

CHILD SURVIVAL AND HEALTH GRANTS PROGRAM INNOVATION CATEGORY

HealthRight International

Partnership for Maternal and Neonatal Health (PMNH)

Arghakhanchi and Kapilvastu Districts, Nepal
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LIST OF ABBREVIATIONS

AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse-Midwives
CB-IMCI	Community Based Integrated Management of Childhood Illness
CB-NCP	Community Based Neonatal Care Program
CHD	Child Health Division
DAO	District Administration Office
DDC	District Development Committee
DEO	District Education Office
DHO	District Health Office
DIP	Detail Implementation Plan
DoHS	Department of Health Services
DPO	District Project Officer
DPS	District Project Supervisor
Dr.	Doctor
DToT	District Training of Trainers
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
HA	Health Assistant
HF	Health Facility
HFA	Health Facility Assessment
HFOMC	Health Facility Operation and Management Committee
HQ	Headquarters
HW	Health Worker
KTM	Kathmandu
LDO	Local Development Office
LZH	Lumbini Zonal Hospital
M&EPC	Monitoring, Evaluation and Project Coordinator
MCHW	Maternal and Child Health Worker
MDG	Millennium Development Goal
MG	Mothers Group
MIRA	Mother and Infant Research Association
MNC	Maternal and Neonatal Care service
MoU	Memorandum of Understanding
NGO	Non-Governmental Organization
PAC	Project Advisory Committee
PD	Project Director
PDI	Positive Deviance Initiative
PHO	Public Health Officer
PPH	Post-partum Hemorrhage
RHCC	Reproductive Health Coordination Committee
SWC	Social Welfare Council
SN	Staff Nurse
ToT	Training of Trainers
TSV	Technical Support Visit
TWG	Technical Working Group
VDC	Village Development Committee
VHW	Village Health Worker
WDO	Women Development Office
WRHD	Western Regional Health Directorate

INTRODUCTION

HealthRight International has been implementing the four-year Partnership for Maternal & Newborn Health (PMNH) in Nepal's Arghakhanchi and Kapilvastu districts since 2009. Both districts lie in the Western Development Region. Kapilvastu is in the southern *terai* (plains), and Arghakhanchi is in the central hills. Both are poor, rural, conflict affected, have poor access to services, and a heavy burden of health needs. The PMNH aims to build an integrated continuum of maternal and neonatal care (MNC) from the household level reaching throughout the health system. To achieve this, the project increases the quality, access, availability, demand, knowledge, and enabling environment for MNC in the community and health system. Primary beneficiaries include neonates and women of reproductive age. Children under five, Female Community Health Volunteers (FCHVs), Health Facility Operation and Management Committees (HFOMCs), and health workers (HWs) also directly benefit from the project.

Focus activities in this 3rd PMNH year included HW capacity building, support in implementing Community-based Newborn Care Program (CB-NCP) data systems in both districts, and provision of supportive supervision and monitoring to HWs and FCHVs. As in previous years, the PMNH has worked in partnership with the District Health Offices (DHOs) in Arghakhanchi and Kapilvastu.

Table 1: Population and Target Groups

Beneficiaries	Arghakhanchi	Kapilvastu	Total
Total population	242,469	580,467	822,936
Total neonates	5,987	13,465	19,452
Infants 0-11 months	8,729	15,054	23,783
Children <5 years	39,067	79,156	118,223
Ever married women of reproductive age (15-49 years)	52,642	138,902	191,544
Total beneficiaries	100,438	233,112	333,550
Expected pregnancies	6,652	14,964	21,616
Female Community Health Volunteers (FCHVs)	842	1,103	1,945
Health facility-based providers	267	166	433
Health facilities (hospital to sub health post)	43	79	122
Village Development Committees (VDCs)	42	77	119

Source: DoHS Target distribution for 2009/2010

Operation Research (OR) activities have continued in partnership with Mother & Infant Research Activities (MIRA), targeting Arghakhanchi district. Administratively, Arghakhanchi has two Electoral Constituencies (ECs). EC II is the OR intervention area, including health facility strengthening activities in addition to district-wide CBNCP. In Kapilvastu, CBNCP is also district-wide, and Positive Deviance activities are implemented in selected Village Development Committees (VDCs)

Table 2: Location of PMNH Activities

Key Interventions	Kapilvastu	Arghakhanchi (OR District)	
		Intervention (EC II)	Comparison (EC I)
1. Community-Based Newborn Care Program (CB-NCP)	√	√	√
2. Community-based PPH prevention (misoprostol) & neonatal cord care	√	√	√
3. Operations Research (OR)	X	√	X
3.1 Health facility strengthening and management (HW/HFOMC training)			
3.2 Verbal autopsy and near-miss reviews			
3.3 Maternal and newborn care quality improvement process			
3.4 Essential newborn care training and MNC equipment support			
Positive Deviance in MNC	√	X	X
Project monitoring and supervision	√	√	√

2.2 MAIN ACCOMPLISHMENTS

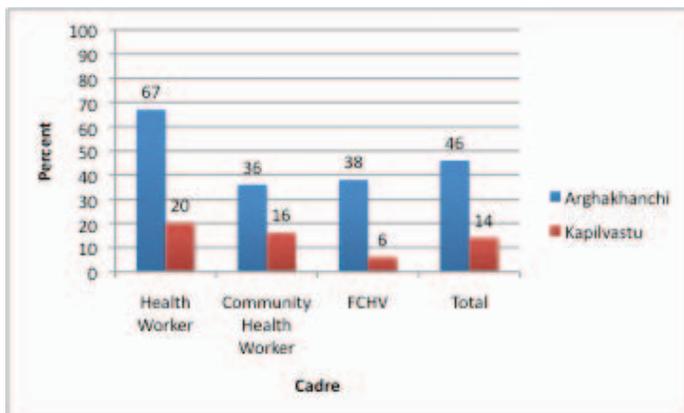
1. COMMUNITY BASED NEWBORN CARE PROGRAM

In this past year, the PMNH trained DHO statisticians in using CBNCP software, including data entry and analysis. Both districts have now incorporated CB-NCP data into the district HMIS.

HealthRight also supported both districts in completing comprehensive CB-NCP training. The training package includes Training of Trainers (ToT), technical training for facility-based HWs, technical training for community-based HWs [(Village Health Workers (VHWs)/Maternal and Child Health Workers (MCHWs)], FCHV training, and orientation for key VDC personnel and HFOMCs. The PMNH finished ToT and facility-based HW trainings in October 2011. The full package of CB-NCP training was completed by December 2011, with 615 FCHVs trained in Kapilvastu and 316 FCHVs trained in Arghakhanchi in the 3rd PMNH year. Additionally, 1,427 community representatives (e.g., VDC/HFOMC members, traditional healers, mothers' groups) received CB-NCP orientation in Kapilvastu, along with 1,0005 representatives in Arghakhanchi. The PMNH also supported FCHVs and facilities by providing recording forms, thermometers, scales, and De Lee suction and ambu bags. Despite government supply challenges, DHO was supplied with Gentamycin and Cotrim for CB-NCP.

As per CBNCP guidelines, the PMNH team conducted post-training follow-up in both districts in August 2012. This follow-up began with a two-day orientation to district supervisors, facility in-charges and auxiliary nurse-midwives (ANMs), followed by a week of field activities and de-briefing at district headquarters. The objectives of follow-up were to assess and reinforce program

performance and provide guidance for program improvement. Assessment specifically reviewed the knowledge and skills of HWs/FCHVs, logistics and supplies, and general CB-NCP management. Feedback from this assessment was shared and responsive actions were identified for the DHO as well as the PMNH team. Issues identified during follow-up involved logistics and supplies as well as skill retention. As shown in Fig. 1, overall skill retention is sub-optimal, particularly in Kapilvastu. Nearly half of respondents (46%)



correctly demonstrated all 5 CB-NCP essential skills in Arghakhanchi. However, in Kapilvastu, only one-fifth of facility-based HWs and one-sixth of community-based HWs demonstrated all essential CB-NCP skills. The vast majority (94%) of FCHVs did not know to perform all essential skills correctly in Kapilvastu. The PMNH team has prepared an action plan to address these gaps/issues.

In Kapilvastu, three sets of Ilaka-level data review and verification meetings have been completed with all 77 health facility in-charges. These meetings resulted in facility in-charges being refreshed in CB-NCP data recording, reporting, monitoring, and incentive management/calculation using VDC-based performance measures. The Arghakhanchi district PMNH team has initiated coaching at all 42 health facilities jointly with DHO supervisors, ensuring data verification and improved CB-NCP recording and reporting. The Nepali government has approved CBNCP performance-based incentives to FCHVs meeting pre-defined performance criteria. VDCs that are best-performing ($\geq 70\%$) receive 400

Nepalese Rupees (NRS) per closed form, better-performing (60-69%) receive 300 NRS per closed form, good-performing (50-59%) receive 200 NRS per closed form, and low-performing VDCs receive no incentive. By the third quarter of Year 3, all but one of the 119 VDCs in the program location were eligible for the best-performing category of performance-based incentives. Table 3 summarizes key CB-NCP outputs and outcomes achieved. CBNCP progress was shared by DHOs at Annual Regional Review meetings organized by the Regional Health Directorate Office in Pokhara.

