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## **Pregnant Women's Groups: An Integrated Approach to Reduce Maternal and Neonatal Deaths in Nepal**

Milestone I

Grant No. AID-OAA-F-14-00025

Submitted: August 29, 2014

Submitted by:

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Plan International USA

## Introduction

Per guidance provided by USAID, Plan completed the requirements under Milestone I for the *Pregnant Women's Groups: An Integrated Approach to Reduce Maternal and Neonatal Deaths in Nepal* project (AID-OAA-F-14-00025). Please find the following deliverables as requirements for Milestone I below:

1. Updated project implementation plan, originally submitted as Annex I in the revised program description on March 28, 2014
2. Updated evaluation plan, including finalized power calculations
3. List of Key Performance Indicators (KPIs)
4. CVs for the Program Manager (Ms. Durga Uprety) and M&E Coordinator (Mr. Rajendra Basnet). Mr. Basnet was hired and started with the project August 1, 2014. Ms. Uprety is expected to start in the first week of September.



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Major Activities linked with Intermediate Results	Year 1				Year 2				Year 3			
using behavioral mapping mat and mother cards followed by distribution of iron folic acid tablet, Chlorhexidine tube, Vitamin A, misoprostol tablets, etc.												
Organize semi-annual VDC group public commitment group meetings			√		√		√		√		√	
Link PWG monthly meetings with outreach clinics (ANC, PNC, and family planning services) and immunization clinics			√	√	√	√	√	√	√	√	√	√
Conduct health education sessions on Water, Sanitation and Hygiene (WASH) and FP in PWG meetings along with ANC, PNC, newborn care and danger signs			√	√	√	√	√	√	√	√	√	√
Disseminate MNCH messages to community groups by FCHVs using mothers cards			√	√	√	√	√	√	√	√	√	√
Support FCHV's access to BCC materials (BPP flip chart, mother cards)			√				√				√	
<b>Monitoring and Evaluation</b>												
Update monitoring and evaluation plan	√											x
Conduct baseline and end line surveys (in treatment and control group VDCs)		√										
Finalize indicator table with definitions, targets, reporting dates, etc. after completion of baseline data, including first rounds of HMIS+FCHV data are collected		√	√									
Hold annual data review meeting at regional and national levels				√				√				√
Integrate PWG approach in quarterly review meetings in Ilakas and at district level (in conjunction with MoHP program meetings)			√	√	√	√	√	√	√	√	√	√
Integrate PWG approach in quarterly review meetings at health facility level including FCHVs who are involved in the PWGs			√	√	√	√	√	√	√	√	√	√
Share PWG experiences at Maternal and Neonatal Technical Group of the Family and Child Health Divisions					√				√			
HMIS and FCHV data collection and analysis		√	√	√	√	√	√	√	√	√	√	√
Final evaluation in intervention and non-intervention VDCs and submit report												√

\*Q1 of the project covers two months – August and September 2014

**Note:**

- 1<sup>st</sup> quarter: August-September\*
- 2<sup>nd</sup> quarter: October-December
- 3<sup>rd</sup> quarter: January-March
- 4<sup>th</sup> quarter: April-June

# Monitoring and Evaluation Plan

## A. Measuring Success

### *Overview*

The monitoring, evaluation, and learning (MEL) for this project are being conducted in close collaboration with MoHP (Ministry of Health and Population). The project's MEL is led by the M&E Coordinator and Project Manager, in partnership with the Management Division of the MoHP. This division maintains the HMIS (Health Management Information System), and the partnership is designed to ensure learning and sustainability beyond the life of the project. Plan has worked closely with MoHP on previous health projects and is continuing this at both the national and district levels.

### *Monitoring and Feedback/Learning Cycle*

Plan's approach to assessing program effectiveness is participatory and continuous and applies high standards of rigor and transparency. Input is routinely solicited from program participants – in this case the FCHVs, pregnant women, and their husbands and mother-in-laws – to continuously improve the intervention. Feedback from the FCHVs comes through their monthly reports as well as from routine support supervision visits from the District Health Office (DHO) and project staff. Given the rollout of PWGs across 15 districts in Nepal and the regular turnover of women in the groups, the PWG approach lends itself to incorporating feedback and making any needed changes in concert with the MoHP.

