

**STRATEGIC OBJECTIVE II (SO II) CLOSE OUT REPORT
USAID NEPAL MISSION**

SO Name: **Build Capacity of Critical Institutions**
SO Number: **II**

Approval Date: August 28, 2006
Completion Date: September 30, 2012

Geographic Area (Nationwide or Region Specific): Nationwide

Figure I. Map of SO II Health Program and Activities



Bilateral Agreement Number: **Strategic Objective Grant Agreement (SOAG) No. 367-011**

Implementing Ministries/Agencies under the Bilateral Agreement: **Government of Nepal (GON) Ministry of Health**

Principal Implementing Partner: John Snow Inc. (JSI) (the full list of partners is found in Appendix II)

Major Counterparts: **Government of Nepal (GON) Ministry of Health**

Table I. Life of SO11 Funding Source, demonstrates the breakdown by type of funding sources and contribution amounts from GON.

USAID/Nepal
Summary Pipeline Report of Expired SOAGs
As of 03/08/2014

| Descriptions | | Start Date | End Date | Obligated Amount (USD) | Expended/ Disbursed Amount (USD) | Unliquidated/ Pipeline (USD) |
|--------------|-----------------------|------------------|------------------|------------------------|----------------------------------|------------------------------|
| SO11 | Health Program | 8/28/2006 | 9/30/2012 | | | |
| | CD/GH-C Funds | | | 15,236,506 | 15,216,302 | 20,204 |
| | AI Funds | | | 135,040 | 135,040 | 0 |
| | CD-POP/GH-C-POP Funds | | | 17,264,397 | 17,254,709 | 9,688 |
| | Total | | | 32,635,943 | 32,606,051 | 29,892 |

**STRATEGIC OBJECTIVE II (SO II) CLOSE OUT REPORT
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ACRONYMS

| | |
|---------|--|
| ADS | Automated Directives System |
| AED | Academy for Educational Development |
| AHW | Assistant Health Workers |
| AMDA | Association of Medical Doctors of Asia |
| ANC | Antenatal Care |
| ANE | Asia and Near East |
| ANM | Assistant Nurse Midwives |
| AO | Assistance Objective |
| AOR | Agreement Officer Representative |
| AR | Annual Report |
| ARI | Acute Respiratory Infection |
| ART | Anti - retroviral Therapy |
| ARV | Anti-Retroviral |
| ASHA | Advancing Surveillance, Policies, Prevention, Care & Support to Fight HIV/AIDS |
| CA | Constituent Assembly |
| CBAC | Community Based ARI and CDD |
| CBC | Communication and Behavior Change |
| CB-NCP | Community-Based Neonatal Care Package |
| CB-IMCI | Community Based Integrated Management of Childhood Illness |
| CB-MNC | Community Based Maternal and Newborn Care |
| CBO | Community Based Organization |
| CDD | Control of Diarrheal Diseases |
| CDR | Crude Death Rate |
| CHD | Child Health Division |
| COFP/C | Comprehensive Family Planning and Counseling |
| CPD | Core Program District |
| CHX | Chlorhexidine |
| CPR | Contraceptive Prevalence Rate |
| CRS | Nepal Contraceptive Retail Sales Company |
| CSP | Country Strategic Plan |
| CSO | Civil Society Organizations |
| CSSA | Child Survival Sustainability Assessment |
| CSW | Commercial Sex Worker |
| COR | Contract Officer Representative |
| CYP | Couple Years of Protection |
| CA | Constitution Assembly |
| CPA | Comprehensive Peace Agreement |
| CSO | Civil Society Organization |
| DACC | District AIDS Coordination Committee |
| DDC | District Development Committee |
| DFID | (Britain's) Department for International Development |
| DHS | Demographic Health Survey |

| | |
|---------|--|
| DQA | Data Quality Assessment |
| DPHO | District Public Health Office |
| EPI | Expanded Program on Immunization |
| FCHV | Female Community Health Volunteer |
| FHD | Family Health Division |
| FHI | Family Health International |
| FSW | Female Sex Workers |
| FIU | Financial Information Unit |
| FP | Family Planning |
| FP/RH | Family Planning / Reproductive Health |
| FY | Fiscal Year |
| GAM | Global Acute Malnutrition |
| GAO | General Accountability Office |
| GATE | Girls Access to Education |
| GESI | Gender Equality and Social Inclusion |
| GHI | Global Health Initiative |
| GON | Government of Nepal |
| GDP | Gross Domestic Product |
| GIS | Geographic Information System |
| HEAL | Health Education and Adult Literacy |
| HFOMC | Health Facility Operation and Management Committee |
| HFMSPP | Health Facility Management Strengthening Program |
| HF | Health Facility |
| HIV/STI | Human Immunodeficiency Virus/Sexually Transmitted Infections |
| HMIS | Health Management Information System |
| HSSA | Health System and Services Assessment |
| IBBS | Integrated bio-behavioral survey |
| IR | Intermediate Result |
| JSI | John Snow Inc. |
| LHGSP | Local Health Governance Strengthening Program |
| LMD | Logistics Management Division |
| LMIS | Logistics Management Information System |
| LQAS | Lot Quality Assurance Sampling |
| MARPs | Most at Risk Populations (groups) |
| MCHW | Maternal and Child Health Worker |
| MD | Management Division |
| MDG | Millennium Development Goal |
| M&E | Monitoring and Evaluation |
| MNCH | Maternal, Neonatal and Child Health |
| MIS | Management Information System |
| MNH | Maternal and Neonatal Health |
| MOF | Ministry of Finance |
| MOH | Ministry of Health |
| MOHP | Ministry of Health & Population |
| NFHP II | Nepal Family Health Program II |
| NHSP 2 | Nepal Health Sector Program 2 |