Table 3. Key Outcomes of CB-NCP program in program districts (Jul 2011- Jul 2012)

Core CB-NCP Indicators	Arghakhanchi		Kapilvastu	
	Number	Percent	Number	Percent
Closed Newborn Service Forms	2648		7303	
Health Facility Delivery among total closed newborn forms	1134	42.82	1595	21.84
SBA Attended Home Delivery among the total Home Delivery	160	10.57	784	13.74
SBA Attended delivery at Health Facility among total health facility delivery	1053	92.86	962	60.31
Presence of FCHVs at Home Delivery among total home deliveries	1220	80.58	5691	99.70
Total Still Birth	29		117	
Initial Stimulation to newborn (HF+FCHV)	234	8.84	150	2.05
Use of De-Lee suction to newborn (HF+FCHV)	127	4.80	31	0.42
Use of Bag & Mask to newborn (HF+FCHV)	38	1.44	11	0.15
Skin to Skin Contact	1101	90.25	5691	100
Breast Feeding within 1 hour	1190	97.54	5691	100
Total LBW babies among closed form (HF+FCHV)	111	4.29	446	6.21
Total VLBW babies among closed form (HF+FCHV)	20	0.77	51	0.71
PNC Visit on 1 st Day by FCHV	1305	49.28	6864	93.99
PNC Visit on 3 rd Day by FCHV	2514	94.94	7022	96.15
PNC Visit on 7 th Day by FCHV	2542	96.00	7222	98.89
Alive Newborn on the 29 th day follow up by FCHV	2559		7253	
Death Newborn among closed form as reported by FCHV	49		97	
Lost to follow up	11		30	

2. COMMUNITY-BASED PROGRAMS: PPH PREVENTION AND NEONATAL CORD CARE

HealthRight initiated training in Arghakhanchi and Kapilvastu on misoprostol for PPH prevention, and its use by FCHVs at the community level. The project completed district orientation (113 participants), ToT (40 trainees), and HW training (139 trainees) in both districts this year. Starting in 2012, the Child Health Division (CHD) of the Department of Health Services has begun national roll-out of chlorohexidine (CHX) for neonatal cord infection prevention. HealthRight integrated CHX into the PPH initiative and began related training in both districts with technical support from the Grand Challenges-funded CHX Navi Care Project (CNCP). HealthRight will complete VHW/MCHW and FCHV Miso+CHX training by November 2012.

3. OPERATIONS RESEARCH (OR)

HealthRight and MIRA are implementing OR activities in Arghakhanchi. In the OR area (EC II), PMNH is supplementing CB-NCP with facility strengthening, building linkages between community and facilities (including stronger referral systems), and integrating maternal care in CB-NCP. The project is comparing outcomes from the CB-NCP PLUS package with those from CB-NCP only area.

3.1 HEALTH FACILITY MANAGEMENT & STRENGTHENING PROGRAM (HFMSPP)

HealthRight has facilitated the HFMSPP in all four health posts (HPs) and one primary health care center (PHCC) of the OR intervention area. Initial HFOMC trainings had been provided at five of the 19 facilities in the OR area in Year 2. In Year 3, PMNH conducted reviews/follow-up for HWs and

HFOMC members, reaching 618 participants through a total of three days of training. At follow-ups, participants reviewed plans prepared during initial training, received guidance in moving forward, and covered technical updates. Since the HFOMC trainings, observed process changes include: HFOMC member profiles posted at facilities, increases in monthly HFOMC meetings, and improved meeting management. As per HFMSM guidelines, each HFOMC is assessed in three outcome areas: 1) institutional development, 2) health facility management, and 3) health service status. Assessments demonstrated that facilities have been strengthened and both service utilization and local resource mobilization have increased (Tables 4 & 5). For MNC-related activities, intervention VDCs allocated a total of 1,033,000 NRS in 2012, compared to 492,600 NRS in 2011. Other examples of positive outcomes are described in the Results Highlight (Annex 4).

Table 4. HFOMC Assessment Scores at Baseline Training and Follow-Ups (F-U)

Facility	Institutional Dev.			Facility Mgmt.			Health Service Status			Aggregate Score		
	Base	F-U 1	F-U 2	Base	F-U 1	F-U 2	Base	F-U 1	F-U 2	Base	F-U 1	F-U 2
Thada PHC	4	10	14	6	15	14	7	7	15	18	33	44
Siddhara HP	7	13	14	7	9	15	5	9	12	13	12	44
Narapani HP	3	5	15	5	4	15	5	3	15	19	31	41
Subarnakhal HP	3	13	8	8	11	15	7	9	17	21	37	46
Pokharathok HP	3	14	15	9	10	14	9	13	17	17	32	43

Note: The maximum score for each dimension is 17; the maximum aggregate score is 51

Table 5: Status of MNH service delivery before (2011) and after (2012) HFMSM

Health facility	1'st ANC (#)		4 ANC (#)		1'st PNC (#)		Delivery (#)	
	Before	After	Before	After	Before	After	Before	After
Thada	278	246	128	155	47	113	46	113
Siddhara	84	109	28	49	8	25	7	25
Pokharathok	119	140	39	49	47	46	47	46*
Subarnakhal	49	64	18	42	0	12	0	12
Narapani	45	63	23	32	0	1	0	1

Out of 42 VDCs across Arghakhanchi, 35 have allocated cash support for FCHVs, staff hiring, facility maintenance, stretchers, and monthly staff meetings in 2012. This may be due to increasing prioritization of MNC following HFMSM and VDC-based CB-NCP orientation meetings.

3.2 MATERNAL/NEWBORN VERBAL AUTOPSY AND NEAR-MISS REVIEW

Near-miss: Near-miss activities were re-energized after mid-term evaluation (MTE). Neonatal near-miss guidelines and forms were developed based on national CB-NCP protocols. Similarly, a maternal near-miss tool was adapted from WHO guidance. MIRA recruited additional field staff for regular review of all neonatal near-miss cases in the OR area (EC-2) and initiated review of maternal near-miss cases. MIRA conducted maternal and neonatal near miss review training for HWs from six facilities in Arghakhanchi. After this training, the district formed a maternal and neonatal near miss review team under DHO chairmanship for periodic meetings to discuss reviewed cases. **Verbal**

Autopsy: In Year 3, the PMNH team reviewed 24 neonatal and two maternal verbal autopsy cases, building on trainings provided to facility staff in the previous year. Following Year 2 verbal autopsy trainings, participants received forms to complete when they encounter neonatal or maternal deaths.

Result	Major activity	Yr 1		Yr 2				Yr 3				Status & Comments	
		Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4		
services.	1.1.1c Provide support to DHO and HF in conducting interaction meeting with MG's and FCHV to identify gaps in feasible and current health behavior on MNC			X	X	X	X	X	X	X	X	X	Ongoing/On Target: through periodic training & meeting opportunities
	1.1.2a Support DHO and stakeholders to design local awareness raising campaigns on MNC services			X	X	X	X	X	X	X	X	X	Completed (>target): Conducted 19 times (Arg: 13, Kpv: 6) on different occasions (e.g., holiday celebrations, integrated camps)
	1.1.3 Provide support to DHO and HFs to implement awareness raising campaigns on key MNC policies such as the free maternity care, free essential health services and drugs etc			X	X	X	X	X	X	X	X	X	Completed (>target): Conducted 19 times (Arg: 13, Kpv: 6) on different occasions (e.g., holiday celebrations, integrated camps)
	1.1.4a Finalize MOU with PDI	X											Not Started Yet
	1.1.4b Implement PD process with selected communities			X	X	X	X	X	X	X	X	X	Not Started Yet
	1.1.4c Monitor PD process			X	X	X	X	X	X	X	X	X	Not Started Yet
	1.1.4d Document PD process, lessons learned, and outcomes			X	X	X	X	X	X	X	X	X	Not Started Yet
IR 2 Increased quality of MNC services at community and facility levels.	2.1.1a District level program orientation workshop for all stakeholders (CB-NCP, MNC)	X											
	2.1.1b Conduct training of district trainers on CB-NCP		X										
	2.1.1c Conduct CB-NCP training of technical health workers (Dr, HA, SN, AHW, and ANM)			X	X								Training to newly transferred health workers (Arg: 1, Kpv: 1)
	2.1.1d CB-NCP training for VHWs/MCHWs					X	X						
	2.1.1e CB-NCP training for FCHVs					X	X	X	X				Completed, (trained 1,098 FCHVs Kpv; 820 FCHVs Arg)
	2.1.1f CB-NCP training to traditional healers							X	X				Completed in both districts
	2.1.1g follow up after training for CB-NCP (Dr, HA, SN, AHW, ANM, and FCHV)							X					Completed in both districts (Arg: 34/42 facilities; Kpv: 61/77 facilities)
	2.1.3a Train facility-based health workers in MNC QI					X	X	X					Completed basic, 1st and 2nd follow up training of MNC-QI, organized grand recognition/award workshop, awarded 8 MNC-QI facilities
	2.1.3b Facilitate implementation of MNC QI tool					X	X	X	X	X	X		Completed a cycle of its' process, district staff will continue to support further
	2.1.3c Conduct supervision site visits to support MNC QI implementation							X	X	X	X	X	Complete/on Target: district staff will continue monitoring
	2.1.3d Facilitate MNC QI review meeting												
	2.1.3e MNC QI process and outcomes via site visits							X	X	X	X	X	Completed: Shared outcomes at district stakeholders workshop
	2.1.2a Train district trainers in management of PPH at home with misoprostol		X										Completed
	2.1.2b Train facility-based health workers in management of PPH at home with misoprostol			X	X								Completed
									X	X	X	X	Ongoing (will be completed by

