broadcasting messages about these issues through local radio stations and through the distribution of IEC material, RHDP facilitated orientations and trainings during MG and HFOMC meetings to sensitize MG, MGN and HFOMC members on DV and UP. Through this local health promoters, in particular MGs/ MGNs, were able to mobilize themselves and play a major role in organising campaigns against DV and UP, using designated days such as Women's Day or FCHV Day to disseminate information and raise awareness within their communities about the issues. With regards to UP, RHDP collaborated with other agencies and financially supported them to run UP camps. Clients who were referred to hospitals were also provided with counselling and transportation costs through RHDP. Additionally, RHDP advocated at the policy level to incorporate and allocate a budget for uterine prolapse in national health programmes.

Data shows that from 2002, almost 6,000 women in the three districts were screened for uterine prolapse with support from RHDP.

District	*Total UP Cases Screened*	*Uterine Prolapse Cases*	*Surgery Cases*
Dolakha	798	239	71
Ramechhap	2985	983	464
Okhaldhunga	2119	436	299
Total	**5902**	**1658**	**828**

Analysis of baseline and endline data shows significant attitudinal and behavioural changes in MG members and the community as a result of this intervention. At baseline, only 15 percent and 22 percent of MG members in Okhaldhunga and Ramechhap, respectively, understood the negative effects of domestic violence on women and children's health. By endline, this had increased to 97 percent and 75 percent, respectively. Because HFOMCs were also sensitised about DV and UP, male HFOMC members were in general more supportive of and lobbied for women's health rights. In addition, by linking the reproductive health needs of women to DV, RHDP was able to generate more support and understanding from men on this sensitive issue.

The percentage of women able to identify the causes and preventative measures of uterine prolapse increased quite significantly in Okhaldhunga from 43 percent to 97 percent, but remained constant in Ramechhap from 73 percent to 72 percent from baseline to endline. Overall, however, the above results are indicative of major shifts in the mindset and attitude of the target population, including the men, without whom real transformation of societal attitude cannot be sustained.

CAPACITY BUILDING OF HEALTH PROMOTERS & HEALTH SERVICE PROVIDERS

Key achievements

- RHDP helped re-activate 2,048 Mothers Groups in the three project districts and provided them with training.
- MGs, MGNs and HFOMCs designed and implemented 288 micro health project activities in the three districts.
- Capacitating MGs and MGNs has resulted in the creation and implementation of innovative ideas like Kosheli Bhet, Juwanoko Jhol, Bhoto Topi, etc.
- RHDP collaborated with the National Health Training Centre to train Auxiliary Nurses Midwives.

Through its capacity building efforts targeting FCHVs, MGs, MGNs and HFOMCs, health workers and the community, RHDP hoped to, in addition to capacitating and increasing their leadership skills, empower them. RHDP carried out trainings, orientations and workshops on organisational development, social inclusion, and local resource mobilization, among other topics, through which they were enabled to carry out their respective responsibilities and were also made more knowledgeable about safe motherhood and other related topics. With regards to empowerment, the capacity building efforts helped increase their participation during their respective meetings; enabled them to voice their opinions and needs, and ultimately enabled them to play a big role as change agents in their communities by:

- Demanding District Development Committees (DDCs) and VDCs allocate budgets for health related activities and integrate community health demands in regular DDC/ VDC plans.
- Mobilising local resources to address local health needs.
- Creating and implementing innovative activities such as Kosheli Bhet, Juwanoko Jhol, Bhoto Topi, etc.
- Playing a significant role in the micro-health project approach.

MOTHER GROUPS AND MOTHER GROUP NETWORKS (MGs AND MGNs)

RHDP strengthened and capacitated MGs and MGNs by: training and orienting them on safe motherhood related topics; sensitising them about DV and UP, and enhancing their leadership and organisational skills through workshops and trainings. Apart from these capacity building activities, the project helped establish and make functional MGs and MGNs. Specifically, RHDP re-activated 2,048 MGs in all three project districts and provided technical support in the formation of MGNs.

As a result of these activities, MGs and their networks have been successful at ensuring that VDC budgets include funds for safe motherhood activities. In addition, capacitating MGs and MGNs has resulted in the creation and implementation of initiatives like Kosheli Bhet, Juwanoko Jhol, Bhoto Topi, etc.

HEALTH FACILITY OPERATION & MANAGEMENT COMMITTEE (HFOMCs)

HFOMCs are crucial at ensuring that health facilities function optimally and play a big role in the planning, execution and monitoring of health activities. HFOMC members were given training to address daily health facility management issues, including the provision of health services, which not only enhanced their capacity but also improved decentralisation of health care and introduced the important concept of local self-governance. RHDP also helped HFOMCs organise review meetings on a bi-annual basis, which not only helped HFOMCs execute their health action plans, but also strengthened the bridge between HFOMCs, the community and health facilities, thus contributing to directly increasing access to health services by the people.