| | |
|--------|--|
| NHTC | National Health Training Center |
| NRCS | Nepal Red Cross Society |
| NTAG | Nepali Technical Assistance Group |
| NVAP | National Vitamin A Program |
| NA | Nepal Army |
| NC | Nepali Congress |
| NCASC | National Center for AIDS and STD Control |
| NGO | Non-Governmental Organization |
| NHTC | National Health Training Center |
| NRM | Natural Resource Management |
| NTAG | National Technical Advisory Group |
| ORS | Oral Rehydration Salt |
| ORT | Oral Rehydration Therapy |
| PA | Project Agreement |
| PHA | Public Health Analytics |
| PI | Performance Improvement |
| PMTCT | Prevention of Mother to child Transmission |
| PMP | Performance Monitoring Plan |
| PPD | Program and Project Development |
| PR | Prerequisite Result |
| PPH | Postpartum Hemorrhage |
| PPP | Public Private Partnership |
| PWD | People with Disabilities |
| QAWG | Quality Assurance Working Group |
| QOCMC | Quality of Care Management Center |
| SBA | Skilled Birth Attendant |
| SO | Strategic Objective |
| SpO | Special Objective |
| TA | Technical Assistance |
| TFR | Total Fertility Rate |
| TIMS | Training Information Management System |
| TSV | Technical Support Visit |
| TWG | Training Working Group |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VDC | Village Development Committee |
| VHW | Village Health Worker |
| VSC | Voluntary Surgical Contraception |
| WHO | World Health Organization |

Background

Development Context

Nepal remains one of the poorest and least developed countries in the world. While there has been some progress, the economy is not keeping pace with its South Asian neighbors and the country suffers from a poor investment and business climate as well as the lack of a coherent policy and regulatory framework. Though hampered by endemic corruption and political gridlock, there is significant potential, particularly in the hydropower, tourism, and agricultural sectors. Nepal faces multiple climate-related and geological hazards, including floods, landslides, and earthquakes. The traditional caste system and multitude of ethnicities in the country exacerbates development challenges. Despite persistent poverty, human development indicators continue to show marked improvement, and there is a commitment by the government and Nepalese themselves — to progress, tolerance, and resilience.

To view Nepal through a short-term lens is to discount the immense changes — social, political, and economic — which have swept the country over the last 60 years and particularly over the last decade. The centuries-old system of monarch rule ended in 1951 with the establishment of a cabinet system of government. A first wave of reforms in the 1990s created a multiparty democracy within the framework of a constitutional monarchy. The 10-year civil war between Maoist insurgents and government forces weakened the country's fragile democratic systems. Peace negotiations between the Maoists and government officials ended the conflict in a November 2006. At the end of this SO, a definitive constitution and election remain elusive. While, there is reason to be positive about Nepal's future and it's potential, hope must be tempered by the realities, uncertainties, and setbacks that are ultimately part of a fundamental democratic, social, and economic transition.

Genesis of SO I I/Background

Prior to 2006, Nepal's health program operated under SO2 (Reduced Fertility and Protected Health of Nepalese Families). As Nepal moved to the future in a post conflict era, health under SO2 was divided into two separate strategic objectives, SO9 (HIV/AIDS) and SO I I (Health and Family Planning). SO I I focuses on building capacity in the health sector at the central, community, and delivery levels.

Nepal has been a model of innovative health programming internationally and has achieved remarkable progress in many areas through the public health system. Despite these impressive achievements, at the time of developing SO I I, the Nepal Demographic and Health Survey (NDHS) showed that much work remained to be done in order to achieve the Millennium Development Goals (MDGs). Although the contraceptive prevalence rate had increased steadily, fertility remained relatively high with a Total Fertility Rate (TFR) of 4.1 (2001 NDHS), as did unmet need for family planning. The high rates of labor migration of males and often unpredictable return dates made family planning service needs and planning unpredictable for many families.

Under five mortality fell from nearly 160 per 1,000 live births in the late 1980s to 91 per 1,000 live births in the late 1990s (NDHS 2001). Much of this mortality reduction is thought to be due to programs such as Vitamin A supplementation, community based integrated management of childhood illness (CB-IMCI), Oral Rehydration Therapy (ORT), and childhood immunizations, all of which required continued monitoring and expansion over the course of this SO.

In 2001, most births (nearly 90%) took place at home and most were attended by relatives or neighbors. Attempts to increase use of skilled birth attendants by placing Auxiliary Nurse Midwives (ANMs) and Maternal and Child Health Workers (MCHWs) in rural areas, training to improve their skills, and measures to increase demand had limited impact. However, a number of rural facilities demonstrated their ability to improve their expertise as Basic and Comprehensive Emergency Obstetric Care facilities, sometimes with a positive impact on the number of deliveries and emergencies referred to them, which influenced the design of this SO. Maternal mortality remained high (539/100,000 live births) in 2001 and the reduction in under five mortality masked the higher proportion of under five deaths due to neonatal causes, resulting in neonatal death becoming an increased focus under this SO. Demonstrated, effective community-based maternal and newborn care models were sorely needed to improve maternal and newborn health and therefore incorporated into this SO design.

Methodology

As stated in **ADS 203.3.11** (dated 09/01/2008), the guidance for Assistance Objective (AO) Close Out Reports clearly indicates that it is mandatory that "AO Teams must produce a brief close out report for each of their AOs when the AO is either completed or terminated. The intended audience for the AO close out report includes development professionals in USAID and partner organizations that seek to learn from broader Agency experience and apply this experience in planning or assessing other development efforts. The AO close out report should summarize overall experience in achieving intended results as well as provide references to related materials and sources of information".

The methodology used for this SO Close Out Report includes: obtaining and reviewing relevant USAID and outside data, documents and sources of information (SOAG, AAD, Result Frameworks, Contracts, Performance Management Plans, Portfolio Reviews, evaluations, assessments and reports); conducting interviews and SO Team level discussions with USAID staff (i.e. program managers past and present) and implementing partners (IPs) for their institutional knowledge and reflections on lessons learned, sustainability and linkages to other SOs; utilizing data and information to draft report; and publishing the report on USAID's Development Education Clearinghouse (DEC). The SO Close Out team identified several major challenges, including difficulties locating final reports for projects and programs, the time lapse between the programmatic close-out and the writing of the SO Close Out Report and the loss of institutional knowledge due to staff turnover.