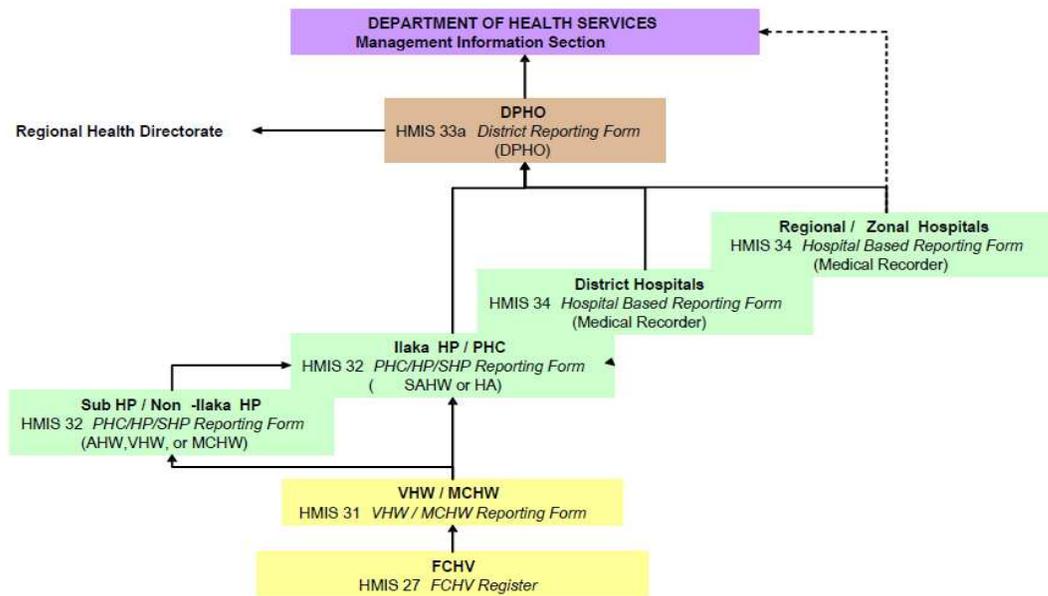
The M&E Coordinator will use scorecards to gather qualitative and quantitative feedback from a sample of women who are/have recently been participants in PWGs, their husbands and in-laws, and the FCHVs who run the groups using Lot Quality Assurance Sampling (LQAS) for continuous feedback. After PWGs have been implemented in a district for one year, the project team will collect input from district, ward, and VDC representatives about the PWG program to complement data collected from participants. Project and MoHP staff will jointly organize a community meeting to discuss the progress made and changes that need to be made ('learnings') to the PWGs and decide collectively on next steps.

The baseline survey data and the process to select intervention and control VDCs will be shared with stakeholders in the MoHP and at the district level. These open discussions of the data and selection process serve several purposes. The baseline data can be used by the MoHP and districts in their planning process or by them and Plan to adapt the design as the project is scaling up. The VDC selection process needs to be understood and owned at the national and local levels to lay the foundation for a better appreciation of the results and to enable them to explain to constituents why some VDCs have PWGs while others do not.

Routine monitoring will be carried out through the government's HMIS in close coordination with the national, regional, and district levels. The M&E Coordinator in Kathmandu is negotiating access to the HMIS and will jointly organize discussion of these data (described above). Figure 1 describes the flow of data in the HMIS.

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Figure 1: HMIS Data flow<sup>1</sup>



The indicators to be tracked through the HMIS are:

- % of pregnant women with first ANC visit
- % of pregnant women with at least 4 ANC visits during their pregnancy
- % of pregnant women immunized with TT2 and TT2+
- % of deliveries by skilled birth attendants (doctor or nurse/midwife)
- % of institutional deliveries at among estimated number of live births
- % of BCG-immunized children (less than one year of age)
- % of postpartum mothers who received Vitamin A supplements
- % of new mothers and newborns receiving first postnatal check-up
- % of pregnant women who received iron folic acid (IFA) tablets or syrup
- Number of women applying CHX on newborn cord (added to the HMIS July 2014)

FCHVs will submit information on the women participating in PWGs through monthly reports to the local health facility. Examples of the indicators to be collected this way are:

- # of PWGs functioning in the previous month (disaggregated by district)
- # of women joining a PWG during the month (disaggregated by district and VDC)
- # of women attending monthly PWG meetings (disaggregated by district and VDC)
- # of pregnant women accessing and self-reporting critical pregnancy milestones (number of ANC visits, IFA and Vitamin A consumption, etc.)
- # of husbands and mother-in-laws/pregnant women who make a public commitment to facility births in the previous month (disaggregated by type of person making it)
- % of newborns whose births are registered within 35 days of birth

The data collected through the HMIS and from FCHV reports will be reviewed with government counterparts on a quarterly basis to track PWG progress. This will be integrated into regular meetings convened by MoHP to review the progress of their programs; Plan will participate in discussions of the

<sup>1</sup> Government of Nepal, *Nepal Health Sector Program II Annual Report 2067/68*, Kathmandu: Ministry of Health and Population, 2011.