FEMALE COMMUNITY HEALTH VOLUNTEERS (FCHVs)

FCHVs also received support from RHDP, particularly through facilitation of and/ or financial contribution to monthly FHCV meetings. The monthly meetings allow FCHVs to receive updates on issues related to health, thereby capacitating them to effectively disseminate health messages to their communities including BPP, family planning, and misoprostol. The meetings also allow them interact and discuss the FCHV fund, collaboration with MG networks, emergency health funds, etc. In addition, RHDP provided FCHVs with basic and refresher training.

LOCAL HEALTH PROMOTERS

RHDP, in coordination with the National Health Training Centre, provided SBA training to auxiliary nurse midwives (ANMs), who were locally hired to fulfil the human resource requirement of 24-hour birthing centres. Hiring ANMs locally and capacitating them with the required training has enabled them to perform life-saving procedures, such as control of post-partum haemorrhage through misoprostol, retained placenta management and vacuum delivery, and has done much to contribute to the increase in institutional deliveries. The training ANMs received has resulted not only in better on-site care, but also in better identification of complications and improved emergency referrals.
RHDP also gave Health Workers training on proper IUCD, implant and VSC procedures, which helped contribute to increasing the use of family planning services by the community.

COUPLE TRAINING

The couples training activity made a noteworthy impact on raising the awareness of the community at large about institutional deliveries in the project districts. This one-day interaction meeting targeted expecting mothers and provided them with training on BPP. It was mandatory that the mothers attended the training sessions with their husbands or mother-in-laws. The training content, which focused on BPP and the three delays that contribute to maternal deaths and related issues, has done much to raise awareness and sensitise not only the mothers but also their family members. Enhancing their understanding has made husbands and mother-in-laws more supportive of expecting mothers and more sensitive to their needs. In addition, attending the training has instilled in them a sense of obligation to ensure that they send their wives/ daughters-in-law to health facilities for delivery. All of this has resulted in contributing to the increase in institutional delivery.

STRENGTHENED LOCAL HEALTH GOVERNANCE

Key achievements

- RHDP helped HFOMCs prepare their perspective five-year health plans, as well as VDC level annual health plans.
- At baseline, **82** percent of HFOMCs had their health plans reflected in VDC plans, increasing to **98** percent at endline.
- A total of **94** million rupees from the VDCs was allocated for health activities, including health facility maintenance, hiring of ANMs and awareness-raising.
- Positive changes were observed in the local bodies, especially with regards to their sense of ownership over planning and implementation of health activities and self-reliance.

Decentralisation and local health governance is playing an increasingly central role in health system strengthening, not only globally but also in Nepal. As per the Local Self Governance Act 1999, health sector decentralisation began in 2002 with formal, phase-wise hand-over of health facilities to HFOMCs in 28 districts. Due to long-standing political instability and lack of locally elected representatives, however, this process never reached the three project districts at the time of Phase VII initiation. For this reason, RHDP laid the foundation and played a vital role in decentralised management and local self governance of health facilities by re-activating HFOMCs and supported them by facilitating their management and providing them with technical training and orientation.

RE-ACTIVATION AND MOBILIZATION OF COMMUNITY GROUPS HEALTH FACILITY OPERATION AND MANAGEMENT COMMITTEES (HFOMCS)