Result	Major activity	Yr 1		Yr 2			Yr 3				Status & Comments		
		Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3		Q 4	
	home with misoprostol											November 2012)	
	2.2.1 Participate in and support annual district-wide health planning meetings with DHO staff			X				X				Completed	
	2.2.2a Conduct joint supervision visits with DHO staff		X	X	X	X	X	X	X	X	X	Completed	
	2.2.2b Conduct joint supervision visits with central MoHP and DHO staff		X				X				X	Completed	
	2.2.3 Introduce near miss maternal and neonatal death review and strengthen existing maternal health audits at district facilities				X	X	X	X					
	2.2.4 Support district statistician to introduce CB-NCP information system						X						
	2.2.5 Provide ongoing supportive supervision for district statistician and store keeper					X	X	X	X	X	X	Ongoing	
	2.2.6 Support DHO supervisors to conduct Ilaka-level health facility data review meetings with health facility staff to ensure regular analysis of MNC services, outcomes, and health indicators			X	X	X	X	X	X	X	X	Completed/On Target: (supported Kapilvastu district with Ilaka-level data verification meetings & Arghakhanchi with Ilaka level In-charges monthly review meetings)	
IR 3 Increased access to, and availability of, MNC services and supplies at community and facility levels.	3.1.1 Encourage emergency transport mechanisms in HFOMC trainings			X	X	X	X	X	X	X	X	Completed; Ensured supply of Stretchers at all health facility level in both districts	
	3.1.2 Resource sharing workshop with WDO to link women's savings and credit group to mother's groups	X	X	X	X	X	X						
	3.1.3 Develop, distribute, and update essential MNH service contact list to strengthen referral mechanisms from communities to and between facilities (e.g. FCHVs, SBAs, ambulances)			X				X				Completed	
	3.1.4 Encourage FCHVs, Mothers' Groups, traditional healers to identify/refer pregnant women to SBAs and FCHVs for appropriate MNC services via trainings listed above.				X	X	X	X	X	X	X	Ongoing: continuously advocated and linked this message at each level of community training	
	3.1.5 Strengthen referral systems for MNC services from health posts and sub-health posts to PHCCs and DHs			X	X	X	X	X	X	X	X	Ongoing: equipped 5 facilities with essential MNC equipment, provided 3 days' Essential Neonatal Training, and strengthened referral capacity	
	3.2.1a Conduct facility assessments with DHO to determine MNC equipment & supply needs	X											
	3.2.1b Prioritize MNC equipment and supply needs with DHO and central MoHP	X											
	3.2.1c Coordinate with Project CURE and GoN to import/deliver equipment and supplies		X	X									
	3.2.2 Facilitate small scale refurbishment for basic MNC infrastructure needs		X	X	X	X							
	3.2.3 Continually assess gaps in procurement chain for MNC supplies & medications, and work with DHO, HFOMCs, and facility staff to address barriers using monitoring checklist.	X		X		X			X		X		Ongoing: Assessed supplies in focused MNC-QI/HFMSP health facilities of Arghakhanchi only

Result	Major activity	Yr 1		Yr 2				Yr 3				Status & Comments	
		Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4		
IR 4 Improved social, policy, and enabling environment for MNC services and supplies.	4.1.1 Form and conduct regular PAC meetings at central and district level	X					X				X	Ongoing/On target: Conducted Arg-4 times, Kpv-2 times and Kathmandu-2 times	
	4.1.2 Participate in central and district MNC networks and TWGs	X	X	X	X	X	X	X	X	X	X	Ongoing/On Target	
	4.1.3 Sensitize VDC level cross-sectoral partners, including religious leaders and other community stakeholders, on MNC issues and importance of MNC services				X	X	X	X	X	X	X	X	Ongoing/On Target
	4.1.4 Advocate for HFOMC representation at annual VDC council meetings to increase use of local government resources for MNC					X	X	X	X	X	X	X	Ongoing/On Target
	4.2.1 Advocate at central and district level for GoN support of birthing center activation/establishment	X	X	X	X	X	X						Ongoing/On Target
	4.2.2 Support HFOMCs to advocate with DHO to address gaps in essential services, drugs and commodities via HFOMC training				X	X	X	X	X	X	X	X	Ongoing/On Target
	4.3.1 Identify facilities lacking HFOMCs and facilitate their establishment				X	X	X						
	4.3.2a Train district trainers on HFOMC in best practices in management of HFOMCs				X								
	4.3.2b Conduct training for HFOMC members in HFOMC management best practices				X	X	X						
	4.3.3 Conduct ongoing capacity building and facilitative supervision of select HFOMCs				X	X	X	X	X	X	X	X	Ongoing/On Target
	4.4.1 Develop MOU with MIRA		X										
	4.4.2 Develop/submit USAID OR Concept	X	X										
	4.4.3 Support data collection as delineated in MOU and Concept note				X	X	X	X	X	X	X	X	Ongoing/On Target
	4.4.4 Jointly analyze data												
	4.4.5 Jointly publish reports, articles												
	4.4.6 Disseminate OR results widely												
Reporting	Monthly reporting of community activities to district level	X	X	X	X	X	X	X	X	X	X	Ongoing/On Target	
	District quarterly report to Kathmandu office	X	X	X	X	X	X	X	X	X	X	Not Yet	
	Monthly reporting to HQ	X	X	X	X	X	X	X	X	X	X	Not Yet	
	Bi-annual report to USAID Nepal Mission		X		X		X		X		X	Not Yet	
	Annual report to USAID		X				X				X	Ongoing/On Target	
	Qualitative monitoring (FGDs, interviews)	X	X	X	X	X	X	X	X	X	X	X	Ongoing (via SWC evaluations)
	Train district staff to conduct verbal maternal or neonatal death audit				X	X							
	Develop and train district staff to complete regular monitoring visit checklist		X	X	X	X	X	X	X	X	X	X	Completed
	Mid-term evaluation						X						
	Final evaluation												
	Final project evaluation (SWC)												
Staff capacity building	Publications/dissemination (e.g., case studies)											Ongoing	
	Monthly staff meetings (district, KTM)	X	X	X	X	X	X	X	X	X	X	Ongoing/On Target	
	Annual program review meeting (district, KTM)		X				X				X	Ongoing/On Target	

C. CONTEXTUAL FACTORS IMPEDING PROGRESS

Misoprostol: Challenges in misoprostol availability from the MOHP Family Health Division (FHD) have delayed community-based PPH prevention activities. Moreover, the government did not complete training materials and monitoring forms for misoprostol scale-up until July 2012. HealthRight participated in finalization of those documents and simplification of recording and reporting forms. With support from UNICEF's misoprostol stock and HealthRight cost-share funding, the PMNH was able to initiate this initiative in the past year, and has now completed district orientation, TOT and facility-based HW trainings. Community-based HW and FCHV training will be completed by November 2012. **Near-miss Reviews:** Due to unavailability of government-endorsed guidelines, HealthRight and MIRA could not initiate maternal and neonatal near-miss reviews at Arghakhanchi as scheduled. However, after the MTE and meetings with MIRA, FHD and the Nepal Society of Obstetricians and Gynecologists, the project adapted near-miss forms/guidelines using WHO templates and nationally approved CB-NCP criteria. The near-miss review process has just started in the Arghakhanchi OR area. **Equipment:** The project faced delays in delivering equipment procured through HealthRight cost-share from Project CURE; there were legal and administrative issues because some equipment was older and second-hand.

D. TECHNICAL ASSISTANCE NEEDS

Specific skills requiring strengthening include: facilitating focus group discussions and key informant interviews, coding and analyzing transcript data using content analysis, and using qualitative software such as ATLAS.ti or NVivo. It is expected that the MIRA and HealthRight team will receive this technical assistance. The team also requires technical assistance in process evaluation related to OR activities. The MIRA and HealthRight team need technical exchanges and possibly external experts to support development of a detailed analysis plan for PMNH final evaluation. The district teams need assistance in adopting gender and social inclusion perspectives in programming and reporting.

E. SUBSTANTIAL CHANGES

There have been no substantial changes from the final, approved DIP.

F. SUSTAINABILITY PROGRESS

The project organized a joint workshop with local stakeholders, DHO, HFOMC chairs and providers from the HFOSP/MNC-QI VDCs of Arghakhanchi. Representatives from USAID, Jhpiego, and the Nick Simon Institute attended this workshop, met HFOMC members, and discussed scaling up MNC-QI. Through this workshop, district stakeholders also received support regarding ensuring local accountability for and continuity of services. The project has begun to develop a sustainability plan for multiple interventions provided through the PMNH. This process includes: meeting with DHO and Local Development Offices (LDOs) to prepare an exit plan through which key PMNH activities can be integrated with the government's workplan; supporting the government to form a QI team at the district level as per MoHP guidelines; advocacy with VDCs and District Development Committees to continue cash and in-kind support for MNC services (e.g. funds for HW recruitment); and developing the capacity of district Reproductive Health Coordination Committee (RHCCs).