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data related to the PWG project. The project monitoring, evaluation, and learning findings will be shared through community, district, regional, national, and international forums.

### *Evaluation Plan*

The scale up of PWGs across 15 districts will be evaluated using outcome and cost-effectiveness indicators with a quasi-experimental design. As is the case for the monitoring data, the majority of the data for evaluating the project are coming from the HMIS, complemented by regular reports from FCHVs on their PWGs and information from community members. Secondary data generated by the GoN, UN agencies, or other actors (e.g. Nepal DHS) will supplement the data from the HMIS, FCHVs, and communities. Data from previous PWGs projects will also be used throughout the MEL process.

A quasi-experimental design is the core of the PWG evaluation approach and uses a two-step selection process. Treatment units (VDCs) are defined as those where PWGs will be fully operational, and control areas/units are those which are similarly disadvantaged, but will not be reached by PWGs during the current project. Within each of the 15 project districts there are approximately 80 VDCs, each with approximately nine wards (containing two to four villages per ward). The VDCs are geographically distant from each other, reducing the risk of contamination from the treatment VDCs to the control VDCs, although the project will monitor for spillover effects.

In the first step of selection, the most disadvantaged VDCs within the 15 districts will be identified using the criteria of the Local Governance and Community Development Program<sup>2</sup>. Once these most disadvantaged VDCs are selected, the second step is to pair them using the criteria below, and then randomly select pairs to be control and treatment VDCs:

- Availability of birthing center facilities. For example, VDCs with a birthing center will be paired with another VDC with a center, and VDCs without birthing centers will be paired with a VDC without one.
- Distance from hospitals. VDCs with similar distances from hospitals will be paired together.
- Utilization of ANC, PNC, institutional delivery, and intake of iron and folic acid tablets (from HMIS). For example, a VDC with approximately 60 percent ANC utilization will be paired with a VDC with similar utilization rates.

To ensure the statistical power required to evaluate the impact of the project, and in light of the large sample size required to power it for MMR and NMR, the project will use the following four proxy indicators for maternal and neonatal mortality:

- % of pregnant women with at least four ANC visits during their pregnancy
- % of deliveries by skilled birth attendants (doctor or nurse/midwife)
- % of institutional deliveries among estimated number of live births
- % of new mothers and newborns receiving postnatal visits within three days

The proxy indicator with the lowest value is institutional delivery (37 percent). Using the Optimal Design freeware (<http://hlmssoft.net/od/>), the sample size calculation was run for this design: Cluster Randomized Trials > with person-level outcomes/Treatment at Level 2 >Power vs. Total Number of Clusters and Power vs. Effect size. The randomization is being done at the VDC level (the cluster), but the expected outcomes are at the level of the woman (person-level). Alpha was set at 0.05, effect size a

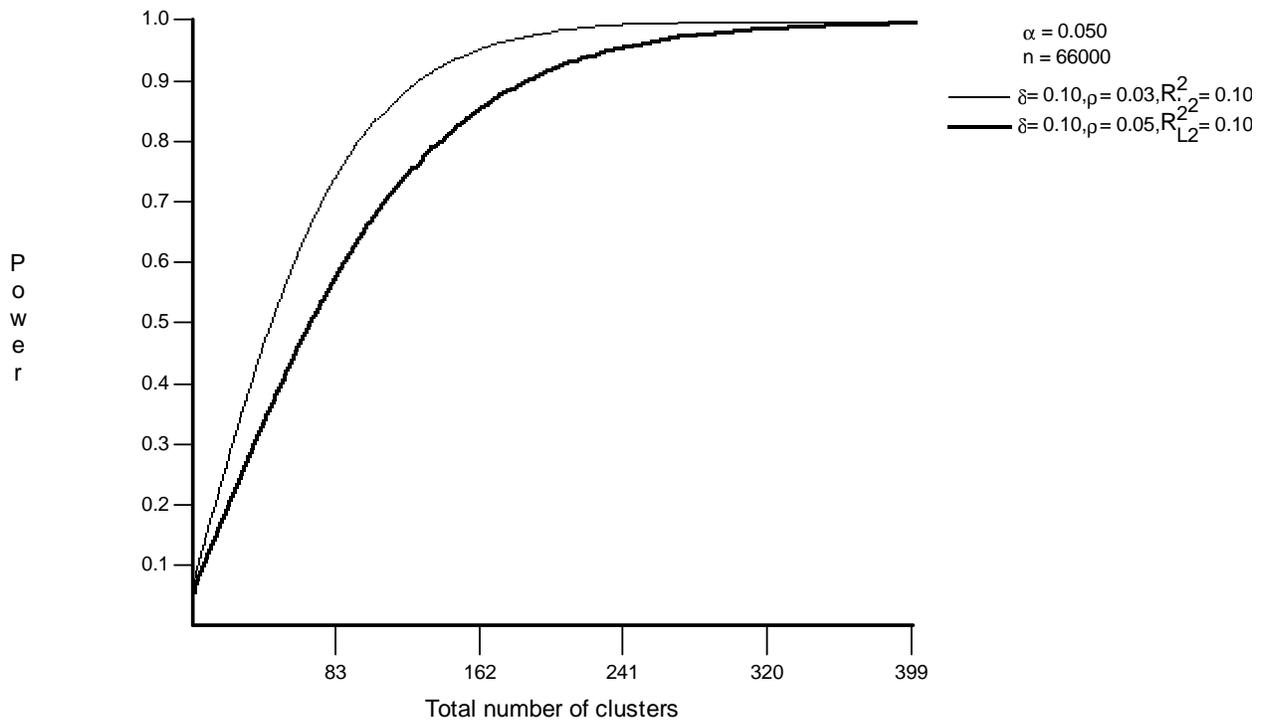
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<sup>2</sup> The Local Governance and Community Development Program is a multi-donor funded program that has already established criteria for identifying disadvantaged VDCs, including concentration of disadvantaged populations such as Dalits, Janjati, and Muslims, as well as low income, poor health indicators, and access to health services.