Results Framework During the Life of SO

USAID/Nepal Mission prepared a new Fragile States Strategy that was approved in 2006. This strategy divided the health activities into two separate objectives and under the Mission's Fragile State Strategy, HIV/AIDS activities were placed within the "Enhance Stability and Security Strategic Objective 9," and family planning, maternal and child health and other public health threats were placed within the "Build Capacity of Critical Institutions Strategic Objective 11." Please refer to *Figure 3. USAID/Nepal Objectives and Program Evolution: 1996-2010* to see the evolution of SO2 to SO9 and SO11.

The graphical representation on the following page illustrates the revised SO9 Results Framework with the corresponding indicators.

USAID/NEPAL S0 11 RESULTS FRAMEWORK

STRATEGIC OBJECTIVE 11

Build Capacity of Critical Institutions

Expected Results:

- SO 11.1 Government leadership and management capacity for basic health and social services strengthened
- SO 11.2 Basic health and social services delivered at scale through improved system and development of scalable program models
- SO 11.3 Community capacity to access and manage basic health and social services improved

PREREQUISITE RESULT 11.1

Increased use of quality family planning services

Indicators:

- 11.1.1 Modern contraceptive prevalence rate
- 11.1.2 Annual couple years of protection (CYP), public sector
- 11.1.3 Annual couple years of protection (CYP), private sector
- 11.1.4 Percentage of health facilities that maintain availability of 7 key commodities in program districts year-round
- 11.1.5 Number of people trained in FP/RH with USG supported funds
- 11.1.6 Number of people that have seen or heard a specific USG-supported FP/RH message

PREREQUISITE RESULT 11.2

Increased use of selected maternal and child health services

Indicators:

- 11.2.1 Percentage of children (6-59 months) nation-wide who received a Vitamin A capsule during the preceding round of supplementation (annual mini-surveys)
- 11.2.2 Percentage of children (6-59 months) nation-wide who received a Vitamin A capsule during the preceding round of supplementation (5-yearly DHS)
- 11.2.3 Percentage of expected pneumonia cases in children (0-59 months) treated by community health workers and health facilities in program districts where community-based pneumonia treatment has been initiated.
- 11.2.4 Percentage of children presenting to health workers (VHW/MCHW/FCHV) with pneumonia symptoms who receive appropriate treatment in program districts where community-based pneumonia treatment has been initiated
- 11.2.5 Percentage of children under five years with diarrhea in preceding 2 weeks who received oral rehydration therapy including ORS or increased fluids
- 11.2.6 Percentage of births attended by skilled attendant
- 11.2.7 Number of postpartum/newborn visits within 3 days of birth in USG-assisted programs
- 11.2.8 Number of newborns receiving antibiotic treatment for infection from appropriate health workers
- 11.2.9 Number of people trained in child health & nutrition through USG-supported health area programs
- 11.2.10 Number of people trained in Maternal-Newborn health through USG-supported programs
- 11.2.11 Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs

Summary of Overall Impact at SO and IR Levels

Strategic Objective Level Impact

SO 11: Build Capacity of Critical Institutions

Indicators: (Intermediate Results)

- IR 11.1 Government leadership and management capacity for basic health and social services strengthened
- IR 11.2 Basic health and social services delivered at scale through improved systems and development of scalable program models
- IR 11.3 Community capacity to access and manage basic health and social services improved

SO 11 Performance Goal: Expand the depth, reach and impact of maternal, newborn, child health and family planning policies and services while strengthening institutional capacity, governance, equitable access and community participation in health and social services.

Program/Projects: Nepal Family Health Program II, ACCESS, ACQUIRE, DELIVER, CRS

Overall, SO 11 met and exceeded all targets under its primary planned objectives. Programmatic and financial support contributed to strengthening central and local capacity and improving health and family planning outcomes.

Build Capacity of Critical Institutions (Health)

Major results at the SO level are presented below:

- With the support from USAID, Nepal is on track to meet MDG 4 and 5, reducing child mortality and improving maternal health. Child mortality and maternal mortality rates have declined in response to concentrated efforts in CB-IMCI, innovations in prevention of maternal and child mortality (CHX, Vitamin A, ORT, misoprostol, calcium, MgSO₄) as well as strides in family planning.
- USAID's family planning and reproductive health (FP/RH) program contributed to improving the health status of women and their families, helping Nepal achieve sustainable improvements in the well-being of its population. Government ownership over family planning activities was apparent as the GON now pays for 74% of total costs for family planning, up from less than 5% in past years. However, while the total fertility rate has continued to decline, the contraceptive prevalence rate (CPR) has slowed with only modest improvements in recent years. More analysis and targeted approaches focusing on the hardest-to-reach populations will be needed to continue and strengthen family planning coverage.
- USAID helped introduce innovative intensive monitoring for CB-IMCI that brought attention to gaps in service delivery while improving performance. USAID also provided support for expansion of community-based newborn care package (CB-NCP), contributing to improved knowledge and behaviors for maternal and newborn care and increased institutional deliveries.

- USAID continued to support the 48,000-strong cadre of Female Community Health Volunteers (FCHVs). FCHVs were provided with additional trainings and skills, especially in the area of family planning, maternal health and child health. In conjunction with the GON, USAID developed training materials on a new FCHV fund to cover medical expenses and other costs and USAID trained 1,225 FCHV fund management committee members in the use of these funds. Today, three-quarters of the VDCs/communities in NFHP II districts provide funds to support FCHVs, largely through cash contributions. A majority of Female Community Health Volunteer (FCHV) are accessing the FCHV Fund in all 75 districts.
- Social inclusion of all ethnic, religious, and social groups improved under SO II. At the same time, the use of health services by Dalits—a disadvantaged group—increased. The ratio of Dalits using health facility services to the number of Dalits living in the catchment areas of SO increased from 1.41 to 1.48. This increase means that more Dalits are seeking health services at public health facilities in their communities. Even with these improvements, there needs to be greater attention to disadvantaged groups in health programming.
- Community literacy training targeted women and girls of disadvantaged groups to promote education and health behaviors. These programs helped women to become empowered to make important health and family decisions, leading to improved outcomes in family planning and health indicators.
- USAID contributed to increased capacity through improved management systems. Over 6,500 Health Facility Operation and Management Committee (HFOMC) members from 612 VDCs in 13 districts received orientation on their role and responsibilities related to the management of local health services. HFOMC experienced increased resource mobilization as well as community participation, including those from disadvantaged groups.
- USAID family planning programs increased couple-years protection (CYP) in the early years of SO II, which is attributed to increases in permanent family planning methods and strengthening logistics systems to ensure availability of contraceptives throughout the year. However, likely due at least in part to the continued outflow of migrants both within Nepal and abroad, CYP fell below expected results in 2010.