G. SPECIFIC INFORMATION REQUESTED IN MID-TERM EVALUATION (MTE)

The MTE was completed in October 2011, led by the Public Health and Infectious Disease Research Center (PHIDReC). MTE recommendations and HealthRight responses are outlined in Annex 4. Key recommendations regarding completion of CB-NCP training and supervision to sustain CB-NCP skills

have been addressed. However, misoprostol training remains incomplete. Another MTE suggestion was to educate fathers' groups about MNC. HealthRight is trying to address this through FCHVs and HFOMC members. To date, HealthRight's greatest success in reaching men has been via street dramas conducted through its complementary USAID-funded program in the program location, "Integrating Family Planning and Maternal and Newborn Care Services in Rural Nepal."

I. MANAGEMENT SYSTEM

Overall, there were no significant changes to management systems in Year 3. Specific updates include: **Financial management:** The SWC evaluation team visited HealthRight's Kathmandu and field offices to observe financial management systems. As per national rules the project is being audited this year. **Human resources:** In Year 3, both original District Project Officers have been replaced. HealthRight conducted a General Staff Meeting as part of its staff retreat during Year 3; activities included orientation regarding security and disaster preparedness. **Communication:** HealthRight has established high quality communication systems; each district office communicates daily via email and phone with the central office. Likewise, the central office communicates daily via email and weekly via Skype with USA headquarters. **PVO coordination and collaboration:** Throughout Year 3, HealthRight staff participated regularly in PVO coordination meetings and networks in Kathmandu and at the district-level, including with the Nepal Family Health Program, Save the Children, CARE, Plan International, Helen Keller International, WHO, UNICEF, and UNFPA. HealthRight participated in several MNC-related forums, such as the Safe Motherhood and Neonatal Sub-Committee, RHCCs, FCHV Committee, Joint Annual Review meetings, FHD RH review workshops, and the CHD CB-IMCI multiyear planning workshop. Through Child Survival Working Group (CSWG) meetings of USAID-funded PVOs, HealthRight has shared and learned about child survival interventions and PVO-specific experiences.

J. LOCAL PARTNER ORGANIZATION COLLABORATION AND CAPACITY BUILDING

HealthRight has worked closely with government counterparts in Year 3 in implementing training activities, including CHD, FHD, Ministry of Women, Children and Social Welfare, SWC, DHOs, LDOs, and Women Development Offices. MIRA is HealthRight's main local NGO partner, responsible for OR activities. A healthy relationship has been built between HealthRight and MIRA through frequent communication, regular in-person meetings, and transparency.

K. MISSION COLLABORATION

USAID's Nepal Mission has been supportive of HealthRight throughout the reporting period, and HealthRight has remained in regular contact with Mission staff. Mission staff have frequently visited PMNH activities at district level and were involved in the MTE. HealthRight also hosted a USAID intern this year, organizing field visits in both PMNH districts. Along with participating in the Mission's CSWG, staff also gave updates on project progress at the Mission's Annual Partner's Consultation Meeting.

ANNEXES

Annex 1: M & E Table

Annex 2: Project 4th Year Work Plan

Annex 3: PMNH Presentations

Annex 4: Result Highlight

Annex 5: MTE Recommendations and Respons

Annex 1: Partnership for Maternal and Neonatal Health Monitoring & Evaluation Table

Objective/Result	Indicators	Source/Measurement method	Frequency	Baseline value	EOP Target	Year 3 Status
Strategic Objective: Increased use of key maternal and neonatal services and practices						
IR 1. Increased knowledge of, and demand for, MNC practices and services. <i>Strategy:</i> Conduct behavior change communication and community mobilization on key MNC practices and services.	% of children age 0-23 months who were dried and wrapped with a cloth or blanket immediately after birth	KPC	KPC- Baseline and Endline	A: 63.6 K: 33.6	A: 75.0 K: 65.0	A: NA K: NA
	% of children age 0-23 months who were put to the breast within one hour of delivery	KPC	KPC- Baseline and Endline	A: 31.1 K: 21.3	A: 75.0 K: 75.0	A: NA K: NA
	% of children age 0-5 months who were exclusively breastfed during the last 24 hours	KPC	KPC- Baseline and Endline	A: 51.4 K: 46.3	A: 80.0 K: 80.0	A: NA K: NA
	% of mothers of children 0-23 months who received four or more ANC visits when pregnant with their youngest child	KPC	KPC- Baseline and Endline	A: 36.8 K: 29.0	A: 70.0 K: 60.0	A: NA K: NA
	% of mothers with children age 0–23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	KPC	KPC- Baseline and Endline	A: 88.0 K: 89.7	A: 85 K: 85	A: NA K: NA
	% of mothers of children 0-23 months who knew at least two danger signs during pregnancy	KPC	Annually	A: 45.5 K: 53.7	A: 75.0 K: 75.0	A: NA K: NA
	% of children age 0-23 months who are underweight (-2SD for the median weight for age, according to WHO/NCHS reference population)	KPC	Baseline and End line	A: 25.0 K: 37.2	A: 15.0 K: 30.0	A: NA K: NA
	% of mothers of children age 0-23 months able to report at least two known neonatal danger signs.	KPC	Annually	A: 30.0 K: 19.3	A: 75.0 K: 75.0	A: NA K: NA
	% of children age 0–23 months whose births were attended by skilled personnel	KPC	KPC- Baseline and Endline	A: 20.8 K: 24.0	A: 50.0 K: 50.0	A: NA K: NA
	% of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	KPC, health facility records	KPC- Baseline and Endline	A: 71.9 K: 75.0	A: 80.0 K: 80.0	A: NA K: NA
	% of mothers of children age 0-23 months who	KPC	KPC-	A: 31.9	A: 50.0	A: NA

Annex 1: Partnership for Maternal and Neonatal Health Monitoring & Evaluation Table

	used a clean delivery kit during the birth of their youngest child		Baseline and Endline	K: 8.3	K: 45.0	K: NA
	% of mothers of children age 0-23 months who took iron tablets before the birth of their youngest child	KPC, health facility records	KPC- Baseline and Endline	A: 85.3 K: 64.7	A: 85.0 K: 85.0	A: NA K: NA
	Focused communications campaigns raising awareness of key neonatal messages implemented in partnership with DHO and HFOMC	Annual report	KPC- Baseline and Endline	A: 0 K: 0	A: 6 K: 6	A: 13 K: 6
	Focused communications campaigns conducted by HFOMC and DHO to raise awareness of key MNC services	Health Facility records	Bi-annually	A: 0 K: 0	A: 6 K: 6	A: 13 K: 6
	Awareness raising campaigns on key MNC policies	Event log	Annually	A: 0 K: 0	A: 6 K: 6	A: 13 K: 6
IR 2. Increased quality of MNC services at community and facility levels. <i>Strategy:</i> Build the capacity of health facility workers in providing MNC services.	# of HW received CB-NCP district trainers training	Training log	Annually	A: 0 K: 0	A: 10 K: 10	A: 10 K: 10
	# of HW trained on CB-NCP	Training log	Annually	A: 0 K: 0	A: 103 K: 134	A: 82 K: 149
	# of community health workers (VHWs, and MCHWs) trained in CB-NCP	Training log	Annually	A: 0 K: 0	A: 74 K: 143	A: 57 K: 137
	# of community volunteer (FCHVs) trained in CB-NCP	Training log	Annually	A: 0 K: 0	A: 842 K: 1105	A: 820 K: 1098
	# of community groups oriented on CB-NCP including TBAs, religious leaders, Mothers' Groups, and traditional healers.	Training log	Annually	A: 0 K: 0	A: 200 K: 375	A: 1005 K: 1427
	% of estimated total pregnancies received and took misoprostol from FCHVs	HFA record, supervision visit	Annually	A: 0.0 K: 0.0	A: 50.0 K: 50.0	A: NA
	% of pregnant women received misoprostol from FCHVs	HFA record, HMIS	Annually	A: 0.0 K: 0.0	A: 75.0 K: 75.0	K: NA
	Number of health facility staff receiving MNC quality improvement training	Training log	Annually	A: 0	A: 5	A: 18
	Number of health facility implemented MNC QI process	Health Facility records	Annually	A: 0	A: 3	A: 8
	% of children age 0-23 months that had clean cord	KPC	KPC-	A: 95.0	A: 95.0	A: NA

Annex 1: Partnership for Maternal and Neonatal Health Monitoring & Evaluation Table

cutting at the time of birth		Baseline and Endline	K: 99.3	K: 95.0	
% of mothers of child age 0-23 months who received a post-partum visit from an appropriate trained health worker within two days after the birth of their youngest child	KPC, Health Facility records	KPC- Baseline and Endline	A: 41.5 K: 47.3	A: 50.0 K: 50.0	K: NA
% of mothers of child age 0-23 months who received 3 post-partum visit from FCHV or facility based health worker	Health Facility Records	KPC- Baseline and Endline	A: 4.2 K: 4.0	A: 50.0 K: 50.0	A: NA K: NA
% of children age 0-23 months who received all three elements of essential newborn care: thermal care, clean cord care, and immediate breastfeeding	Health Facility Records	KPC- Baseline and Endline; HFR - Annually	A: 18.2 K: 5.7	A: 75.0 K: 65.0	A: NA
% of newborn receiving care 1-2days after delivery	Health Facility Records	Baseline and Endline	A: 41.0 K: 48.0	A: 70.0 K: 70.0	A: 49.28 K: 93.99
% of newborn receiving care 3-7 days after delivery	Health Facility Records	Baseline and Endline	A: 49.6 K: 25.1	A: 75.0 K: 75.0	A: 95.47 K: 97.52
% of young infants (0-2 months) with PSBI seen by VHW who completed the full course of Gentamycin	Health Facility Records	Baseline and line	NA	A: 80.0 K: 80.0	A: NA K: NA
% of women whose home birth was conducted by skilled Birth Attendant	Health Facility Records	Baseline and Endline	A: 2.4 K: 2.5	A: 5.0 K: 5.0	A: 10.57 K: 13.74
% of home deliveries where FCHV attended newborn	Health Facility Records	Baseline and Endline	A: 6.2 K: 7.5	A: 80.0 K: 80.0	A: 80.58 K: 99.7
% of mother whose newborn was kept skin to skin contact immediately after birth where FCHV attended to the newborn	Health Facility Records	Baseline and Endline	NA	A: 80.0 K: 80.0	A: 90.25 K: 100
% of mother who breast feed their newborn within 1 hour where FCHV attended to the newborn	Health Facility Records	Baseline and Endline	Not available yet	A: 80.0 K: 80.0	A: 97.54 K: 100
% of delivery conducted at health institution by SBA	Health Facility Records, RH	Annual Baseline and	A: 25.5 K: 26.8	A: 40.0 K: 40.0	A: 39.77% K: 13.17