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0.10, and the sample size at 66000 (see Figure 2). The required number of clusters (VDCs) required is >350. The project is intervening in 372 VDCs (336 in Terai districts and 36 in non-Terai)<sup>3</sup>, so the required power is available for the four proxy indicators.

Figure 2: Sample Size Calculation



In addition to the data collected on the baseline and end line surveys (see KPIs), two more indicators will be collected in five districts (two Terai and three non-Terai districts) to establish maternal and neonatal mortality rates (MMR and NMR). The oversampling of the non-Terai districts is intentional as PWGs are being piloted in this setting. The Sisterhood method requires a smaller sample size than other tools and provides accurate estimates of MMR and NMR. Women are asked about their reproductive history and childbirth experiences as well as those of their sisters, based on the assumption that women will know their sisters' reproductive history and whether a sister lost a newborn or the sister herself died perinatally. The MMR and NMR gathered in these five districts will be compared to the HMIS data for the VDC and district and, based on the variation observed between the rates, a decision made with the MoHP and donor about the need for a repeat of field-level NMR and MMR at the end of the project.

### Cost Effective MEL

By using primarily HMIS and FCHV data, building on previous evaluations, plus secondary data (e.g. LIBON, NDHS, MCHIP, and UNICEF) the costs of doing rigorous MEL for this project are intentionally

<sup>3</sup> The project is creating and supporting 3300 PWGs, reaching approximately 66,000 women per year. These are broken down by Terai (n=12) and non-Terai (n=3) districts as follows: 250 PWGs/Terai district = 1 PWG/ward \* 9 wards per VDC = 28 VDCs/district, and 100 PWGs/non-Terai district = 1 PWG/ward \* 9 wards per VDC = 12 VDCs/district.

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kept low. The project's M&E Coordinator will work with Plan USA's Senior M&E Advisor on the analyses required by the treatment/control design, and lead on the routine monitoring and reporting.

Secondary data on maternal and neonatal health in Nepal are of high quality and internationally recognized and cited. The NDHS was conducted in 2011 and is an excellent source to compliment data from the HMIS, plus the project's monitoring and focused evaluations.

The project will incorporate all MEL functions into the MoHP by the end of the project to ensure sustainability. This has been designed by using existing HMIS and FCHV data, reviewing the PWG progress as part of ongoing ministry meetings (rather than add a separate meeting), working in close collaboration with MoHP staff, sharing all project-generated data with government counterparts, and ensuring that MEL costs are kept low. Overall, PWGs are cost effective not only in terms of low cost per beneficiary, but have also been proven to be effective for long-term health behavior change and outcomes, including saving lives of women and newborns.

The project is tracking its programmatic expenditures to estimate four cost-related indicators. The first two are the cost to set up new PWGs and the monthly operating costs of PWGs once they are established. These are listed in the KPI document and will be reported on after all the PWGs are operational. The on-going operational costs per PWG may vary from district to district or over time, so both these indicators will be disaggregated by district, and the operational cost of operating an established PWG will be calculated every six months.