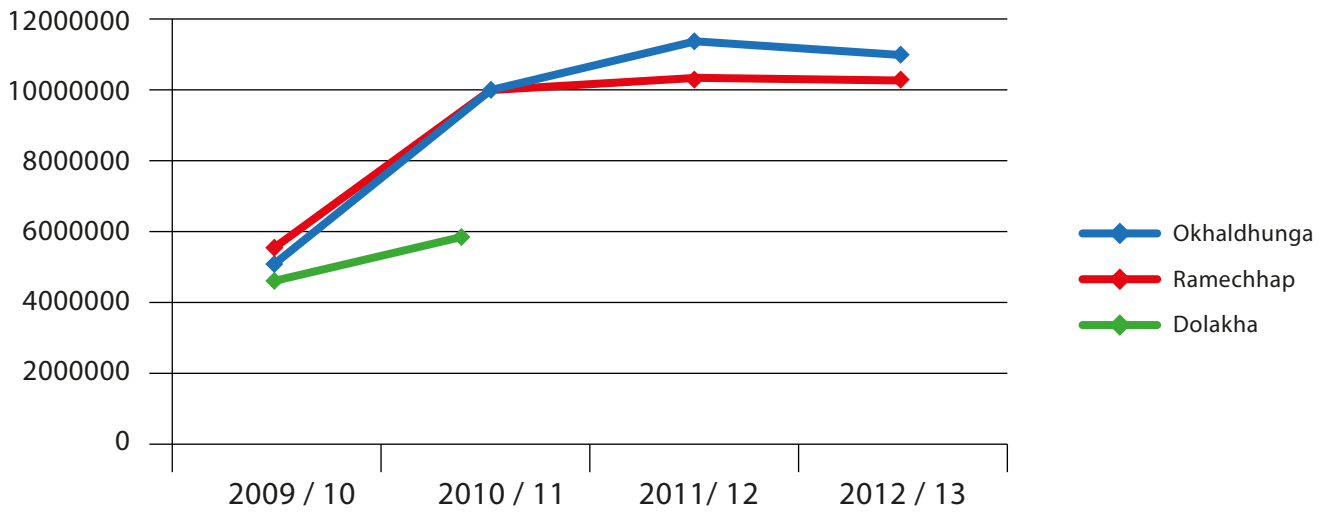
RHDP assisted the government's move to decentralise the health sector by reactivating the local HFOMCs and facilitating their training and meetings to strengthen them. RHDP ensured that HFOMCs followed inclusive composition in the formation of the committees and had representation of all political parties. HFOMCs were also given a series of technical training and capacity building on how to address health facility management issues such as provision of services and the roles and responsibilities of the HFOMCs and their members. The Project also helped HFOMCs organise their bi-annual review meetings and prepare five-year health action plans according to community needs.

HEALTH MOTHER GROUPS (MGs) & MOTHER GROUPS NETWORKS (MGNs)

RHDP had a tremendous role to play in the creation of the health Mothers Group Networks (MGNs). Based on several MGs wish for a VDC-level forum, MGNs were formed at each VDC to serve as a platform for women and to mobilize MGs and FCHVs on women's health rights.

MGNs are made up of 15-16 members, with representatives from all MGs in the VDC. They work as a community of health promoters and manage domestic violence, safe motherhood, and neonatal health issues in close coordination with VDCs, HFOMCs and other community-level institutions. The formation of MGNs brought about a lot of positive transformations, not only in improving health indicators but also in the empowerment of the members themselves and their communities. MGNs became change agents and played a significant role in raising awareness on DV and UP, developing innovative activities, and putting pressure on VDCs to ensure local resources were mobilized and allocated for health activities, such as establishment of and locally hiring ANMs at 24-hour birthing centres.