Intermediate Results Level Impact

I.R. 11.1 – Government Leadership and Management Capacity for Basic Health and Social Services Strengthened

11.1.1 Support for Family Planning

11.1.2 Maternal, Child and Newborn Health and Nutrition

USAID support has contributed to:

- An increase in the contraceptive prevalence rate (CPR) from 37.3 to 38.2 for any method among all women and among married women it increased from 48.0 to 49.7. These are modest increases and more needs to be done to increase the CPR.

- A reduction in the total fertility rate from 3.1 children per woman in 2006 to 2.6 children per woman in 2011.
- An increase in the MOHP share in funding for commodities from 5% in 2001/2001 to 74% in 2011/2012. This indicated a positive shift in commodity security and less dependence on external donor funds for procurement.
- 72% of MoHP health facilities in 18 core program districts offer delivery services, and among those facilities, 90% offer 24-hour services.
- 1,941 service providers trained in clinical family planning methods and comprehensive family planning services.
- Development of effective management of overall supply chain system and improved availability of family planning (FP) and maternal and child health (MCH) commodities and essential drugs at service delivery sites.
- With the help of USAID, the MOHP developed the National Family Planning Strategy, which provides clear guidelines and options for future family planning programming to meet FP needs.
- Establishment of Training Working Groups (TWG) which helped to develop integrated training plans, proper reporting and recording of training data, and better coordination among stakeholders.
- The MoHP adopted innovations, based on successful pilot studies, in reducing maternal and newborn mortality. Misoprostol and chlorhexidine (CHX) were rolled out in 27 districts to reduce postpartum hemorrhage (PPH) and newborn sepsis.

I.R. 2.2 – Basic Health and Social Services Delivered at Scale through Improved Systems and Development of Scalable Program Models

USAID support has contributed to improved systems and service delivery in Nepal as illustrated below:

- Significant improvements were observed in pregnant women receiving antenatal (ANC) counseling and the full course of iron tablets (except when national iron stock-outs occurred), institutional deliveries, and the use of misoprostol in home deliveries. Monitoring data also showed an increase in FCHVs contacting pregnant and postpartum women to promote service use. The percentage of women receiving antenatal visits nearly doubled during the life of the SO, with 50% of women receiving four or more antenatal visits. Skilled birth attendants (SBA) at time of delivery also almost doubled in the past five years to 36% of all births. Furthermore, 44% of women received a postnatal check-up within two days after birth.
- Fewer than 25% of health facilities experienced stock outs for essential drugs; and less than 2% of facilities witnessed a stock out of family planning commodities
- Improved Logistics Management Systems (LMS) for better commodity security, improved data systems and training in LMS.
- Continued support of the national Vitamin A supplementation program, including emergency logistics backstopping, community mobilization, and monitoring and increased efforts in urban areas where coverage is lower. Coverage remained high

through the life of SOII with vitamin A supplementation among children 0-5 years reaching 90.4%, according to the 2011 DHS.

I.R. 2.3 – Community Capacity to Access and Manage Basic Health and Social Services Improved

USAID contributed to increased community capacity in the areas of maternal, newborn and child health and family planning as illustrated below:

- Supported the training of over 22,000 FCHVs in family planning and maternal and child health services. In rural and marginalized groups, USAID contributed to the FP and interpersonal communication skills training of 1,114 FCHVs.
- Trained a total of 93,489 health volunteers, service providers, and community leaders, contributing to strengthened quality health care services at the community level.
- Increased and strengthened support for the FCHVs through a revised strategy which included the establishment of the FCHV fund for income generation activities, leading to more empowered FCHVs.
- Expanded CB-IMCI to all 75 districts by the end of 2010. CB-IMCI supported better management of care for children with pneumonia, diarrhea, malaria, measles, and malnutrition. This resulted in a 10% increase from 2006 to 50% of children under 5 being treated for diarrhea with oral rehydration therapy (ORT) including oral rehydration salts (ORS) or increased fluids. Monitoring data also showed that FCHVs are using correct case management of pneumonia in over 95% of cases, and 70% of those cases treated at the community level, 52% were treated by FCHVs.
- With the help of USAID, the MoHP continued to roll out the community based CB-NCP, expanding into 10 new districts and providing additional trainings for FCHVs and others. CB-NCP added sepsis and birth asphyxia to its portfolio to address the spectrum of contributors to neonatal mortality. Under 5 mortality decreased from 61 to 54 deaths per 1,000 live births. At the conclusion of the SO, 95% of cases were handled correctly according to CB-IMCI guidelines.
- A total of 10,024 women of reproductive age completed health education and literacy (HEAL) classes, including women of disadvantaged groups, and a total of 4,393 adolescent girls participated in Girls Access to Education (GATE) during the program period and most were subsequently enrolled in formal schools.
- Trained 93,489 health volunteers, service providers, and community leaders, including 27,120 in child health and nutrition, 721 in MNH, 1,941 in FP/RH.

Summary of SO Programs & Projects

Refer to *Appendix II: Summary of SO Programs & Projects* for a list of activities with a short description, funding amount, start and end dates, prime implementing organizations, USAID program manager and documents.

Sustainability – Prospects/Impacts/Interventions, Principle Threats/Challenges and Linkages/Missed Opportunities

Prospects/Impacts/Interventions

The various interventions under SO 11 include promising practices that strengthened the GON clinical management and delivery system to provide care and support to Nepalese families in health and family planning.