The other two cost effectiveness indicators are cost per maternal life saved and per neonatal life saved. The estimates of maternal and neonatal deaths expected during the course of the project will be calculated using the LiST method (Health Policy Initiative), and actual deaths subtracted from these estimates to arrive at the number of lives saved. These values will be divided by programmatic expenses to arrive at cost per maternal and neonatal death averted.

## Key Performance Indicators (KPIs)

The Key Performance Indicators (KPIs) for the *Pregnant Women's Groups* project are collected from the following four sources. The indicators and rationale for each are outlined in the tables below.

- A. The Health Management Information System (HMIS) in Nepal under the Management Division of the Ministry of Health and Population (MoHP);
- B. Female Community Health Volunteers' (FCHVs) monthly reports that include data collected at monthly PWG meetings;
- C. Household surveys conducted at baseline and end of the project; and
- D. Project documents, particularly financial records to measure cost-effectiveness.

### A. HMIS Indicators

HMIS data are collected monthly from health facilities and entered into an online system. Plan will coordinate with the MoHP to gain access to the HMIS for the ten indicators below, from both intervention and control VDCs and the project will submit a report to USAID every four months, 30 days after the data is available in the HMIS (exact timeline to be determined). The HMIS data is disaggregated by district, including health facility and VDC level, but not to the Ward level.

HMIS Indicator	Rationale	Recording Form	Reporting Form	
1	% of pregnant women with first ANC visit	A measure of how engaged women are with the health system during pregnancy in accessing ANC services	HMIS 3.6	HMIS 9.3/9.4
2	% of pregnant women with at least 4 ANC visits during the pregnancy	A measure of the percentage of women accessing the complete package of ANC services	HMIS 3.6	HMIS 9.3/9.4
3	% of pregnant women who received TT2 and TT2+	A measure of the percentage of women and births protected against tetanus at the time of delivery	HMIS 2.2	HMIS 9.3/9.4
4	% of pregnant women receiving IFA tablets or syrup (during their last pregnancy)	A measure of the percentage of women who received recommended amounts of iron and folic acid during pregnancy and is a proxy for the quality of ANC services	HMIS 3.6	HMIS 9.3/9.4
5	% of deliveries by skilled birth attendants (nurse/midwife or doctor)	A measure of a women's use of delivery care services and a measure of the health system's functioning and potential to provided adequate coverage for deliveries	HMIS 3.6	HMIS 9.3/9.4
6	% of institutional deliveries	A measure for births that take place in health facilities in which obstetric complications can be treated when they arise to reduce maternal and neonatal mortality	HMIS 3.6	HMIS 9.3/9.4
7	% of children under one year immunized with BCG vaccine	A measure for children under one year immunized against Tuberculosis/infants receiving recommended preventive services	HMIS 2.2	HMIS 9.3/9.4
8	% of postpartum mothers who received Vitamin A supplements	A measure of women who receive vitamin A supplements to improve vitamin A status of mother and, via breast milk, her infant	HMIS 3.6	HMIS 9.3/9.4

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<b>9</b>	% of new mothers (and newborns) receiving first postnatal check-up	A measure of service use for newborns in this critical period	HMIS 3.6	HMIS 9.3/9.4
<b>10</b>	Number of women applying CHX on newborn cord*	A measure of CHX availability and use	HMIS 4.2	HMIS 9.3

\*This indicator was added to the HMIS July 2014 and will be tracked during the project.

### B. FCHV Monthly Register Report

FCHVs send monthly reports to the health facility to be incorporated within the HMIS. Plan will coordinate with the MoHP to facilitate the inclusion of the following indicators, into the current FCHV report with data coming from the *Mothers' Health Group Register* and the *FCHV Register*. This ensures that project data are collected within the government system, by not creating a parallel system. As needed, a separate form for collecting PWG-level indicators may be created. These indicators assist in monitoring the coverage and performance of PWGs.

FCHV Register Indicator		Rationale
<b>1</b>	# of PWGs currently functioning (disaggregated by district) in previous month	Coverage
<b>2</b>	# of new pregnant women joining PWG every month (disaggregated by district and VDC)	Coverage
<b>3</b>	# of pregnant women attending monthly meetings (disaggregated by district)	Coverage
<b>4</b>	# of pregnant women accessing and self-reporting critical pregnancy milestones (4 ANC, IFA tablet, Vitamin A, etc.)*	Performance
<b>5</b>	# of husbands and/or mother-in-laws/pregnant women attending PWG who make a public commitment to facility births – in previous month*	Performance
<b>6</b>	% of newborns whose births are registered within 35 days of birth	Plan tracks birth registration because it is the basis of a child's ability to his/her rights

\*This indicator will be further disaggregated in FCHV reporting tool for monitoring pregnant women.

