



One Heart

WORLD-WIDE

Dining for Women - Final Progress Report

Organization Name: One Heart World-Wide

Program Title: Training Community Outreach Providers to Increase Access to Safe Births in Remote Rural Areas of Nepal. (Dhading, Sindhupalchok, Bhojpur, Taplejung, & Khotang)

Grant Amount: \$60,000 over three years (\$20,000 per year)

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1. Recap briefly what outcomes the program was designed to achieve:

The program was designed to improve the quality of healthcare services in rural, remote areas of Nepal and ultimately improve access to and utilization of these services for pregnant women and their newborn children by training community outreach providers in quality healthcare delivery. Community outreach providers are composed of Female Community Health Volunteers (FCHVs) and Health Workers - active members of the community that have been trained in safe motherhood practices. They are trained to relay messages to prepare pregnant women and their families to better understand the pregnancy process, potential risks, danger signs and the need for a safe and clean birth.

Our program is a critical supplement to the Nepali government's efforts to reach out to Nepali women, especially in the rural areas where access to health facilities is sparse. After our training programs, both FCHVs and Health Workers are better equipped to recognize maternal and neonatal emergencies and can provide appropriate outreach to the communities they serve, improving access to pregnancy related services and ultimately working to reduce the rates of maternal and neonatal mortalities in these remote areas of Nepal.

2. What was accomplished in connection with this project? Please address each stated objective. If any project objectives were changed, please also explain the circumstances leading to the modification of the objective(s). COMPLETE

From December 2015 through December 2018, One Heart Worldwide has trained a total of **5,154** Community Outreach Providers in the 5 targeted districts. These trainings include:

- FCHVs trained as community outreach providers (BPP-Miso) - 2 days
- Health providers trained in Birth Preparedness Package/Misoprostol (BPP-Miso) - 1 day
- Community Based Integrated Management of Newborn and Childhood Illnesses (CB-IMNCI) - 6 days

- Maternal and Neonatal Health (MNH) clinical updates and refresher training - 3 days
- SBA certification training - 2 months
- Rural Ultrasonogram (RUSG) training - 21 days
- Newborn referral site (SNCU level II) training - 6 days
- Clinical mentor development training
- On-Site coaching and mentoring for SBA & non-SBA health staffs (3 days)

Once trained, the outreach providers use their newly acquired skills and reach out to their respective communities. They identify and counsel pregnant women in their areas and prenatal supplements and refer potential problems to the nearest facilities. They raise maternal and neonatal health awareness at the community level and ensure that each pregnant woman under their care attends correct prenatal care, delivers with an SBA, and for home deliveries. ***Since 2015, we have reached 176,266 pregnant women and newborns (88,133 pregnancies) in our five target districts.***

3. What challenges did you face in connection with this project? How did you address these challenges?

With the new federal structure in place, the key challenges over the duration of this grant were largely in terms of adjusting our training activities to comply with the significant political shifts which have occurred, as well as implementation delays while waiting for official curriculum updates and approvals.

OHW has shifted its primary partnership from the district level to the palika level. We work in direct collaboration with the government through locally elected representatives for each palika (municipality) with technical oversight from officials at the District Health Office (DHO). Following the recent decentralization, the oversight of healthcare delivery was officially moved to the palika (municipality) level. However for continuity's sake, authorities at the DHO level remain part of the process as the logistical details of the transition are still being navigated.

Within this new political system, OHW must now meet with local representatives for each municipality where we work. This entails significant extra effort and time as the previous structure required planning and finalization only with the single district health office. Instead, there are now between 6 and 12 municipalities within each district. As a result, each new district now typically requires a 12-month timeline to effectively set-up the program. Furthermore, some of the newly elected local representatives at the municipality level are struggling to understand the intricacies of the Nepali healthcare system, highlighting the need for additional training for community stakeholders. In response, we plan to spend more time providing additional training to the palika representatives in our program districts in order to increase their understanding of our program model and thereby further strengthen the local health system.