Principle Threats/Challenges

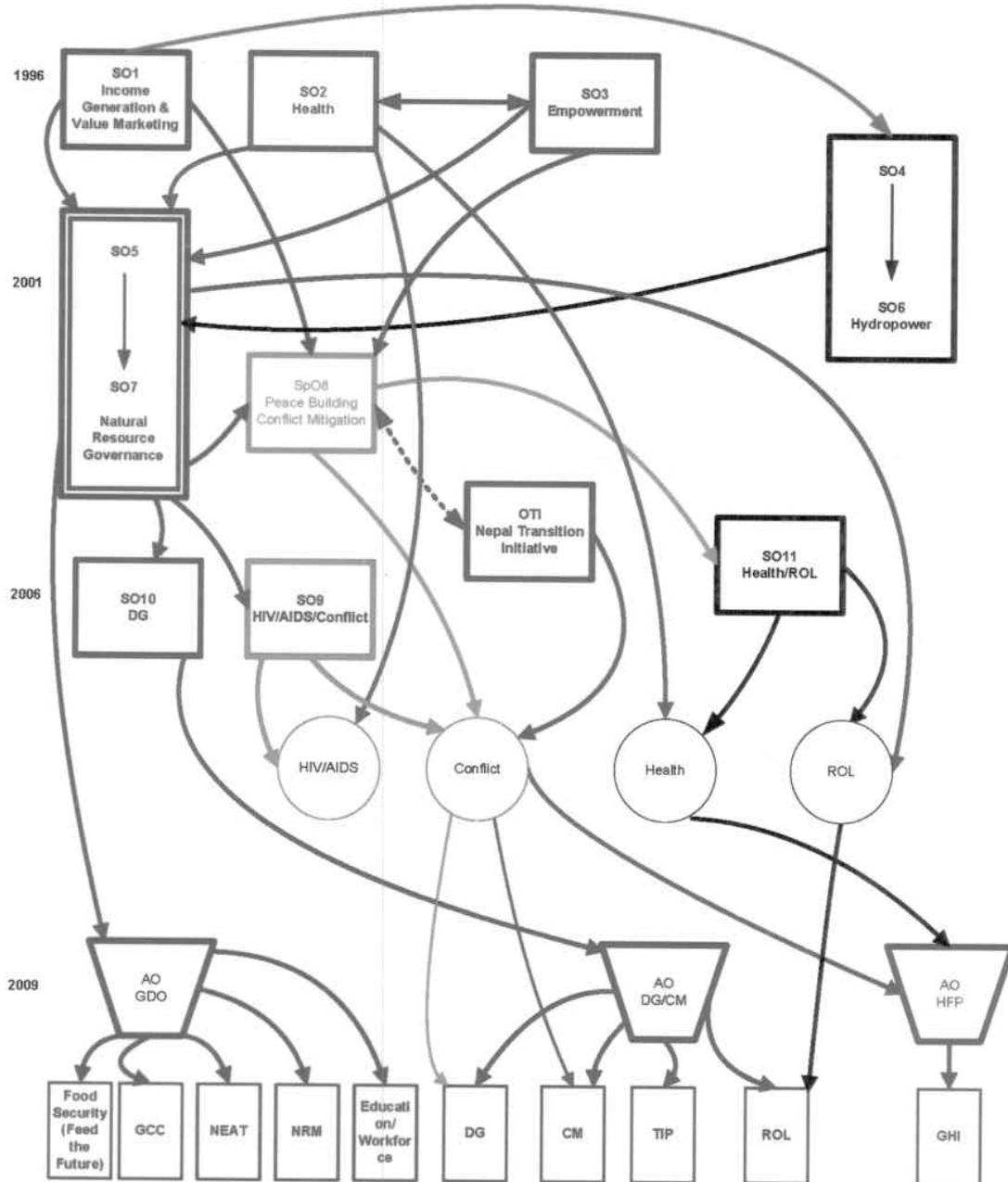
- SO 11 operated under post conflict times with many uncertainties; however, health programs continued uninterrupted during this time period.
- During the post conflict years, multiple political parties arose, each capturing different levels of influence at local levels. Additionally, local elections were not held for many years, leaving vacancies at the district level. The vacancy of chairpersons impacted the ability to coordinate with VDC's in project implementation. The lack of a direct, elected person of contact was a challenge to working with VDCs.
- Retention of trained staff at district level continued to be problematic for health/clinical providers as well as store keepers in health commodity warehouses. Staff were reassigned constantly, often leaving gaps in trained staff coverage.
- The overall terrain and lack of roads continued to be problematic in achieving greater service coverage.

Linkages between SO 11 and other SOs/:

- SO 11 and SO 9 were both derivatives of the previous SO2. During the post conflict period, SO 2 was divided into two separate objectives, SO 9 “*Enhanced Stability and Security*”, IR 9.1 “*Enhanced prevention, care and treatment in support of the Emergency Plan*” and SO 11 “*Build Capacity of Critical Institutions*”, IR 11.1 “*Increased use of quality family planning services*” and IR 11.2 “*Increased use of selected maternal and child health services*” to meet HIV/AIDS, maternal-child health and family planning indicator goals in Nepal; together, SO9 and SO 11, cover the full range of health programming.
- Large-scale migration due to the conflict resulted in an intensified HIV/AIDS response and encouraged SO 9 and SO 11 to be more strategic with focused interventions and coordinated planning to target along highway and urban areas of migratory routes.
- Initiated by SO2, governance and institutional capacity building were carried forward by SO9, SO 11 and the current AO through increased community involvement in health facility management.

As illustrated in the Figure 3. USAID/Nepal Objectives and Program Evolution: 1996-2010, SO2 served as pilot and foundational elements of SO9, SO11 and evolution towards AO HFP.