TREND OF VDC BUDGET ALLOCATION

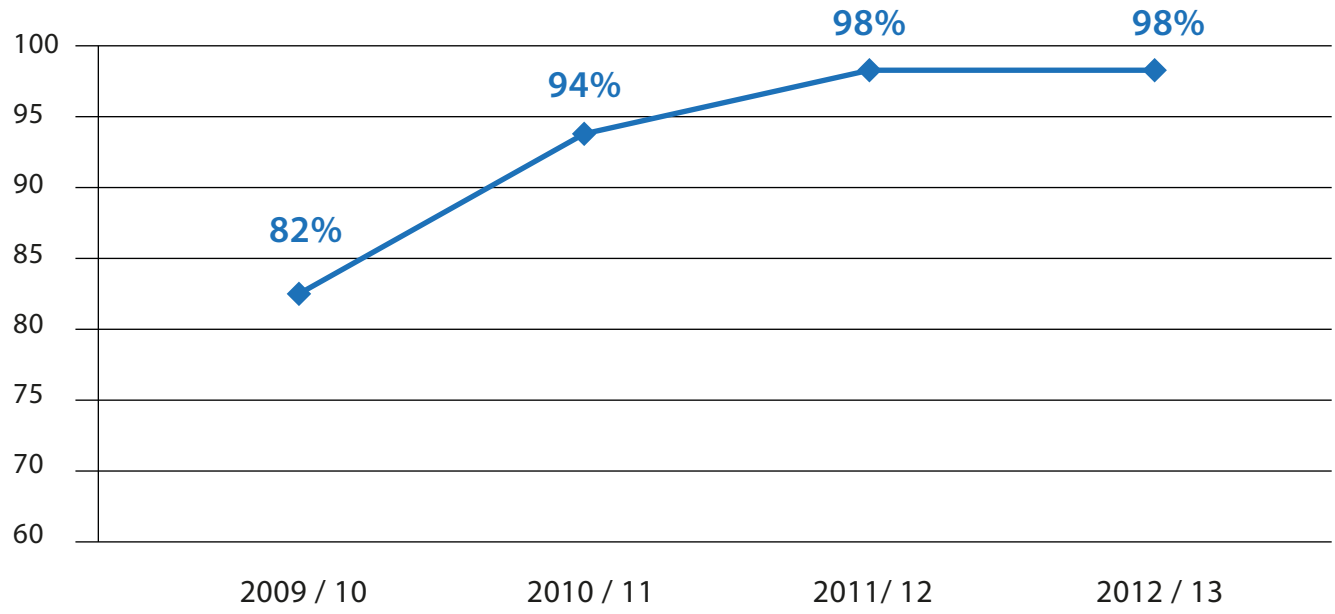


LOCAL HEALTH PLANS TIED TO VDC PLANS

To help HFOMCs pursue local health governance approaches, the RHDP supported them in the following ways: develop health plans according to specific health facility/ community needs; provide training and orientation on the importance of allocating budgets and funds for health programmes, and through its constant facilitation role.

As part of decentralisation and local governance efforts, MGs, MGNs, and HFOMCs have started to demand utilization of local resources for carrying out health activities and initiatives. To this end, these local community groups prepared and handed over five-year health plans to VDCs and DDCs, to include and tie them with the overall VDC and DDC periodic plans. At baseline, 82 percent of HFOMCs had their health plans reflected in VDC planning, which increased to 98 percent at endline (Figure 7). RHDP's role in this included capacity building training to HFOMC, MG and MGN members, to help them prepare the perspective health plans, along with facilitating the preparation of the VDC-level annual health plans based on those perspective plans. In other words, HFOMC, MG and MGN efforts have begun institutionalising the process of prioritising health within regular government plans, a clear indicator of improvements in governance.

Figure 7 : Health Plans Reflected in VDC Plans



LOCAL RESOURCE MOBILIZATION

RHDP's technical support to strengthen these local bodies has resulted in a substantial amount of money being allocated by the DDCs and VDCs to health programmes and activities. Indeed, it was only after RHDP began its intervention that DDCs/ VDCs began allocating money for health from block grants provided by the government.

As a result of this effort, a total of 94 million rupees from the VDCs were allocated for health activities during Phase VII. Most of the money was used primarily to hire human resources such as ANMs; manage birthing centres and health facilities; co-fund the EHF; carry-out awareness raising activities, and to conduct monthly meetings, among other activities. To ensure transparency, RHDP helped HFOMCs carry out public audits of these activities.

A total of 94 million rupees from the VDC was allocated for health activities, such as health facility maintenance, hiring of ANMs and awareness raising.

Overall, because of RHDP efforts, significant changes were seen in MGs, MGNs and HFOMCs, especially with regards to their sense of ownership and self-reliance. It also helped increase local participation in the management of health care and improved the responsiveness of health facilities, all of which are clear indicators that local health governance has been strengthened in the project districts.

WOMEN'S EMPOWERMENT FOR HEALTH

Empowerment of the community, in particular women, was a key focus area for RHDP, the Project worked diligently towards this end to enable women to realize and exercise their rights and responsibilities at the local level. The Project empowered women, including MG/ MGN members and FCHVs, by involving them and ensuring their participating at all stages of the Project cycle, including planning, implementation and monitoring of activities. Not only did they participate at all stages, but they were also included in the decision-making process. In addition, many of the trainings RHDP held for women did much to increase women's knowledge on pertinent issues, which consequently also played a part in empowering them.

Activities that played a significant role in empowering women in the communities included:

- Training that focused on the Birth Preparedness Package for safe delivery to reduce maternal and neonatal deaths.
- Provision of training and orientation on: sexual and reproductive health rights; domestic violence and uterine prolapse issues, and social inclusion.
- Enhancing their programme planning capacity through various meeting and workshops.
- Organising exposure visits to health facilities in order to exchange knowledge and experience and ultimately translate that knowledge to demand for quality health services at their respective health facilities.
- Provision of leadership management and proposal writing training to enhance the capacity of women to advocate for inclusion of health activities and programmes that target women and disadvantaged people in VDC plans, and ensure that local resources are mobilized and allocated for their implementation.
- Organising Appreciate Inquiry training to sensitise women on health issues and bring about positive thinking in the development of their own community groups.

As a result of the aforementioned activities, very clear changes and improvements were observed. Specifically, because of these efforts to empower women, they are now playing a vital role in society as change agents by mobilizing local resource and groups in health awareness programmes and are seen as activists not only in their respective communities, but also at the district level.