Annex 1: Partnership for Maternal and Neonatal Health Monitoring & Evaluation Table

	% of delivery conducted at health institution by SBA	Health Facility Records, RH review meeting	Annual Baseline and Endline; RH meeting - annually	A: 25.5 K: 26.8	A: 40.0 K: 40.0	A: 39.77% K: 13.17 %
Strategy: Increase capacity of District Health Office (DHO) and HFOMCs to facilitate and monitor quality of MNC services.	Participate and support annual district-wide health planning meetings with DHO staff	Meeting minutes	Annually	A: 0 K: 0	A: 3 K: 3	A: 4 K: 3
	Number of quarterly review meetings conducted by the health facility staff with FCHVs	Health Facility Records	Annually	A: 0 K: 0	A: 8 K: 8	A: 6 K: 6
	Number of joint supervision visits conducted with central and DHO staff	District report	Annually	A: 0 K: 0	A: 4 K: 4	A: 18 K: 19
	Number of near miss maternal and neonatal death reviews conducted	Health Facility Records	Annually	A: 0	A: 10	A: 0
	Number of neonatal deaths reported by FCHVs	Health Facility Records	Endline	Expected around 5-10 (based on CBR)	A: 20 K: 20	A: 49 K: 97
	Number of maternal deaths reported by FCHVs	Health Facility Records	Endline	Expected 1-2	A: 10 K: 10	A: 4 K: NA
	% of newborn recorded by FCHVs with PSBI	Health Facility Records	Baseline and Endline	NA	A: 25.0 K: 25.0	A: 0.79 K: 0.003
	Number of DHO data review supervision visits conducted with health facility staff	Health Facility records	Annually	A: 0 K: 0	A: 12 K: 12	A: 11 K: 12
	Health facility receiving at least minimum required number of supervision visits in last six month	Supervision visit	Annually	A: 0 K: 0	A: 2 K: 2	A: 17 K: 30
	% of VHW, MCHW and FCHVs who reported that last supervision visit was helpful ??	Supervision visit	Annually	NA	A: 70.0 K: 70.0	A: 100.0 K: 100.0
IR 3. Increased access to, and availability of, MNC services and supplies at community and facility levels.	# of HFOMC that have an emergency transport mechanism in place	HFA, supervision visit	Annually	A: 0	A: 10	A: 42
	# of HFs, VHWs, MCHWs and FCHVs having emergency contact list	Supervision visit	Annually	A: 0.0 K: 0.0	A: 1009 K: 1372	A: 1009 K: 1372
	Average # of pregnant women referred by FCHV	Health facility and	Bi-annually	A: 0	A: 5	A: 2.18

Annex 1: Partnership for Maternal and Neonatal Health Monitoring & Evaluation Table

IR 3. Increased access to, and availability of, MNC services	# of HFOMC that have an emergency transport mechanism in place	HFA, supervision visit	Annually	A: 0	A: 10	A: 42
	# of HFs, VHWs, MCHWs and FCHVs having emergency contact list	Supervision visit	Annually	A: 0.0 K: 0.0	A: 1009 K: 1372	A: 1009 K: 1372
	Average # of pregnant women referred by FCHV for MNC services in last six month	Health facility and FCHVs records, supervision visit	Bi-annually	A: 0 K: 0	A: 5 K: 5	A: 2.18 K: 3.13
	Average # of newborns referred by FCHVs for newborn care services in last six month	Health facility and FCHVs records, supervision visit	Bi-annually	A: 0 K: 0	A: 5 K: 5	A: 0.02 K: 0.03
	Average # of pregnant women referred from health facilities to higher health facilities for MNC services in last six month	Health facility and FCHVs records, supervision visit	Bi-annually	A: 0 K: 0	A: 5 K: 5	A: NA K: NA
	Average # of newborns referred from health facilities to higher health facilities for newborn care services in last six month	Health facility and FCHVs records, supervision visit	Bi-annually	A: 0 K: 0	A: 5 K: 5	A: NA K: NA
<i>Strategy:</i> Improve infrastructure and availability of MNC equipments, supplies and drugs	# of Health Facility Assessments conducted with DHO team to determine BEOC needs and neonatal care	Service log	Annually	A:0 K:0	A: 6 K: 1	A: 11 K: 5
	# of HealthRight International-supported sites having essential medicines and supplies	Health Facility Records	Bi-annually	A:0	A: 6	A: 5
	# of birthing centers and/or maternity waiting homes established/strengthened by HFOMCs and are operational	Health Facility Records	Bi-annually	A: 2	A: 6	A: 13
IR 4 Improved social, policy, and enabling environment for MNC services and supplies	Number of central/district project advisory committee meetings conducted per year	Meeting minutes	Annually	A: 0.0 K: 0.0	A: 6 K: 6	A: 4 K: 2
	Project district annual program plan included in DDC council	DDC annual plan	Annually	A: 0.0 K: 0.0	A: 3 K: 3	A: 3 K: 1
<i>Strategy:</i> Improve coordination of, and linkage between and among MNC interventions at the facility and community level	# of central annual program plan included in DoHS (CHD, FHD) annual plan	Red book annual plan	Annually		Kath: 4	Kath: 3

Annex 1: Partnership for Maternal and Neonatal Health Monitoring & Evaluation Table

	Gaps in essential services, drug supplies discussed with DHO and a strategy identified to address barriers	Review report	Annually			Yes
<i>Strategy:</i> Increase number of well-functioning Health Facility Operation and Management Committee (HFOMCs) (including community and facility representatives) in operation	# of HW received MTOT on HFOMC	Training log	Annually	A: 0	A: 6	A: 18
	# of HFOMCs members trained in local management and operation of health facility.	Training log	Annually	A:0	A: 54	A: 57
	# of functional HFOMCs	Supervision visit, Training log	Annually	NA	A: 6	A: 5
	# of HFOMCs receiving VDC and DDC fund for health program	Supervision visit	Annually	NA	A: 6	A: 6
<i>Strategy:</i> Conduct operations research on program innovation and disseminate results.	Produce operation research (OR) report	OR Report	End line	NA	Report available	Ongoing Process documentation
	No. of conferences/meetings at which study findings are presented	Conference reports / meeting minutes; Annual report	End line	NA	10	3
	Number of articles published based on study findings in journals and gray literature	Annual report	End line	NA	2	0

Annex 2: Partnership for Maternal and Neonatal Health 4th Year Workplan

Abbreviations:

DPS = District Project Supervisor

DPO = District Project Officer

CR = Chandra Rai, Project Director/Country Representative

M&E = Monitoring, Evaluation, and Project Coordinator

PA = Project Associate

TOO = Training Operation Officer

Result	Major activity	Year 4				Responsible Personnel
		Q1	Q2	Q3	Q4	
Strategic Objective: Increased use of key maternal and neonatal services and practices.						
IR 1 Increased knowledge of, and demand for, MNC practices and services.	1.1.1a Provide facilitative supervision for FCHVs, VHW/MCHWs and SBAs in conducting interpersonal and group education	X	X	X		DPS
	1.1.1b Monitor FCHV records to ensure regular Mothers' Group meetings and one-on-one communication	X	X	X		DPS
	1.1.1C Provide support to DHO and HF in conducting interaction meeting with MG's and FCHV to identify gaps in feasible and current health behavior on MNC	X	X	X		DPS
	1.1.2a Support DHO and stakeholders to design local awareness raising campaigns on MNC services	X	X	X		DPO, DPS
	1.1.3 Provide support to DHO and HFs to implement awareness raising campaigns on key MNC policies such as the free maternity care, free essential health services and drugs, etc.	X	X	X		
	1.1.4a Finalize MOU re: Positive Deviance Inquiry (PDI)	X				HQ, CR
	1.1.4b Implement positive deviance (PDP process with selected communities	X	X			DPO
	1.1.4c Monitor PD process	X	X			M&E
	1.1.4d Document PD process, lessons learned, and outcomes	X	X	X	X	M&E, HQ
IR 2 Increased quality of MNC services at community and facility levels.	2.1.3b Facilitate implementation of MNC QI tool	X	X			TOO, DPO
	2.1.3c Conduct supervision site visits to support MNC QI implementation	X	X			CR, TOO
	2.1.3d Facilitate MNC QI review meeting		X			CR, TOO