### C. Baseline and Final Household Surveys

The project is conducting a household survey in the intervention and non-intervention VDCs, at the beginning and end of the life of the project. The ten indicators being collected from the HMIS are repeated on the survey questionnaire to allow the project to compare self-reports of behaviors and services received with the data reported via the HMIS.

Survey Indicator		Rationale
<b>Antenatal</b>		
<b>1</b>	% of pregnant women with first ANC visit	Rationale given in Table A
<b>2</b>	% of pregnant women attending at least four ANC Visits	Rationale given in Table A
<b>3</b>	% of pregnant women who received TT2 and TT2+	Rationale given in Table A
<b>4</b>	% of pregnant women who received iron folic acid (IFA) tablets	Rationale given in Table A
<b>5</b>	% of women who received CHX during their pregnancy (from FHCV or at ANC)	A measure of CHX availability and coverage
<b>Delivery</b>		

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6	% of deliveries conducted by a skilled birth attendant (doctors or nurse/midwife)	Rationale given in Table A
7	% of institutional deliveries	Rationale given in Table A
<b>Knowledge and Practice</b>		
8	Percent of pregnant women who know at least three danger signs during delivery	A measure of the health education effectiveness
9	Percent of mothers of children aged 0-5 months who know at least two danger signs after delivery	A measure of the health education effectiveness
10	Percent of mothers of children aged 0-5 months who know at least two danger signs among newborns	A measure of the health education effectiveness
11	Percent of mothers of children aged 0-5 months who know how to apply CHX on the umbilical stump	A measure of the health education effectiveness
<b>Neonatal</b>		
12	Percent of newborns who were breast-fed within one hour of birth (all are self-reports)	A measure of behavior change that promotes newborn survival
13	Percent of newborns immediately after birth, who were dried off, exposed to a heating source (including kangaroo care) and avoided bathing for 24 hours	A measure of behavior change that promotes newborn survival
14	Percent of newborns who had CHX applied to their umbilical cord at birth	A measure of behavior change that promotes newborn survival
<b>Postnatal</b>		
15	% of women who had at least three postnatal check-ups (per protocol)	A measure of post-natal health promotion behavior (mother/baby)
16	% of mothers with a mother card for the youngest child (under 12 months)	A measure of ANC attendance
17	% of new mothers and newborns receiving first post-natal check-up	Rationale given in Table A
18	% of postpartum mothers who received Vitamin A supplements	Rationale given in Table A
19	% of mothers who received at least 1 month of iron tablets during the first two months after delivery	A measure of availability and access to health promotion materials
<b>Immunization</b>		
20	% of children aged 0-23 months who have a vaccination card	A measure of behavior that promotes access to preventive services
21	% of children 12 months and under immunized with BCG	Rationale given in Table A
<b>WASH</b>		
22	% of mothers who usually wash their hands with soap or ash before food preparation (self-report)	Hygienic behaviors that promote health and the effectiveness of health education messaging
23	% of mothers who usually wash their hands after defecation and after attending to a child who has defecated (self-report)	Hygienic behaviors that promote health and the effectiveness of health education messaging
<b>Community-level mortality data</b>		
24	Estimated number of neonatal deaths/population*	The modified sisterhood method will be used to estimate neonatal deaths in 5 districts and compared to HMIS values
25	Estimated number of maternal deaths/population*	The sisterhood method will be used to estimate maternal deaths in 5 districts and compared to HMIS values

\*The last two indicators will only be collected in 5 of the 15 intervention districts at baseline and end line.

#### D. Financial Indicators

Project documents, particularly finance records, are main the source of the data for the cost-effectiveness KPIs. The projection of maternal and neonatal lives saved (deaths averted) for the intervention and control VDCs are calculated using the LiST method, a tool developed by the Health Policy Initiative.

No.	Financial Indicators	Elements needed for calculation
1.	Cost of setting up one PWG	Number of PWGs established during reporting period/project costs going toward PWG start-up (direct and ODC)
2.	Cost of implementing PWG monthly meetings	Sum of all operational costs once the PWGs are established and divide by the number of PWGs operating in the reporting period
3.	Cost per maternal death averted	Number of maternal deaths projected for coverage area during the life of the project – number of maternal deaths occurring = maternal deaths averted/project costs
4.	Cost per neonatal death averted	Number of neonatal deaths projected for coverage area during the life of the project – number of neonatal deaths occurring = neonatal deaths averted/project costs