Examples of some tangible changes observed include:

- MGNs distinct role in preparing local health plans and demanding they be included in VDC plans and also participating in and advocating for the VDC council to allocate VDC budgets as per the Block Grand Guideline to implement health activities that target the disadvantaged, women and poor.
- Mobilisation by MGNs to reduce gender based violence, by getting support from the police to stop actual cases of violence.
- Development of MGNs strategies and visions based on what they learned during organisational development training.
- MGNs advocating for women's reproductive health right and access to services by disadvantaged groups as a fundamental human right.
- Increases in the participation of women in different community forums/ committees, etc.
- MGNs playing a major advocacy role to ensure good governance and social inclusion.
- Recognition by stakeholders that MGs and MGNs are legitimate forums for women and women's issues at the district level, and are agents of change for overall district development.

INVOLVEMENT OF LOCAL BODIES FOR 'RURAL HEALTH'

RHDP's working approach ensured the meaningful involvement of local bodies for 'rural health'. It started from the formation of HFOMCs, and District Advisor Committees (DAC) where the committees are chaired by the VDC and DDC Chairpersons to ensure they are involved in each step of the project implementation i.e. planning, implementation and resource allocation, and programme monitoring and evaluation. RHDP has ensured the participation of every political party in the HFOMC, which has made it easier to ensure health budgets from VDCs. Further more, RHDP provided different capacity building activities to the local bodies through AI training, HFOMC management training, different exposure visits and regular facilitation during HFOMC meetings. RHDP has supported the DDC's District Periodic Plan in Okhaldhunga and Ramechhap where a long-term health plan has been included. This plan has been a guiding principle for the DDC Council in both the districts for planning and budgeting for health. Similarly, through the HFOMC's plan RHDP facilitated to incorporate their health plan into the VDC's Annual Plan.

RHDP's facilitation support to strengthen local bodies has resulted in a substantial amount of money being allocated by the DDCs and VDCs to health programmes. Indeed, it was only after RHDP began its intervention that DDCs/ VDCs began allocating money for health from the block grants provided to them by the government. A total of 94 million rupees from the VDCs was allocated for health activities during Phase VII. It ranges per year from a minimum of 50,000 to 600,000 rupees. Most of the money was primarily used to hire additional ANMs and to run 24 hours birthing centres; co-fund implementation of the Micro Health Project and the EHF and support the FCHVs to carry-out awareness raising activities. To ensure transparency, RHDP helped HFOMCs carry out public audits of these activities.

MOTHERS GROUPS NETWORK (MGN)

The Mothers Groups Network (MGN) is one of the new initiatives initiated by the Health Mothers Groups (MG) and a nominal facilitation support was provided from the project. When the Health Mothers Groups were (re) formed and received different trainings from RHDP, the MG became more active. They started having their own regular meetings, discussed health and social issues, provided backstopping to their concerned FCHVs, and implemented small scale Micro Health Projects with the support of RHDP and local VDCs. At that time they recognised a need for a common forum to strengthen their communication mechanism, coordinate among each other, tap local resources and initiated the formation of the health MGN in, initially, each VDC then in each Ilaka.

This is the first initiative in Nepal to form MGNs, with representatives from all MGs in the VDC. They work in close coordination with VDCs, HFOMCs, local health facilities and other community-level institutions and have become well recognised in Ramechhap and Okhaldhung for their health and safe motherhood promotion and actions against domestic violence. The formation of MGNs brought about a lot of positive transformations, not only in improving health indicators but also for social transformat ion. MGNs have become change agents and played a significant role in raising awareness on DV and UP, developing innovative activities, and putting pressure on VDCs to ensure local resources were mobilised and allocated for health activities, such as the hiring of ANMs and the establishment of 24-hour birthing centres.

SAFE MOTHERHOOD FUND

The HFOMC at Rampur VDC, Okhaldhunga began the Safe Motherhood Fund to ensure sustainability of the birthing centre at the Rampur health facility. The idea for the Fund evolved upon the realization that only one ANM is not sufficient to adequately address the demand for safe motherhood services and that at least two are required.

Because the VDC-allocated budget would be insufficient to hire an additional ANM, the HFOMC decided to establish an emergency fund, which could be used not only to hire the required additional human resource, but also during times when there are shortage of medicines such as oxytocin and magnesium sulphate, and for other related emergencies.

The Rampur HFOMC carried out many fund-raising activities in the community to raise money for the fund and also requested RHDP for financial support. Twenty-one other birthing centres in Okhaldhunga have now established the Safe Motherhood Fund, with RHDP providing each with 50,000 rupees.