USAID/NEPAL OBJECTIVES & PROGRAM EVOLUTION: 1996-2010



Key Lessons Learned

GON and Community Ownership:

- Reached communities through community-centric approach and training to develop trust and paved way for other opportunities and programming.
- The Government contribution towards the purchase of family planning commodities is important for ownership of both public health problems and solutions.
- Focus on policy change at the national level is crucial, and requires active leadership, strong personal relations, mutual respect, and established reputation for policy changes to be effective and lasting.
- Community level engagement is critical, as well as intensive focused programs, community based approaches should be strengthened, use the existing platforms to introduce new interventions

Disadvantaged/Marginalized Group Inclusion Central for All Programming

- Women have a synergetic role as programs focusing on women groups, education for young girls and women adult literary, strengthening technical skills and empowering female health workers led to improving women's status in society, financial independence and decision making powers.
- The significant improvement in MCH is attributable to increased women's education, women's financial status and family planning.
- More specific and targeted approaches are needed to reach disadvantaged populations, including migrants and spouses of migrants.

Focused and Undiluted Programming:

- Improved the logistics management information system to deliver services and commodities to communities.
- While great improvements have been made in family planning and maternal and child health, CPR and maternal mortality rates have remained relatively stagnant over the past 5 years. To continue to increase FP coverage and lower maternal and neonatal mortality rates, more focused and specific programs are needed, with specific attention at the district level to increase ownership and participation.

Innovations

- Integrate technology into health programming. This can be done with television, mobile phones, web-based systems.
- Continue to find ways to scale up innovative approaches in the health sector.

Sustainability/Capacity Building

- Include a sustainability plan into project design, providing means for projects to continue after funds go away.
- Evaluate costs before implementation and scale up. Implement only those programs that are evidence based, tested and verified, scalable with modest costs. Programs or interventions may be effective, but if they are too expensive, then they will not be sustainable over time.

- Capacity Building is a continuous process and needs consistent effort over time, including training, coaching, etc.

Monitoring Programs

- A strong monitoring system is extremely valuable to understand the success of a program/project. It can strengthen overall implementation and help fill gaps and prepare for future programs. Monitoring helps inform the government and other donors about the program and results. Include monitoring plans into all program design plans.
- Program and data coordination. Use existing data collection methods (DHS) to keep methods synchronized.

Appendix I: SO Level Performance Indicators

Performance Data Table SO 11 from Nepal PMP Report 2008. In 2008 to fulfill the agreement of reporting on uniform Maternal-Child Health (MCH) indicators, thirteen new MCH indicators have been added to the PMP 2008 and will also be added to future Operating Plan documents.

| SO or PR | Results Statement | Indicator | Unit of Measure | Disaggregation | Base line Year | Baseline Value | | | | | | | | | | | 2006 Target | 2006 Actual | 2007 Target | 2007 Actual | 2008 Target | 2009 Target | 2010 Target | 2010 Actual |
|-----------|---|---|--|----------------|----------------|----------------|--|--|--|--|--|--|--|--|--|--|-------------|-------------|-------------|--------------------|---|-------------|--------------------------------|-------------|
| SO 11.1 | Build capacity of critical institutions | Total fertility rate (as reported in the 5-yearly DHS) | Average number of children born to a woman in her childbearing years | No | 1991 | 5.1 | | | | | | | | | | | 3.6 | 3.1 | | NA | NA | NA | NA | 2.6 |
| PR 11.1.1 | Increased use of quality family planning services | Modern contraceptive prevalence rate (as reported in the 5-yearly DHS) | Percentage of married women of reproductive age using modern contraceptive methods | No | 1991 | 24% | | | | | | | | | | | 41% | 44.2 % | | NA | NA | NA | NA | 43.2 % |
| PR 11.1.2 | Increased use of quality family planning services | Annual couple years of protection (CYP) – public sector | Annual protection against pregnancy afforded by contraceptives distributed, as reported in HMIS | No | 1996 | 730,000 | | | | | | | | | | | 1,625,124 | 1,628,156 | 1,709,564 | 1,564,819 | 1,611,763 | 1,644,000 | 1,921,407 | 1,888,345 |
| PR 11.1.3 | Increased use of quality family planning services in the private sector | Annual Couple Years of Protection (CYP) – private sector | Annual protection against pregnancy afforded by contraceptives distributed in the private sector | No | 2002 | 161,002 | | | | | | | | | | | 390,898 | 331,635 | 284,073 | 289,835 | 312,781 | 343,641 | AED's task order ended in 2009 | N/A |
| PR 11.1.4 | Increased use of quality family planning services | Percentage of health facilities that maintain availability of 7 key commodities in program districts year round | Percentage of health facilities | No | 2001 | 20% | | | | | | | | | | | 50% | 77% | 75% | 78% | 55% Lower Percent age reflects 20 new districts | 60% | 65% | NA |
| PR 11.1.5 | Increased use of quality family planning services | Number of people trained in FP, RH with USG funds | Number of people trained | sex | | | | | | | | | | | | | | | | F 5,046 M 5,187 | F 5,700 M 3,315 | TBD | 550 | 505 |

| SO or PR | Results Statement | Indicator | Unit of Measure | Disaggregation | Base line Year | Baseline Value | | | | | 2006 Target | 2006 Actual | 2007 Target | 2007 Actual | 2008 Target | 2009 Target | 2010 Target | 2010 Actual |
|-----------|--|---|--|----------------|----------------|-------------------|--|--|--|--|-----------------------------|--|--|-----------------------------|----------------------------|---------------|---------------|---------------|
| PR 11.1.6 | Increased use of quality family planning services | Number of people that have seen or heard a specific USG-supported FP/RH message | Number of people reached based on equation specific to mode of message | sex | | | | | | | | | | F 18,521,510 M 1,595,286 | F 3,098,841 M 4,055,564 | TBD | 167,000 | 8,153,479 |
| SO 11.2 | Increased use of selected maternal and child health services | Under-five mortality rate (as reported in the 5-yearly DHS) | Number of child deaths per 1000 live births | sex | 1991 | 144 | | | | | 70 disaggregate by sex | 61 Next measure in 2011 (Target is 46) | NA | NA | NA | NA | NA | 54 |
| SO or PR | Results Statement | Indicator | Unit of Measure | Disaggregation | Base line Year | Baseline Value | | | | | 2006 Target | 2006 Actual | 2007 Target | 2007 Actual | 2008 Target | 2009 Target | 2010 Target | 2010 Actual |
| PR 11.2.1 | Increased use of selected maternal and child health services | % of children nationwide who received a vitamin A capsule during the preceding round of supplementation (mini-surveys reported annually) | % of children | No | 1993 | 0% in 0 districts | | | | | 90% or more in 75 districts | (3159089) | 90% or more in 75 districts (3160000) | 98% (3315661) | 92% (3200000) | 92% (3300000) | 92% (3350000) | 92% (3350000) |
| PR2.1 1.2 | Increased use of selected maternal and child health services | % of children nationwide who received a vitamin A capsule during the preceding round of supplementation (as reported in the 5-yearly DHS) | % of children | Sex | 1996 | 32% | | | | | 90% or more (75 districts) | | 90% or more (75 districts) Next measure in 2011 | NA | NA | NA | NA | 90% |