## Curriculum Vitae

### Durga Uprety Program Manager

#### SUMMARY

Durga Uprety is a trained nurse and public health specialist with 15 years of progressive experience implementing community-based projects in close collaboration with the District Health Office (DHO) and health facility workers in hard-to-reach and disadvantaged districts in Nepal. In addition to her program management and nursing experience, Ms. Uprety served as a lecturer and clinical instructor on midwifery, community health nursing and pediatrics in Kathmandu. She has a strong understanding of the health system in Nepal having worked extensively with INGOs, and managed bi-lateral donor-funded projects from USAID and DFID. Since 2004, Ms. Uprety has worked with the National Family Health Program (NFHP), the National Health Sector Support Programme (NHSSP/MoH) and with Save the Children and Care Nepal on planning, implementation, coordination and financial and human resources management for various health projects supported by the Ministry of Health. In addition, she has experience providing technical assistance to district health office staff and has been involved in coordinating with central, regional and district-level government bodies to achieve project goals.

#### TECHNICAL EXPERTISE

- Maternal and Child Health
- Sexual and Reproductive Health
- Nutrition
- HMIS

#### RELEVANT PROFESSIONAL EXPERIENCE

##### Senior Project Coordinator

September 2013-April 2014

*Save the Children, Baitadi district, Nepal*

Responsible for the management of the USAID-funded Maternal, Neonatal, Child Health and Nutrition project in Baitadi district in close collaboration with MoHP (FHD, CHD, RHD and DHO). Represented Save the Children at regional meetings, and worked in coordination with the Government at the national, regional and district levels to ensure an enabling environment for the project. Involved in routine technical, programmatic and financial monitoring, including timely submission of reports to donors. Proactively identified other actors (EDPs) working in the region to improve MNCH services.

##### Maternal, Neonatal, and Child Health Specialist

April 2012-August 2013

*Nepal Health Sector Support Programme (NHSSP), MoH, Siraha District, Nepal*

Designed and implemented technical assistance to the Regional Health Directorate (RHD) and government health structures in strengthening health system and capacity enhancement for MHCH programming. Supported the mainstreaming of BCC and GESI (Gender Equality and Social Inclusion) in Essential Health Care Services. Contributed to the planning and monitoring of the health program at the regional level to achieve MDGs by 2015 based on the result framework for NSHP II.

##### Family Health Field Officer

November 2004-January 2006

*National Family Health Program (NHFP), Siraha District, Nepal*

Led the planning, implementation, and evaluation of district level family health and child health activities for a DFID-funded grant. Provided technical support to MoHP networks in coordination with other INGO partners. Implemented BCC and health logistic activities.

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### **Lecturer**

December 2003-October 2004

*Himalayan Medical Education Society Pvt. Ltd. (Nursing Campus), Kathmandu, Nepal*

Worked as a lecturer at the CTEVT-affiliated College. Taught theoretical and clinical coursework in Midwifery, Community Health Nursing, and Pediatrics. Provided hands-on clinical training for community nursing practice and clinical case studies.

### **Staff Nurse**

November 2000-November 2001

*PHECT, Model Hospital, Kathmandu Nepal*

Worked as the Emergency and Out-Patient Department Nurse. Day-to-day responsibilities included dealing with a caseload covering medical, surgical, gynecological, and ENT patients.

### **Health Supervisor**

March 1999-August 2000

*CARE Nepal, Bajura District, Nepal*

Planned, implemented, and conducted monitoring and evaluation for the USAID-funded Family Health Program. Provided technical assistance to DHO staff and supported the district health office in implementation and monitoring.

### **Staff Nurse**

October 1997-March 1999

*National Academy of Medical Sciences, Bir Hospital, Kathmandu, Nepal*

Worked in the Emergency Department and specialized in medical, surgical, disaster and trauma patients. Supported and guided student nurses in theoretical and clinical training.

## **RESEARCH AND PUBLICATIONS**

*Technical Paper on Hepatitis (1995)* published by Nepal Nursing Association

*Improving Utilization of Delivery Care Service by Skilled Birth Attendant in Nepal (2009)*, Thesis for Master of Public Health, University of Leeds, UK

*Private Sector in Public Health in Far Western Region (2013)* published on Nepal Public Health Association, Public health Newsletter, vol. 1, issue 4 published on [www.journal.nepha.org.np](http://www.journal.nepha.org.np)

Case study on *Saving Mothers and Neonates (2013)* published on [http://www.nhssp.org.np/case\\_study.html](http://www.nhssp.org.np/case_study.html)

## **LANGUAGES**

Fluent in English and Nepali

## **EDUCATION**

2009 Masters of Public Health (MPH), focus on health systems research methods, monitoring and evaluation, human resources planning and management for health, Health Management Information Systems (HMIS)  
University of Leeds, Leeds, United Kingdom