This activity showcases HFOMCs' will and creativity for optimal functioning and sustainability of health facilities in their communities to ensure that health services can be availed by the people at all times at the present and in the future.

PROMOTION OF LOCALLY INITIATED PRACTICES

Nepal is enriched with many traditional practices in promoting health of postpartum mothers and new borne babies from ancient period. Among such culturally associated practices, Kosheli Bhet, Jwano ko Jhol, Bhoto Topi conveying greeting and compliments are few instances that have really impact on promotion of children and mothers' health. RHDP has facilitated and supported in up scaling and promoting these practices in the project working districts.

KOSHELI BHET

One of the most successful interventions that the RHDP supported to promote safe motherhood was the Kosheli Bhet, a creative initiative formed by the Sarashwoti MG in Okhaldhunga in 2007.

Upon learning about BPP, Sarashwoti MG came up with an innovative idea where, on delivery, mothers would receive gifts such as mustard oil, spices, ghee, chicken and other nutritious food items on behalf of their MG. However, in order to receive this kosheli or gift, the mothers would have had to follow the advice recommended in the BPP, especially the four routine ANC check-ups, delivery at a health institution and PNC check-ups to ensure continuum of care for both mothers and babies.

This intervention has done much to increase ANC visits and safe delivery practices by the target population, as well as make the community take on greater responsibility to protect the lives of mothers and newborns.

Because of its success, Kosheli Bhet was rapidly scaled-up by 2008 in all three project districts, with significant support from RHDP.

JUWANO KO JHOL

To promote institutional delivery and 24-hour birthing centres, MGs carried out the juwanoko jhol, an innovative activity which cleverly institutionalised a traditional Nepali custom. If women delivered at a health facility, the MGs provided them with juwanoko jhol (a soup made of carom seeds), traditionally given to post-partum women throughout Nepal. This conveys the message that, in addition to receiving care customarily received at home there is also the added benefit of safer delivery at the health institutions. This novel practice helped health facilities support the following objectives:

- Increase in the number of patients using 24-hour birthing centres.
- Create an enabling environment for institutional deliveries.
- Promote and raise awareness on safe motherhood-related messages and information to both mothers and their caretakers.

In addition to financial support from RHDP, local resources and VDC-allocated budget was used to carry out this activity.

BHOTO TOPI

A majority of women who deliver at health facilities, indeed even at home, do not have extra clothing for themselves or their newborns after they give birth. Because hypothermia is a leading cause of neonatal death, keeping newborns warm, dry and clean is a must. To address these facts and at the same time increase institutional deliveries, some MGs began the Bhoto Topi activity in Ramechhap.

The MGs began to provide mothers with a bhoto (Nepali shirt often worn by babies) and topi (hat) for their babies as well as dhotis/ saris for themselves upon delivery. In Ramechhap, the bhoto/ topi and dhoti/ sari are given to mothers at the health facility itself, while in Okhaldhunga; this activity has been linked with Kosheli Bhet and is given to them during Kosheli Bhet events.

This activity has had a two-fold effect – one, it decreased the chances of newborns becoming ill and dying, and two, the incentive of receiving new clothes has encouraged mothers and has resulted in increases in institutional delivery.

RHDP provided 50 percent of the required budget for this activity, with the rest being mobilized through local resources.

Photo Courtsey: **Mr. Bal Krishna Sharma**

LESSONS LEARNED

TRAINING AND STRENGTHENING HFOMCS, MGNS AND MGS meant they were able to demand that the health activities and programmes outlined in their plans be incorporated and included as major components of DDC and VDC periodic plans. These community groups' active involvement has made a clear difference in the allocation of VDC budgets for health programmes and activities. MGs and MGNs in particular have played a vital role to ensure that DDC/ VDC planned health activities target women and discriminated groups. Establishing MGNs in other sectors can also have a tremendous impact on strengthening governance in general.

TIMELY PREPARATION AND SHARING OF THE PROJECT'S EXIT STRATEGY with stakeholders and communities during district-level workshops and orientation programmes was essential for building a common understanding on RHDP's exit plan and for ensuring commitment to sustainability of the project's many activities and programmes.

THE INCREASE IN THE NUMBER OF WOMEN BENEFICIARIES is attributed in large part to the involvement of MGs, MGNs and FCHVs, which - because of their female constitution and institutionalisation - indicates that this trend will likely sustain beyond project closure.

WOMEN WERE EMPOWERED, HAVE BECOME AGENTS OF CHANGE in their communities and are playing an influential role to make social transformations, by being increasingly more involved in activities that go beyond health. This includes their role in raising awareness about UP, DV, and participating in local level meetings and other activities in the districts.