4. Is your organization or program situation different than presented in the approved proposal? For example, new executive director, significant program staffing changes or NGO affiliation, loss of large funding, or other significant changes?

There are no major programmatic changes. In 2015, at the beginning of this grant term, OHW had programs in only 5 districts total (Baglung, Dolpa, Dhading, Sindhupalchok, and Bhojpur). As of the end of 2018, OHW has grown to include 15 districts across Nepal, with plans to add three new districts in 2019 (though this does not directly impact the present proposal). Reflecting this organizational growth, our personnel needs have increased from 30 in 2015 to 80 full time employees from the Nepal and US offices in 2018.

There have been two recent organizational changes:

- The Nepal team's Admin and Finance Director, Mr. Purushottam Pradhan, retired in the second half of 2018, replaced by Ms. Poonam Shakya who joined the team in November.
- Additionally, Luke Ifland, our Director of Administration and Development, recently submitted his resignation in order to transition to a different career path. Our program has grown up constantly and team as well since 2015. Right now we have about 80 staff including Nepal and US office which was about 30 in 2015.

5. What were the most important lessons learned?

Following the adoption of the new constitution in mid-2015, our most important lessons were largely in terms of learning how to adapt our current training program to align with the changes within the healthcare delivery system. Learning early that we would need to establish critical partnerships with the municipalities and local stakeholders, we were able develop these key relationships and ensure that maternal and newborn health would be priorities for the new leadership. As a result, we were able to successfully advocate for increased resource commitments from palika leadership to implement the Network of Safety components (like Community Outreach Provider investment and training), tremendously increasing long-term sustainability and community ownership of our programs, and thereby ensuring long-term success for the OHW programs.

6. What has changed within your organization as a result of this project?

As a result of this project, it became clear to us that health workers needed support in addition to the clinical trainings provided. As a result, over the past year we have begun Clinical Mentor Development Trainings, while onsite clinical mentorship trainings have been provided to SBAs and non-SBA health workers to better support those on the ground.

Additionally, the decentralization has placed financial authority at the municipality level instead of at the district level, meaning that those closest to the communities and with arguably the best understanding of local needs and priorities, now have the financial authority to budget according to local needs. As a result, we've been working with authorities at the municipality level and local stakeholders to commit additional resources and cost-sharing towards maternal and newborn health, including training for Community Outreach Providers.

7. Describe the unexpected events and outcomes, including unexpected benefits.

As previously mentioned, the decentralization process had the unexpected benefit of improving local resource commitments from palika leadership in our program districts to implement the Network of Safety, including training for COPs. This commitment of resources towards our program activities tremendously increases long-term sustainability and community ownership of our programs, thereby ensuring long-term success for the OHW programs.

8. Did you change your strategy as a result of the obstacles you encountered? How will you address these challenges in the future?

There were no major changes to our strategy beyond extending and strengthening our partnerships with the municipalities as already mentioned. Delays related to official approval for the training curriculum will improve as the new healthcare structure strengthens and simply requires time. Communicating effectively with local authorities and ensuring our continued alignment with local priorities will be the best solution to addressing these challenges moving forward.

9. Approximately how many lives have been touched, both directly and indirectly, by the program?

Our program reaches a population of 97,1119 (indirect beneficiaries), as well as 29,371 pregnancies (direct beneficiaries) annually across all 5 target districts. ***Over the past 3 years of the grant period, OHW touched the lives of 291,357 indirect beneficiaries and 176,266 pregnant mothers and their newborns (88,133 pregnancies - direct beneficiaries).*** This has been brought about through the cumulative training of:

- 5154 Community Outreach Providers
- 844 SBAs
- 5142 HFOMC members (local stakeholders)

10. What are the measurements used to monitor success and how was this information measured (e.g. surveys, observation)? Be specific and include measurable results.