2003 B.A., Nursing, focus on community health, leadership management, medical and surgical nursing, mental health and sociology  
Rajiv Gandhi University, Bangalore, India

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1996 Post-Certificate, Nursing, focus on community health, nursery, midwifery, pediatrics, leadership and management.  
National Academy of Medical Sciences, Bir Hospital, Kathmandu, Nepal

**REFERENCES**

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**Mr. Rajendra Basnet**  
**Monitoring and Evaluation Coordinator**

**KEY QUALIFICATIONS**

Mr. Basnet is a development professional with 13 years' experience in program monitoring and evaluation in health sector programs. As the planning, monitoring and systems strengthening specialist for the Nepal Health Sector Support Program, Mr. Basnet manages the collection, quality assessment and evaluation of system-wide data for the Mid-Western Health Directorate of Nepal. Additionally, he oversees the training and capacity building of health sector personnel in monitoring and evaluation. In addition, Mr. Basnet provided technical expertise in the health sector for numerous donor-funded programs, and is adept at working with local stakeholders. He holds an M.Phil degree in Public Health from the University of Bergen.

**PROFESSIONAL EXPERIENCE**

**Consultant**

February 2014 – April 2014

*University of Queensland, Australia*

- Worked as a short-term consultant to evaluate the Micronutrient Initiative Programme in Nepal in coordination with the MoHP and District Health Offices in three districts.

**Planning, Monitoring and System Strengthening Specialist**

July 2011 – August 2013

*Nepal Health Sector Support Programme, Surkhet, Nepal*

- Responsible for health systems planning, monitoring, research and evaluation for the Regional Health Directorate
- Provide technical back stopping and skills transfer to the regional health staff
- Facilitate coordination between various external development partners (EDPs) and international non-government organizations (INGOs)

**Monitoring and Evaluation Manager**

April 2010 - May 2011

*Population Service International (PSI), Kathmandu, Nepal*

- Responsible for routine monitoring and evaluation of PSI Nepal programme
- Assessed the capacity of sup-recipients and conducted routine supervision and monitoring of partners
- Coordinated with Epidemiology and Disease Control Division and Family Health with Division on monitoring and evaluation

**Health Advisor**

August 2008 - March 2010

*International Nepal Fellowship, Kathmandu, Nepal*

- Provided technical support to tuberculosis control, HIV prevention and drug awareness, leprosy control programs for INF
- Developed five-years strategic plan for health programs
- Provided technical support to government TB, leprosy and HIV prevention programs at regional and district levels in the mid-western region

**Monitoring and Evaluation Officer**

August 1998 - July 2008

*International Nepal Fellowship, Kathmandu, Nepal*

- Developed program monitoring, evaluation strategy, tools, manuals, guidelines and ensured its implementation by INF programs and partners
- Developed INF's health programs strategy and plans

## Pregnant Women's Groups: An Integrated Approach to Reduce Maternal and Neonatal Deaths in Nepal Milestone I Report

- Facilitated regional health planning, monitoring and evaluation meeting of government stakeholders
- Coordinated with national and regional government agencies, donors (the Global Fund, WHO, EU, GLRA) and local partners
- Collected and analyzed TB, HIV, leprosy, maternal and child health data and drafted project progress reports based on evaluation of existing data.
- Conducted seven project evaluations

### **EVALUATIONS CONDUCTED**

- |   |      |
|---|------|
| ▪ Evaluation of National Malaria Program  | 2011 |
| ▪ Evaluation of DOTS program in Jumla   | 2011 |
| ▪ Evaluation of leprosy work INF Green Pasture Hosp. & Referral Centre in Pokhara | 2010 |
| ▪ Evaluation of leprosy work of INF Surkhet Program                               | 2010 |
| ▪ Evaluation of Drug awareness and Rehabilitation Centre (DARC) in Nepalgunj      | 2009 |
| ▪ Evaluation of multi drug resistant TB program in Nepalgunj                      | 2009 |
| ▪ Evaluation of health program of INF in Dang                                     | 2009 |

### **EDUCATION**

#### **M. Phil., Public Health**

2008

*University of Bergen, Norway*

#### **Bachelor in Medical Record Science**

2000

*Christian Medical College, Vellore, India*

#### **MBA**

1996

*Tribhuvan University, Nepal*

#### **Bachelor in Management**

1994

*Tribhuvan University, Nepal*

#### **Intermediate Certificate in Management**

1991

*Tribhuvan University, Nepal*

### **LANGUAGES**

English, Nepali