MALE PARTICIPATION THROUGH COUPLES TRAINING ON BIRTH PREPAREDNESS brought about positive changes in the health seeking behaviour of communities - particularly among disadvantaged groups – especially with regards to ANC visits, and providing pregnant women with nutritious food and preparedness to manage possible complications. In addition, their participation in DV related orientation helped them become more understanding and supportive of the needs of women.

PARTNERING WITH LOCAL NGOS AT THE BEGINNING OF THIS PHASE INSTEAD OF THE LAST YEAR, would have meant better ownership over RHDP interventions by the NGOs as well as more time to orient and capacitate them and update their skills.

THE IMPLEMENTATION OF MHP has done much to increase the communities' confidence in health facilities and the demonstrated capacity of the MGs and HFOMCs indicates that it is possible to sustain these results at the community level, even after RHDP phases out.

COMMUNITIES ARE INTEGRAL TO THE HEALTH SYSTEM, receiving not only health services, but contributing significantly as agents of change. Empowering local communities allows for them to exercise their rights as users of health services, demand appropriate and optimal delivery of health care and services and hold the government responsible and accountable, thus not only playing a significant role in health outcomes but also contributing positively to local health systems strengthening.

Financial Management and Expenditure

The financial expenditure of RHDP has increased positively in successive years from fiscal year 2009-10 to 2012-13 (Figure 8). A total budget of 4 million CHF was allocated for Phase VII of RHDP and an expenditure of 117% (NRs 303,320,786) was invested to complete planned activities. The reasons for over expenditure were due to high demand from communities and also adequate budget as a result of exchange gain.

In overall, high volume of budget (131%) was invested on safe motherhood related activities, strengthening health service delivery sites such as birthing centers (161%) and support in consolidation and sustainability aspects (176%) for capacitating mother's groups (MG), mother group networks (MGN), disadvantaged groups, and female community health volunteer (FCHV) so that afore mentioned health promoters and health service providers are able to provide quality of health care at the community level in birthing centers and health facilities. On the other hand, relatively less budget was utilized in Adolescent Sexual and Reproductive Health (ASRH) i.e. 61% and 62% budget was used in Gender Based Violence and Uterine Prolapsed issues. Since GoN started allocating budget for uterine prolapsed operations during this phase, and project funds were utilized only for providing transportation cost to operation clients, particularly from disadvantaged community.

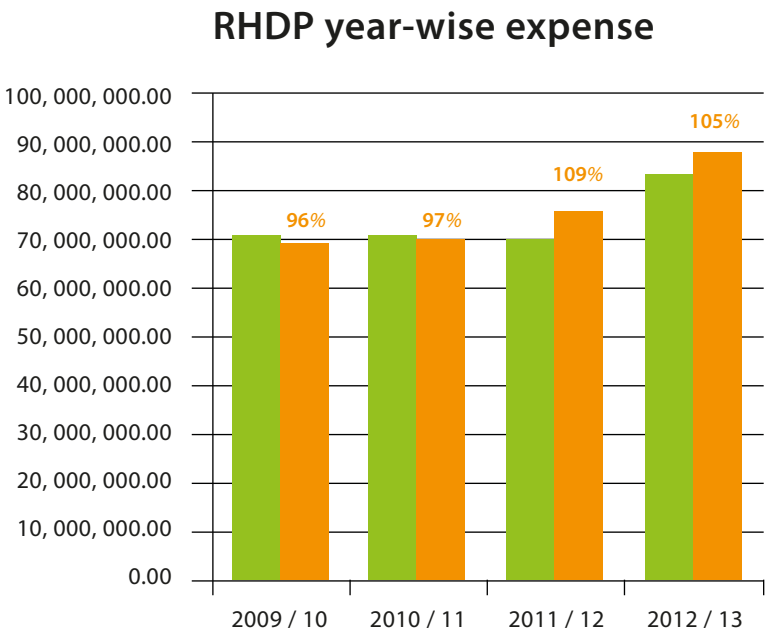


Figure 8

Fund Flow Analysis (FFA); a very useful tool to monitor the trend of cash flows and benefits of project activities towards important variables such as geographical, social, and economy and RHDP is using FFA as a project monitoring and steering tool for ensuring the maximum utilization of funds. Analysis of FFA results for the past 4 years during Phase VII showed that disadvantaged group (DAG), women and poor community were benefitted hugely from RHDP's fund. For instance, FFA of 2009-10 demonstrates from beneficiaries' perspective, 29% DAG and 24% non-DAG people benefitted from RHDP supported activities, which remained consistent up to 2011-2012 at 24% for DAG and 24% for non-DAG. In 2012-13, DAG beneficiaries decreased to 20% and non-DAG remained at 24% as more investment was on sustainability related activities and knowledge management.