| SO or PR | Results Statement | Indicator | Unit of Measure | Disaggregation | Base line Year | Baseline Value | | | | | 2006 Target | 2006 Actual | 2007 Target | 2007 Actual | 2008 Target | 2009 Target | 2010 Target | 2010 Actual |
|-----------|--|---|---|----------------|----------------|----------------------|--|--|--|--|-----------------------------|---------------------|-----------------------------|-----------------------------|------------------------|----------------------|----------------------|-------------|
| PR 11.2.3 | Increased use of selected maternal and child health services | % of expected pneumonia cases in children (2-59 months) treated by community health workers and health facilities in program districts where community-based pneumonia has been initiated | % of cases in children [absolute number] | No | 2001 | 62% [156,010] | | | | | 70% | 66% [295165] | 70% [300,000] | 60% [399,196] | 68.3% [100,000] | 70% [550,000] | 70% [600,000] | |
| PR 11.2.4 | Increased use of selected maternal and child health services | % of children presenting to health workers with pneumonia symptoms who receive appropriate treatment in program districts where community-based pneumonia treatment has been initiated | % of children receiving 3 rd day follow-up and appropriate drug dosage for age; and # of districts | No | 1997 | 70% in 4 districts | | | | | 90% or more in 22 districts | 98% in 21 districts | 90% or more in 22 districts | 90% or more in 22 districts | 98% in 22 districts | 98% | 98% | |

| SO or PR | Results Statement | Indicator | Unit of Measure | Disaggregation | Base line Year | Baseline Value | | | | | 2006 Target | 2006 Actual | 2007 Target | 2007 Actual | 2008 Target | 2009 Target | 2010 Target | 2010 Actual |
|-----------|--|--|-----------------|----------------|----------------|----------------|--|--|--|--|-------------|------------------------|----------------------|-------------|-------------|-------------|-------------|-------------|
| PR 11.2.5 | Increased use of selected maternal and child health services | % of children (under 5 years) with diarrhea in preceding 2 weeks who received Oral Rehydration Therapy (ORT or increased fluids) (as reported in the 5-yearly DHS) | % of children | sex | 1996 | 26% | | | | | 60% | Male 46% Female 34% | Next measure in 2011 | NA | NA | NA | | 50% |

| SO or PR | Results Statement | Indicator | Unit of Measure | Disaggregation | Base line Year | Baseline Value | | | | | | | | 2006 Target | 2006 Actual | 2007 Target | 2007 Actual | 2008 Target | 2009 Target | 2010 Target | 2010 Actual |
|------------|--|--|--|----------------|----------------|--|--|--|--|--|--|--|--|-------------|------------------------|----------------------------|-------------------------------|-----------------------------|-------------|-------------|-------------|
| PR 11.2.6 | Increased use of selected maternal and child health services | Percentage of births attended by a skilled attendant (as reported on the 5-yearly DHS) | % of births | No | 2001 | 12.5 | | | | | | | | 18% | 19% | Next measure in 2011 | NA | NA | NA | NA | 36% |
| PR 11.2.7 | Increased use of selected maternal and child health services | Number of postpartum/newborn visits within 3 days of birth in USG assisted program | # of PPW visited by FCHVs within 3 days of delivery-recorded in register | No | 2006 NFH PII | 28,724 Year 2007 was first full year | | | | | | | | | 7,427 | 9,000 | 28,724 | 29,000 | 30,000 | 25,000 | 27,051 |
| PR 11.2.8 | Increase use of selected maternal and child health services | Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs | # of newborns treated listed in GON records | No | 2006 NFH PII | 723 Year 2007 was first full year | | | | | | | | | 968 | 1000 | 734 | 1200 | 2,000 | 2,500 | 1,073 |
| PR 11.2.9 | Increased use of selected maternal and child health services | Number of people trained in child health & nutrition through USG supported health area program | # of men and women | sex | NFH PII | F 10,974 M 3,371 Year 2007 was first full year | | | | | | | | | 1003 F 591 M 871 | 3791 F 4,128 M 2,937 | 14,345 F 10,974 M 3,371 | 6,065 F 4,128 M 1,937 | 5,000 | TBD | |
| PR 11.2.10 | Increased use of selected maternal and child health services | Number of people trained in maternal and newborn health through USG supported programs | # of men and women | sex | 2006 NFH PII | F 2538 M 445 Year 2007 was first full year | | | | | | | | | | | F 2528 M 445 | 2,500 F 2,000 M 500 | 2,500 | 6,000 | 11,219 |

| SO or PR | Results Statement | Indicator | Unit of Measure | Disaggregation | Baseline Year | Baseline Value | | | | | | 2006 Target | 2006 Actual | 2007 Target | 2007 Actual | 2008 Target | 2009 Target | 2010 Target | 2010 Actual |
|------------|--|---|------------------------------|----------------|---------------|--------------------------------------|--|--|--|--|--|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| PR 11.2.11 | Increased use of selected maternal and child health services | Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs | # of service delivery points | No | 2006 NFH PII | 108 Year 2007 was first full year | | | | | | | 131 | 80 | 108 | 50 | 135 | 118 | 34 |