Annex 2: Partnership for Maternal and Neonatal Health 4th Year Workplan

	2.1.3e MNC QI process and outcomes via site visits	X	X			CR, TOO, M&E
	2.1.2c Train FCHVs in management of PPH at home with misoprostol	X				DPO, DHO facilitators
	2.2.1 Participate in and support annual district-wide health planning meetings with DHO staff	X				DPO
	2.2.2a Conduct joint supervision visits with DHO staff	X	X	X		DPO, M&E, TOO, CR
	2.2.2b Conduct joint supervision visits with central MoHP and DHO staff				X	CR, M&E, TOO, DPO
	2.2.3 Introduce near miss maternal and neonatal death review and strengthen existing maternal health audit system at district and select health facilities	X	X	X		MIRA
	2.2.5 Provide ongoing supportive supervision for district statistician and store keeper	X	X	X		DPO
	2.2.6 Support DHO supervisors to conduct Ilaka-level health facility data review meetings with health facility staff to ensure regular analysis of MNC services, outcomes, and health indicators	X	X	X		DPO
IR 3 Increased access to, and availability of, MNC services and supplies at community and facility levels.	3.1.1 Encourage emergency transport mechanisms in HFOMC trainings	X	X	X		M&E, DPO
	3.1.2 Resource sharing workshop with WDO to link women's savings and credit group to mother's groups	X				DPO
	3.1.3 Develop, distribute, and update essential MNH service contact list to strengthen referral mechanisms from communities to facilities and between facilities (e.g. FCHVs, SBAs, ambulances)	X				DPO, DPS
	3.1.4 Encourage FCHVs, Mothers' Groups, and traditional healers to identify and refer pregnant women to SBAs and FCHVs for appropriate MNC services via trainings listed above.	X	X	X		DPS, DPO
	3.1.5 Strengthen referral systems for MNC services from health posts and sub-health posts to PHCCs and DHs	X	X	X		
	3.2.3 Continually assess gaps in the procurement chain for MNC supplies and medications, and work with DHO, HFOMCs, and health facility staff to address barriers using monitoring checklist.	X		X		DPS
IR 4	4.1.1 Form and conduct regular PAC meetings at				X	CR, DPO

Annex 2: Partnership for Maternal and Neonatal Health 4th Year Workplan

IR 4 Improved social, policy, and enabling environment for MNC services and supplies.	4.1.1 Form and conduct regular PAC meetings at central and district level				X	CR, DPO
	4.1.2 Participate in central and district MNC networks and TWGs	X	X	X	X	CR, PC, TOO, DPO
	4.1.3 Sensitize VDC level cross sectoral partners, including religious leaders and other community stakeholders, on MNC issues and the importance of community-facility based MNC services	X	X	X		DPO, DPS
	4.1.4 Advocate for HFOMC representation at annual VDC council meetings to increase use of local government resources for MNC services	X	X	X		DPS
	4.2.1 Advocate at central and district level for GoN support of birthing center activation/establishment	X	X	X		CR, M&E, DPO
	4.2.2 Support HFOMCs to advocate with DHO to address gaps in essential services, drugs and commodities via HFOMC training	X	X	X		TOO, DPO
	4.3.3 Conduct ongoing capacity building and facilitative supervision of select HFOMCs	X	X	X		MIRA
	4.4.4 Jointly analyze data	X	X	X	X	M&E, MIRA
	4.4.5 Jointly publish reports, articles	X	X	X	X	M&E, HQ, PA, CR, MIRA
	4.4.6 Disseminate OR results widely			X	X	PM, CR, M&E, DPO
Reporting	Monthly reporting of community activities to district level	X	X	X	X	DPS
	District quarterly report to Kathmandu office	X	X	X	X	DPO
	Monthly reporting to HQ	X	X	X	X	CR, M&E
	Bi-annual report to USAID Nepal Mission		X		X	CR, M&E, HQ
	Annual report to USAID				X	CR, M&E, HQ
	Qualitative monitoring (FGD, In-depth interview)	X	X	X	X	DPO, DPS
	Develop and train district staff to complete regular monitoring visit checklist	X	X	X	X	M&E, DPO, DPS
	Final evaluation			X	X	M&E, CR, HQ
	Final project evaluation (SWC)			X	X	CR
	Publication and dissemination (case studies, articles etc)			X	X	CR, M&E, HQ
Staff capacity	Monthly staff meetings (district and KTM level)	X	X	X	X	CR
	Annual program review meeting (district, KTM)				X	M&E

ANNEX 3: PARTNERSHIP FOR MATERNAL & NEONATAL HEALTH PRESENTATIONS

What	When	Where	Audience
Sharing of MNC-QI final results: Arghakhanchi	Sept 27, 2012	District Health Office, Arghakhanchi, in MNC-QI final evaluation workshop	Chief District Officer, Local Development Officer, health workers, HFOMC chairs
IFP-MNH Final evaluation findings presentation	September 03, 2012	SWC conference hall, Kathmandu	SWC
Presentation of CB-NCP post-training follow up findings: Arghakhanchi & Kapilvastu	September & July, 2012	Districts	DHO staff, HP/PHCC in-charges, CHD & RHD supervisors/resource persons
Sharing lessons of Integrated FP & MNH project	August 26, 2012	NHTC Hall, Kathmandu	National Health Training Center staff and other stakeholders
Family Planning Status and Way Forward: Sustainability Planning Workshop on Integrated FP and MNH	17 July, 2012	District Health Office, Arghakhanchi	District supervisors, long acting FP-trained health workers
Update on lessons of Integrated FP & MNH project	July 15, 2012	Child Survival Health Working Group (CSHWG) Meeting-National Family Health Program (NFHP) Hall, Kathmandu	USAID local mission staff and CSHWG partners
Periodic Project progress to Central Project Advisory Committee (C-PAC)	June 5, 2012	C-PAC Meeting, Dhokaima Kafey, Kathmandu	C-PAC members
PMNHP mid-term evaluation findings presentation	May 30, 2012	SWC conference hall, Kathmandu	SWC people
Update on CB-NCP progress status at districts	27 March, 2012	NFHP-KLM Hall, Kathmandu	CSHGP partners, USAID local mission staff

Annex 4: PMNH Result Highlight | Promising Practice: Health Facility Management Strengthening

Problem: Health Facility Management and Operating Committees (HFOMCs) are a local governance structure within the Nepali health system. However, many HFOMCs are non-functioning or have limited capacity. This is implicated in poor staffing and quality of care at many community health facilities. **Intervention:** To address this, a key intervention within HealthRight’s Partnership for Maternal and Neonatal Health (PMNH) was HFOMC strengthening, addressing good governance, transparency, accountability and participation at health facilities in Arghakhanchi district. HFOMC strengthening was implemented by the PMNH in 5 facilities: 4 health posts (HP) and 1 primary health care center (PHCC). These facilities cover a catchment area of 35,368 people. HealthRight was supported by local partner Mother and Infant Research Activities (MIRA) and trainers from the National Technical Assistance Group (NTAG). HFOMC strengthening included: a Training of Trainers (ToT); on-site HFOMC training; debriefing/review workshops at the District Health Office (DHO); and two follow-ups at 8 and 14 months after initial training.

Basic Training (7 days)		1 st Follow-up (F-U 1, 4 days)		2 nd Follow-up (F-U 2, 2 days)	
TOT	HFOMC Members	Refresher TOT	HFOMC Members	Refresher TOT	HFOMC Members
18	57	18	56	15	54

Results: Facilities were assessed at baseline and two follow-ups on institutional development, facility management, and health services status. On average, the aggregate score increased from 35% to 84% of maximum.

Facility	Institutional Dev.			Facility Mgmt.			Health Service Status			Aggregate Score		
	Base	F-U 1	F-U 2	Base	F-U 1	F-U 2	Base	F-U 1	F-U 2	Base	F-U 1	F-U 2
Thada PHC	4	10	14	6	15	14	7	7	15	18	33	44
Siddhara HP	7	13	14	7	9	15	5	9	12	13	12	44
Narapani HP	3	5	15	5	4	15	5	3	15	19	31	41
Subarnakhal HP	3	13	8	8	11	15	7	9	17	21	37	46
Pokharathok HP	3	14	15	9	10	14	9	13	17	17	32	43

Note: F-U = follow-up. The maximum score for each dimension is 17; the maximum aggregate score is 51

Human resource gaps are a crucial factor in poor MNC in Nepal. Four intervention HFOMCs have addressed this by mobilizing staffing support from VDCs and the District Health Office (DHO). For example, Thada HFOMC recruited two general assistants, one lab assistant, two Auxiliary Health Workers, and one Auxiliary Nurse-Midwife.

Across the five intervention HFOMCs, VDCs have increased total MNC resources by a 110% over baseline.