District-Level Impact Data for the Grant Period:

DISTRICTS (program start date)	Appropriate ANC	Delivering with SBA*	Institutional deliveries*	Maternal Deaths	Neonatal Deaths
Dhading (beginning of 2015)	No change**	54% increase (goal exceeded)	55% increase (goal exceeded)	86% decrease (goal exceeded)	40% decrease (goal exceeded)
Sindhupalchok (beginning of 2015)	No change**	78% increase (goal exceeded)	110% increase (goal exceeded)	83% decrease (goal exceeded)	17% decrease (in progress)
Bhojpur	No change**	57% increase	58% increase	14% decrease	28% decrease

(beginning of 2016)		(goal exceeded)	(goal exceeded)	(in progress)	(in progress)
Khotang (beginning of 2016)	7% increase (in progress)	122% increase (goal exceeded)	87% increase (goal exceeded)	40% decrease (goal exceeded)	36% decrease (goal exceeded)
Taplejung (end of 2016)	No change**	57% increase (goal exceeded)	53% increase (goal exceeded)	71% decrease (goal exceeded)	42% decrease (goal exceeded)

IMPACT ASSESSMENT:

Impact indicators: OHW conducts an impact assessment in each district to determine the long-term changes resulting from our program outcomes. To improve the reliability of our data, OHW contracts out all of our impact assessment processes to determine both baseline and endline data. At the beginning of our program (during the set-up period) and at the end of transition, we hire a team of external consultants to conduct an external evaluation of our main indicators:

- Maternal Mortality, and
- Neonatal mortality.

Proxy/service indicators: Because it can take up to six years to begin seeing any direct impact on mortality, we also use the following three proxy indicators: percentage of pregnant women receiving appropriate antenatal care (ANC); percentage of deliveries attended by a skilled birth attendant (SBA); and percentage of facility-based deliveries. OHW expects each district to see the following outcomes:

- Proxy indicators increased by at least 30% after 3 years
- Maternal and Neonatal mortality decreased by at least 30% after 3 years, and 50% after 6 years.

Our mortality data is obtained annually from the government via their official Health Management Information System (HMIS) which compiles the monthly data from health personnel across the nation. We also collect data directly from the health facilities and communities in our program areas to confirm this information. All maternal and neonatal deaths are followed up with a verbal autopsy questionnaire.

In addition, we also collect knowledge and skill assessments among our trainees as well as long-term retention one year post-training. Both quantitative (surveys and record reviews) and qualitative (in-depth interviews, direct observation, focus groups) data collection methods are used. We collect data from all of our trainees (female community health volunteers, health workers, skilled birth attendants and other health facility staff). We also collect data from the pregnant women who benefit from our programs, from local stakeholders and from the government institutions. Our local team conducts all the data collection under the supervision of OHW COO, Dr. Kristensen, a perinatal epidemiologist.

11. If the program is ongoing, please provide plans and expected results, including projected timeframe.

FCHV and HW training has been completed in all five districts, leaving only HFOMC training in four districts (Sindhupalchok, Bhojpur, Khotang, and Taplejung). In 2019, we plan to train 399 (Taplejung- 126, Bhojpur- 63, Khotang- 98 and Sindhupalchok- 112) health facility operation management committee members (HFOMC) from four districts who will provide political support in the municipalities for FCHVs and Health Workers. Dhading will begin to transition out of our program to local ownership this year, thus active implementation for OHW will cease and future COP training will be the responsibility of local authorities.

12. Provide a detailed list of all expenses incurred during the grant cycle which have been paid for with the Dining for Women grant.

Attached to email.

13. Did this grant and relationship with DFW assist your organization in obtaining other funding, partnerships with other organizations, or public recognition in some capacity?

Yes; this grant has been key to the growth of our training program as part of the *Network of Safety* implementation in Nepal. The progress seen in these districts, the lessons learned, and the critical role we know COPs play in the ultimate improvement of maternal and newborn health in these remote areas have helped us obtain additional funding for training in our newer districts and overall program support. Additionally, our founder Arlene Samen, received the Global Thinker Forum's *Award for Excellence* in 2016 to honor OHW's work towards eliminating maternal and newborn mortality around the globe.