In fund receiver's perspective, 24% discriminated community people received fund out of total cash flows while 76% non-discriminated communities received the remaining fund in 2009-2010 which was increased to 42% for discriminated and decreased to 58% for non-discriminated people in 2012-2013 as major part of the fund was utilized for funding and collaborating with mother's group and mother's group network to run safer motherhood activities. In terms of geographical coverage, 54% budget was spent in district and rural areas and only 46% budget was used in central level in 2012-2013, which is consistent with 56% in rural/district and 44% in central in 2009-2010. Similarly, from gender beneficiary perspective, 70% female and 30% male beneficiaries benefitted from RHDP interventions in safe motherhood related programs in 2012-13. Which was similar in 2009-10 as the beneficiaries remained 73% for female and 27% for male. Furthermore, in 2012-2013, 30% female and 70% male benefitted from local health governance promotional related activities that remained 40% for female and 60% for male in 2009-2010.

- Although behaviour pertaining to safer delivery practices has improved in the project areas, it remains to be a widely adopted practice, especially among the poor and discriminated. In addition, challenges such as preference for home deliveries with traditional birth attendants, difficulty travelling to health facilities and unequal gender relations at the household level remain, hampering coverage of institutional delivery. More awareness-raising and behaviour change communication efforts are needed, not only on safe motherhood but on gender equality, and related social issues to create and sustain changes in the health-seeking behaviour of the wider community.

- Despite the success of activities such as Khosheli Bhet, Juwanoko Jhol, Bhoto Topi, they have yet to be fully institutionalised and therefore require continued support from MGs, MGNs, HFOMCs as well as DHOs to ensure they are sustained.

  HFOMCs and MG networks have begun contributing to the EHF, but further funding will be required to match the demand. To ensure that the fund is sustained in the long term, more fund-raising and management initiatives are necessary.

- While the awareness levels of adolescents increased as a result of the ASRH component, this was not complemented in availability of adolescent-friendly health services. In addition, it was found that much of the resources available in the youth corners at health facilities were not tailored for the needs of adolescents. To address this, it is important that the health facility in-charges and health workers that received training on ASRH translate their new-found knowledge into practice and take a proactive role to ensure that the youth corners have the necessary materials.

- Despite the increase in the number of 24-hour birthing centres and the consequent increase in institutional deliveries, it remains very much in isolation – there are no linkages with higher level health facilities, which limit opportunities to address difficult cases, emergencies and arrange for referrals. It is essential that there are referral linkages with higher level facilities, which would not only create a more enabling environment for the SBAs, but also ensure that mothers receive comprehensive care.

- The hiring of ANMs locally has had a vital role in the increase in safer delivery practices by the community. However, their retention may become a challenge in the future because they are hired by the government on one-year contracts. As such, the government should consider multi-year contracts for ANMs to ensure continuity of the valuable service they provide.

ABBREVIATIONS

AI	:	Appreciative Inquiry
AIDS	:	Acquired Immunodeficiency Syndrome
ANC	:	Antenatal Checkup
ANM	:	Auxiliary Nurse Midwife
ASRH	:	Adolescent Sexual and Reproductive Health
BPP	:	Birth Preparedness Package
CPR	:	Contraceptive Prevalence Rate
DAC	:	District Advisory Committee
DDC	:	District Development Committee
DHO	:	District Health Office/ District Health Officer
DOHS	:	Department of Health Service
DV	:	Domestic Violence
EHF	:	Emergency Health Fund
FCHV	:	Female Community Health Volunteers
FHD	:	Family Health Division
HFOMC	:	Health Facility Operation and Management Committee
HIV	:	Human Immunodeficiency Virus
IEC	:	Information, Education and Communication
IUCD	:	Intra Uterine Contraceptive Device
LDO	:	Local Development Officer
MDG	:	Millennium Development Goals
MG	:	Mother Group
MGN	:	Mothers Group Network
MHP	:	Micro Health Project
MOHP	:	Ministry of Health and Population
PAC	:	Project Advisory Committee
PHC MCH FP	:	Primary Health Care Mother Child and Family Planning Project
PNC	:	Postnatal Checkup
RHDP	:	Rural Health Development Project
SBA	:	Skilled Birth Attendant
SDC	:	Swiss Agency for Development and Cooperation
STI	:	Sexual Transmitted Infection
UP	:	Uterus Prolapse
VDC	:	Village Development Committee
VSC	:	Voluntary Service Contraception

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