	Thada PHC	Siddhara HP	Pokharathok HP	Subarnakhal HP	Narapani HP
2011 Funds	100000	125000	79000	117000	71600
2012 Funds	300000	255000	226000	165000	87000
% Increase	200%	104%	186%	41%	22%

Other examples of ways in which HFOMCs have worked to revitalize MNC include:

- Four intervention facilities now provide 24-hour delivery services, vs. just one before the trainings.
- HFOMC members have begun conducting supportive supervision to primary care/outreach clinics.
- Four of five intervention facilities have started long-acting family planning services, including in postpartum care.
- Intervention VDCs have identified and funded self-generated strategies to promote MNC, e.g.:
 - Purchasing stretchers for FCHVs (Subarnakhal VDC)
 - Providing facility delivery referral incentives to FCHVs (Subarnakhal HP & Siddhara HP)
 - Purchasing clothing for newborns delivering at facilities (Thada PHC)
 - Instituting maternity waiting homes (Siddhara HP)
 - Initiating emergency reproductive health funds (Siddhara & Pokharathok HPs)

Impact, Sustainability and Scale-up: Uptake of MNC services has increased in HFOMC intervention facilities (see PMNH Annual Report). In addition to achieving rapid results, this intervention appears highly sustainable – there is now a pool of 18 trainers at the district who can serve as local resources; the DHO has already expanded this initiative to four additional health facilities using its own funds. These results suggest that this intervention is a model for health system strengthening that should be scaled up in additional districts.

Annex 5: Partnership for Maternal and Neonatal Health | Mid-term Evaluation Recommendations and Responses

Findings	Recommendations	Action Plan for Response	Timeline	Status
Delay in Positive Deviance (PD) initiation	- Early initiation of PD for MNH to obtain desired outcome in Kapilvastu	- PD assessment and dialogue with District and village committee -PD process initiation	Planned in Q1 of YR3 (2011). Date to be confirmed with district team	VDC identified and baseline conducted
Took long time to complete CBNCP training	- Speed up remaining FCHVs' training and traditional healer orientation - Start CBNCP follow up after training to find out any coaching/support needed to the earlier group of the trainees.	- FCHVs training will be completed by the end of Q1 Y3 (2011) - Coordinate with CBNCP stakeholders and consultant for the CBNCP follow up	Date to be confirmed with district team	Completed
Some health facilities with SBAs are not providing 24-hr delivery services	- Promote birthing centre for 24-hour delivery services, especially in those Health facilities where SBAs are available.	Continue dialogue/discussion with DHO and HFs to find out the reasons for not providing 24-hr delivery services and identify if any support is needed	Ongoing	Increased number of birthing centers in both districts. Arghakhanchi has gone from 3 (baseline) to 13; Kapilvastu has gone from 3 (baseline) to 7.

Annex 5: Partnership for Maternal and Neonatal Health | Mid-term Evaluation Recommendations and Responses

<p>Delay in implementing PPH prevention and management with misoprostol tablet at home delivery</p>	<ul style="list-style-type: none"> - Continue coordination and follow up with government and other stakeholders to obtain misoprostol drug for prevention and management of PPH at community level. - Suggested to explore private funders or other sources to speed up the program if delay in misoprostol procurement through the government continues. 	<p>Coordination with FHD and HealthRight HQ</p>	<p>Ongoing</p>	<p>Initiated program in both districts integrating CHX program. District orientation, TOT and health workers training completed. Tablet misoprostol procured by HealthRight with cost-share funds. Continued follow-up with government for misoprostol supply from the government supply chain.</p>
<p>So far all (8) neonatal death reported from the health facilities. However, majority of deaths occur in the community.</p>	<ul style="list-style-type: none"> - Collect maternal and neonatal death from community level. 	<p>Will coordinate with FHD, NESOG and other relevant stakeholders for near miss maternal and neonatal death reviews immediately</p>	<p>Ongoing</p>	<p>Initiated maternal and neonatal near miss and death review. Data from community and health facilities now being collected.</p>
<p>Delay in CB-NCP software installation at district level due to the revision of the software.</p>	<ul style="list-style-type: none"> - Initiate CB-NCP reporting using CHD/CB-NCP Excel spreadsheet containing the same indicators as the software while it the software is being finalized. 	<p>Coordination with CBNCP secretariat initiated</p>	<p>Ongoing</p>	<p>CB NCP software installed in both district, DHO and district project staff oriented. Data now regularly coming through DHO HMIS system.</p>

ADDENDA (Submitted November 2, 2012)

Addendum 1: Major Project Accomplishments & Project Activity Status Tables

Addendum 2: Operations Research Study Progress and Achievements Table

Addendum 3: Learning Brief | Strengthening Health Facility Management

HealthRight Addendum 1: Major Project Accomplishments & Project Activity Status

Table 1: Summary of Major Project Accomplishments (1 Oct 2011 – 30 Sept 2012)

[COMPLEMENTS SECTION A OF SUBMITTED ANNUAL REPORT]

Project Objective: To improve quality of maternal and newborn care services

Project Inputs	Activities	Outputs	Outcomes
- CBNCP supplies, drugs,, training curricula, and human resources at community level of Arghakhanchi and Kapilvastu district	-Train FCHVs on CBNCP - Orient Traditional healers and VDC members - Conduct CBNCP post-training follow up	- 931 FCHVs trained - 2432 traditional healers and VDC members oriented. - Post-training follow-ups at/with 95 health facilities, 144 health workers, 149 VHWs/MCHWs, 145 FCHVs. - Increased community awareness regarding MNC issues	- Capacity to implement CB-NCP across all health facilities and VDCs in both districts. - CBNCP-trained FCHVs present during birth 80.58% (1220/1514) and 99.70% (5691/5708) in Arghakhanchi and Kapilvastu respectively.
- Government approval for misoprostol and chlorohexidine (CHX) roll out for PPH prevention & neonatal infection prevention at community	- Orient stakeholders at district - Conduct TOT - Conduct training for health workers	-113 stakeholders oriented - 40 Trainers trained - 139 health workers trained	- Increased health worker capacity in both districts. - Application of CHX on newborns' cords initiated at 4 hospitals across both districts.
Operation Research Objective: to compare quality, utilization, and MNC knowledge and care seeking behavior in the integrated intervention area, versus in "CB-NCP only" implementation areas of Arghakhanchi District.			
- MNC QI tools, trainings, and evaluation materials - Technical assistance from MCHIP	- Conduct midline and endline evaluation of MNC QI process	- Eight health facilities of intervention areas assessed using MNC QI tools.	- District-aggregated scores (across 8 facilities) ≥80% in all nine MNC-QI technical areas
- HFOMC strengthening interventions, supplies, equipment at five facilities - capacity building of HFOMC members - VDC/DHO resources	- Conduct follow up to trainers and HFOMC members	-72 trainers and HFOMC members followed up	- Increased HFOMC function scores across all five target facilities - VDCs allocated a total of 1,033,000 NRS in 2012, compared to 492,600 NRS in 2011 for MNC-related activities and supplies.

Table 2: Project Activity Status [Complements Table 7 in submitted Annual Report]

Project Objectives/Results	Related Key Activities (Outlined in DIP)	Status of Activities (Completed, on target, not yet on target)	Comments
IR 1: increase knowledge of, and demand for, MNC practices and services	-- BCC and awareness raising - Interpersonal and group education by FCHVs and SBAs	On target	Conducted through FCHVs' mother group meeting
	-Positive deviance in Kapilvastu district	On target - 2 meetings conducted with DHO, Kapilvastu - Identified wards with poor maternal and newborn status* - Shared information with HFOMC members and communities of Dumara VDC * VDCs have nine wards	Ward # 4 identified for PD process.
IR2: increase quality of MNC services	-- Train community and facility- based health providers - (CBNCP and misoprostol roll out for PPH prevention)	On target - CBNCP training completed - CBNCP after training follow up completed - (CHX) for cord care training to health workers completed.	- CHX for cord care was not planned in the DIP. The PMNH is supporting the government to scale up recently-endorsed intervention in two districts by integrating with misoprostol training.
	- Build capacity of DHO and HFOMCs to monitor service quality	On target	
IR3: increased access to, and availability of, MNC services and supplies	- Improve referral mechanism	On target	- Contributed in National obstetric referral guideline development.
	- Strengthen facility infrastructure	On target -15 health facilities received basic MNC equipment.	14 of 15 facilities are serving as 24hr birthing centers. Narapani Health Post is building 24hrs birthing centre, mobilizing resources from local authorities and communities.
IR4: improved social, policy, and enabling	- Strengthen cross-sector coordination and linkages. - Use of data for decision	On target - Joint supportive supervision with DHO	Begun to receive CBNCP data through existing

Table 2: Project Activity Status [Complements Table 7 in submitted Annual Report]

Project Objectives/Results	Related Key Activities (Outlined in DIP)	Status of Activities (Completed, on target, not yet on target)	Comments
environment for MNC services and supplies	making	- Trained DHO and project staff to use CBNCP data software and installed at the DHO's computers.	HMIS. CBNCP progress was shared by DHOs at Annual Regional Review meetings organized by Regional Health Directorate Office in Pokhara.
	Conduct Operation Research - Train and build capacity of HFOMCs	Completed. - 3-day review meeting and follow up conducted for 72 trainers and HFOMC members	- Intervention VDCs allocated 1,033,000 NRS in 2012, compared to 492,600 NRS in 2011 for MNC-related activities and supplies.
	Strengthen quality of MNC care - Conduct midline and endline evaluation of MNC QI process	Completed - Baseline, midline and endline evaluation of eight intervention facilities conducted using the MNC QI tools.	- Received technical assistant from MCHIP. - ≥80% scored (as district-aggregated) in all nine tools across 8 facilities.
	Identification of near-miss/death root causes - Develop neonatal near-miss guidelines and forms based on the CB-NCP protocol. - Adapt maternal near-miss tool. - Training to health workers	On target. - Training given DHO and project staff. - Maternal and neonatal near miss and death review team formed at district.	- Reviewed 24 neonatal and two maternal death cases.