Appendix II: Summary of SO Programs & Projects

SO11:
2006-2010 **Build Capacity of Critical Institutions**

| Intermediate Results | Program & Projects | Start Date | End Date | Program Description | Obligated USD | Prime Implementing Partner(s) | Sub-Contract Implementing Partner (s)/Field Support (List of Partners Organizations) | USAID Program Managers (COTR/A OTR) & Year | Documents & Reports |
|---|--------------------------------|------------|----------|--|---------------|---|--|--|--|
| IR 11.1: Government Leadership and management capacity for basic health and social services strengthened | Nepal Family Health Program II | 2007 | 2012 | Bilateral program to support the GON in its long term goal of reducing fertility and under-5 mortality, improving the delivery and use of public sector family planning and maternal and child health services. | | John Snow Research and Training Institute, Inc. (JSI) | EngenderHealth, Jhpiego, Save the Children, World Education Inc., Nepali Technical Assistance Group, Nepal Fertility Care Center, Management Support Services Private Ltd., Nepal Red Cross Society, United Mission to Nepal, BBC Media Action, Digital Broadcast Initiative Equal Access, Family Planning Association of Nepal, and Center for Population and Development Activities. | Deepak Paudel | Nepal Family Health Program Evaluation (2011); NFHP II Final Project Report (2012) |
| | ACCESS | 2004 | 2009 | The Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) Program seeks to increase use and coverage of maternal, neonatal and women's health and nutrition interventions. In Nepal, specific | | Jhpiego | Save the Children, Constella Futures, the Academy for Educational Development, American College of Nurse-Midwives and IMA World Health | N/A-Field Support | ACCESS Final Report (2008) |

| | | | | | | | | | |
|---|--------------------------------|------|------|---|--|---|--|-------------------|---|
| | | | | interventions were for maternal and newborn care (kangaroo mother care, low birth weight, antenatal care, and SBA) | | | | | |
| | | | | The overall purpose of this project is to increase young married adolescents' access to reproductive health information and services in Dhanusha and Parsa districts of Nepal. | | | | | Reproductive Health for Married Adolescents In Dhanusha and Parsa Districts of Nepal, Revised Project Document (2006) |
| | ACQUIRE | 2004 | 2007 | | | CARE, EngenderHealth | | N/A-Field Support | |
| IR 11.2: Basic health and social services delivered at scale through improved systems and development of scalable program models | Nepal Family Health Program II | 2007 | 2012 | Bilateral program to support the GON in its long term goal of reducing fertility and under-5 mortality, improving the delivery and use of public sector family planning and maternal and child health services. | | John Snow Research and Training Institute, Inc. (JSI) | EngenderHealth, Jhpiego, Save the Children, World Education Inc., Nepali Technical Assistance Group, Nepal Fertility Care Center, Management Support Services Private Ltd., Nepal Red Cross Society, United Mission to Nepal, BBC Media Action, Digital Broadcast Initiative Equal Access, Family Planning Association of Nepal, and Center for Population and Development Activities. | Deepak Paudel | Nepal Family Health Program Evaluation (2011); NFHP II Final Project Report (2012) |
| | ACCESS | 2004 | 2009 | The Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) Program seeks to increase use and coverage of maternal, neonatal and | | Jhpiego | Save the Children, Constella Futures, the Academy for Educational Development, American College of Nurse-Midwives and IMA World Health | N/A-Field Support | ACCESS Final Report (2008) |
| | | | | | | | | | |

| | | | | | | | | |
|---|--------------------------------|------|------|---|---|--|-------------------|---|
| | | | | women's health and nutrition interventions. In Nepal, specific interventions were for maternal and newborn care (kangaroo mother care, low birth weight, antenatal care, and SBA) | | | | |
| IR 11.3: Community Capacity to access and manage basic health and social services improved | Nepal Family Health Program II | 2007 | 2012 | Bilateral program to support the GON in its long term goal of reducing fertility and under-5 mortality, improving the delivery and use of public sector family planning and maternal and child health services. | John Snow Research and Training Institute, Inc. (JSI) | EngenderHealth, Jhpiego, Save the Children, World Education Inc., Nepali Technical Assistance Group, Nepal Fertility Care Center, Management Support Services Private Ltd., Nepal Red Cross Society, United Mission to Nepal, BBC Media Action, Digital Broadcast Initiative Equal Access, Family Planning Association of Nepal, and Center for Population and Development Activities. | Deepak Paudel | Nepal Family Health Program Evaluation (2011); NFHP II Final Project Report (2012) |
| | ACQUIRE | 2004 | 2007 | The overall purpose of this project is to increase young married adolescents' access to reproductive health information and services in Dhanusha and Parsa districts of Nepal. | CARE, EngenderHealth | | N/A-Field Support | Reproductive Health for Married Adolescents In Dhanusha and Parsa Districts of Nepal, Revised Project Document (2006) |
| | | | | | | | | |

Appendix III: Key Contacts and People Involved in the SO

| | Name | | Role |
|-------|------------------------------|--|------|
| USAID | Anne M. Peniston | apeniston@usaid.gov | CTO |
| | Linda Kentro | LKentro@usaid.gov | CTO |
| | Dharmpal Raman (2002 - 2009) | DRaman@usaid.gov | CTO |
| | Deepak Paudel | DPaudel@usaid.gov | CTO |

Appendix IV: References of Reports, Evaluations and Assessments

USAID. February 2008. "USAID/Nepal Performance Management Plan Health 2008 for Strategic Objective 9 and 11". Kathmandu, Nepal: USAID.

Riggs-Perla, J., Adhikari, M., Adhikari, R., Armbruster, D., Paudel, D., Prasai, D., Pkhrel, M. July 2011. "Nepal Family Health Program (NFHP) II Evaluation". USAID.

JSI Research and Training Institute, 2012. "Nepal Family Health Program II: Final Report". Washington, D.C.

Engender Health. 2006. "Reproductive Health for Married Adolescents in Dhanusha and Parsa Districts of Nepal: Project Document".

Jhipiego. 2008. "ACCESS Year 4 Annual Report".