HealthRight Addendum 2: Operations Research Study Progress and Achievements

Table 3: OR Study Progress and Achievements in Year X			
OR Study Key Milestones (i.e., formative phase)	Related Key Activities (as outlined in OR concept paper)	Progress Status of OR Activities (completed, on target, not on target)	Comments (Challenges, contributing factors, change, etc.)
<i>Formative phase</i>	Developed MOU with MIRA	Completed 2010	
	Reviewed baseline evaluation report to determine OR and non OR geographic areas	Completed 2010	
	Shared OR concept paper with Family Health Division and built consensus	Completed Jan 2011	Obtained approval letter from Family Health Division
	Hired OR staff in coordination with DHO	Completed Jan 2011	First OR Officer left; new OR Officer hired
	Briefed DHO team about OR and incorporated feedback	Completed Jan 2011	
	Submitted final OR concept paper and obtained OR ethical approval from Nepal Health Research Council	Completed March 2011	
<i>Implementation phase</i>			
HFOMC Strengthening	Trained District Trainers on HFOMC Strengthening	Completed March 2011	
	Conducted HFOMC member training	Completed March 2011	
	HFOMC follow-up training and review meetings (2 times)	Completed November 2011, June 2012	
	Conduct ongoing capacity building and facilitative supervision of selected HFOMCs	Ongoing/ On target	
MNC-QI	Trained facility-based health workers in MNC QI	Completed July 2011	
	Facilitated implementation of MNC QI process in 8 health facilities including baseline, midline and endline evaluation.	Completed baseline 2011 Completed midline Jan 2012 Completed endline Sep 2012	
Maternal and neonatal near-miss & death reviews	Trained health workers to conduct verbal maternal or neonatal death audit	Completed July 2011	
	Trained health workers to conduct verbal maternal or neonatal near-miss audit	Completed June 2012	
	Formed maternal and neonatal near-miss and death audit team at district.	Completed June 2012	

Table 3: OR Study Progress and Achievements in Year X

OR Study Key Milestones (i.e., formative phase)	Related Key Activities (as outlined in OR concept paper)	Progress Status of OR Activities (completed, on target, not on target)	Comments (Challenges, contributing factors, change, etc.)
Cross-cutting health systems strengthening	Advocate for HFOMC representation at annual VDC council meetings to increase local government resources for MNC	In 2010, 2011 and 2012	
	Encourage emergency transport mechanisms in HFOMC trainings	Ongoing/On target	
	Assessed gaps in procurement chain for MNC supplies & medications; work with DHO, HFOMCs, and facility staff to address barriers using monitoring checklist.	Completed 2011	
	Supported MNC equipment and supplies	Supported in 2011	
	Coordinated with Project CURE and GoN to import/deliver equipment and supplies	Equipments are in delivery process	Supported through HealthRight matching fund
	Facilitate small-scale refurbishment for basic MNC infrastructure needs	Ongoing/On target	
OR data collection	Data collection as delineated in MOU and OR concept paper	Ongoing/On target	
<i>Dissemination phase</i>	Analyze data	Annually, with focus on Yr 4/On target	Jointly with HealthRight, MIRA and DHO
	Present and publish reports, articles	Ongoing/On target (EX: Sep 2011 at International conference of Perinatal Society of Nepal)	Jointly with HealthRight, MIRA and DHO
	Disseminate OR results	In YR 4	Jointly with HealthRight, MIRA and DHO

Partnership for Maternal and Neonatal Health | HealthRight International - Nepal Learning Brief | Strengthening Health Facility Management

Program Context:

HealthRight International is implementing the Partnership for Maternal and Neonatal Health (PMNH) in the Argakhanchi and Kapilvastu districts of Nepal, supported by USAID’s Child Survival and Health Grants Program. These are two rural Western districts with limited health infrastructure and significant health systems and access challenges affecting community health. The PMNH is partnering directly with local governments, health facilities, and community groups and volunteers to strengthen access to quality care for mothers and newborns and reduce maternal and neonatal mortality in remote regions of western Nepal.

Problem:

Health Facility Management and Operating Committees (HFOMCs) are a local governance structure within the Nepali health system. However, many HFOMCs are non-functioning or have limited capacity. This is implicated in poor staffing and quality of care at many community health facilities and, therefore, in poor coverage with essential maternal and newborn care (MNC) interventions.

Intervention and Beneficiaries:

To address this challenge, a key PMNH intervention is HFOMC strengthening, addressing good governance, transparency, accountability and participation at health facilities in an operations research area of Arghakhanchi district. HFOMC strengthening includes a 7-day Training of Trainers (ToT); 3-day on-site HFOMC training by these trainers; a 1-day debriefing/review workshop at the District Health Office (DHO); initial follow-up at 8 months after training, including refresher ToT; and final follow-up six months after the first follow-up. HealthRight was supported in these activities by its local partner Mother and Infant Research Activities (MIRA) and trainers from the National Technical Assistance Group (NTAG). HFOMC strengthening was implemented by the PMNH in 5 facilities: 4 health posts (HP) and 1 primary health care center (PHCC). These facilities have a catchment area of 35,368 people.

HFOMC Strengthening: Inputs & Trainees					
Basic Training		1 st Follow-up		2 nd Follow-up	
TOT	HFOMC Members	Refresher TOT	HFOMC Members	Refresher TOT	HFOMC Members
18	57	18	56	15	54

Results:

HFOMC Performance: Facilities were assessed at baseline and two follow-ups on three dimensions: institutional development, facility management, and health services status. Each dimension had a maximum score of 17, for a maximum aggregate score of 51. On average, the aggregate score increased from 35% to 84% (of 51).

HFOMC/Facility Performance at Baseline, First Follow-up (F-U 1), & Second Follow-up (F-U 2) – Numeric Scores												
Facility	Institutional Development			Facility Management			Health Service Status			Aggregate Score		
	Baseline	F-U 1	F-U 2	Baseline	F-U 1	F-U 2	Baseline	F-U 1	F-U 2	Baseline	F-U 1	F-U 2
Thada PHC	4	10	14	6	15	14	7	7	15	18	33	44
Siddhara HP	7	13	14	7	9	15	5	9	12	13	12	44
Narapani HP	3	5	15	5	4	15	5	3	15	19	31	41
Subarnakhal HP	3	13	8	8	11	15	7	9	17	21	37	46
Pokharathok HP	3	14	15	9	10	14	9	13	17	17	32	43

Human Resources for MNC: Human resource gaps are a crucial factor in poor MNC in Nepal. Four intervention HFOMCs have addressed this by mobilizing staffing support from VDCs and the District Health Office (DHO). For example, Thada HFOMC recruited two general assistants, one lab assistant, two Auxiliary Health Workers, and one Auxiliary Nurse-Midwife.

Financial Resource Mobilization: Across the five intervention HFOMCs, VDCs have increased total MNC resources by an average of 110% over baseline.

MNC Resources – VDC Funding for Intervention Facilities					
	Thada PHC	Siddhara HP	Pokharathok HP	Subarnakhal HP	Narapani HP
2011 Funds	100,000	125,000	79,000	117,000	71,600
2012 Funds	300,000	255,000	226,000	165,000	87,000
% Increase	200%	104%	186%	41%	22%

Re-vitalizing MNC: HFOMCs have also strengthened MNC through other investments, including:

- Four of five intervention facilities now provide 24-hour delivery services, vs. just one before the intervention.
- Four of five intervention facilities have started long-acting family planning services, including in postpartum care.
- HFOMC members have begun conducting supportive supervision to primary care/outreach clinics.
- Intervention VDCs have identified and funded creative strategies to promote MNC, e.g.:
 - Purchasing stretchers for FCHVs (Subarnakhal VDC)
 - Providing facility delivery referral incentives to FCHVs (Subarnakhal HP & Siddhara HP)
 - Purchasing clothing for newborns delivering at facilities (Thada PHC)
 - Instituting maternity waiting homes (Siddhara HP)
 - Initiating emergency reproductive health funds (Siddhara & Pokharathok HPs)

Impact: Increased Uptake of MNC

The most notable impact of these HFOMC strengthening outcomes is an increase in the provision of MNC services to community women and newborns. Four of the five facilities have increased the number of first antenatal care (ANC) visits provided, by 20-40% over the previous year. All facilities have increased the number of women receiving the recommended four ANC visits, with Subarnakhal HP more than doubling provision of this service. Two facilities provided safe delivery care for the first time after HFOMC strengthening interventions, and Thada HP more than doubled the number of women using its birthing center. Similar increases have been seen in postnatal care (PNC) visits. The increased uptake of ANC, safe delivery, and PNC represents increased coverage of women and newborn with essential, evidence-based, life-saving interventions, including access to emergency obstetric and neonatal care.

Challenges:

While the PMNH faced no serious challenges in implementing HFOMC strengthening, intensive supervision and frequent contact was initially required to regularize HFOMC meetings and motivate HFOMC members regarding their ability to affect local health facility governance and services.

Sustainability and Scale-up:

In addition to achieving rapid outcomes, this intervention appears highly sustainable – there is now a pool of 18 trainers at the district level that can serve as local resources; the DHO has already expanded this initiative to four additional health facilities using its own funds. These results suggest that this intervention is a model for low-cost health system strengthening through existing structures that can be scaled up in additional districts.

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