THANKYOU FINAL REPORT

Grant Period: July 15th, 2020 - July 14th, 2021
Grant Amount: $750,000 AUD ($527,775.00 USD)

MILESTONES: PROGRAM DELIVERY, COVID RESPONSE, PROGRAM PHASES AND PROGRAM COVERAGE

https://docs.google.com/spreadsheets/d/19QXfRd-qSLLO6w19LaFOJRbmV4J0dKcJ/edit#gid=518462190

EXPANDED PROGRAM UPDATE:

Despite all of the challenges we faced over the past year, our team was able to reach most of our regular program targets in addition to deploying COVID specific relief activities.

- **Change in Program districts:** We had originally planned to expand to Rolpa and Rukum East in 2021, but changed our targets to Salyan and Rukum West based on the request of our government partners.
- **Delays in program rollout:** The repeated lockdowns in 2020 and 2021 have resulted in approximately 6 months of delays for our program rollout. This is particularly evident in our new districts. Sarlahi, Parbat and Myagdi, who were originally scheduled to start implementation in January of 2021, were delayed to August 1, 2021. We expect Salyan, Rukum West, and Rautahat to face delays as well before implementation can be launched due to COVID and to our delayed Project agreement renewal process (as part of our new project agreement, these 3 new districts cannot be started until the project agreement is signed).
- **Renewal of our 5 years project agreement:** We are in the process of renewing our 5 year project agreement with the Social Welfare Council (SWC). Over the past 6 months, our team has been outlining the details of the activities we plan to deploy over the next five years in Nepal. This process includes a new government mandate requiring OHW to involve local NGOs as implementing partners in our new districts. We expect to submit our Project agreement to the SWC in September 2021, with hopes to get it finalized by the end of 2021. This process has been delayed because of COVID. We are unable to move forward with activities in new districts (Salyan, Rukum West and Rautahat) until this new project agreement has been approved.
- **Digitizing programs:** Over the past year, the emergence of COVID-19 required us to rapidly and aggressively adapt our programs to ensure the continuity of essential maternal and newborn care (MNH) during the pandemic. Some of these changes are as simple as reducing the size of our in-person training workshops to allow proper safety for our trainees, while others are more complex and require increasingly virtual solutions as in our telehealth program and our MNH helpline. These new virtual programs are now possible in rural Nepal thanks to the tremendous

growth in the local telecoms infrastructure in recent years. Given the difficult logistics for travel both for our team and providers in remote locations, we are finding that some programs, particularly in terms of training and refreshers, could feasibly be conducted and even benefit from virtual delivery long-term. We have learned a great deal over the past year which we continue to apply in order to adapt and improve our program delivery to ensure pregnant mothers and their newborns in rural Nepal can continue to access quality MNH care no matter where they live, in the midst of a global pandemic and beyond.

- **COVID-19:** The COVID-19 pandemic severely impacted the MNH system in Nepal. The country is at a conflicting juncture with the nation having shifted the bulk of its resources towards its COVID response at the expense of the regular needs and programs designed for pregnant women and newborn infants. Compounding these challenges are the imposed travel restrictions and the disparity in access to the limited COVID vaccines currently available. Travel restrictions are resulting in less institutional deliveries in the larger health facilities and increased attendance to local birthing centers, which consequently struggle if not properly equipped and staffed.
- **Variances in our regular program targets:** Most of our program indicators were above 90% and many were well above 100%. The one indicator that was really impacted by the COVID pandemic in our current report is the technical assistance to the Palikas. This is an activity that is deployed yearly in Q2, when the local municipalities work on their annual plans and budgets. The Q2 lockdown in 2021 severely impacted our ability to reach our municipality partners for this yearly exercise. We were able to do some virtual sessions and visit others, but we were overall only able to achieve 62% of our program targets.

OUR COVID RESPONSE THIS PAST YEAR:

Thanks to the generosity of our donors and partners, we were able to distribute over $2M worth of essential emergency medical equipment and supplies (including PPE) to ensure:

1. All rural health facilities providing essential care to pregnant women and their newborn infants in our program districts could safely maintain their services.
2. Health facilities managing COVID patients had all of the necessary equipment and supplies they needed to manage patients
3. Pregnant and recently delivered women who were in isolation due to COVID had the required supplies they needed to manage their quarantine period

We have learned a great deal since the beginning of the pandemic which we continue to apply in order to adapt and improve our program delivery to ensure pregnant mothers and their newborns in rural Nepal can continue to access quality MNH care:

- **Government service delivery guidelines training:** This activity aims to ensure that local stakeholders and health facility staff continue to adhere to appropriate guidelines for MNH service provision during the pandemic and protect the safety of mothers and newborns.
- **Moving existing programs to a virtual platform:** We continue to seek new ways to apply lessons learned and incorporate various virtual platforms into our implementation strategy to allow the safe execution of our life-saving interventions during the pandemic and beyond if proven successful. We are also exploring a hybrid approach which would conduct the initial training in-person and all follow-ups remotely, increasing the engagement frequency while saving travel time and maintaining the program's integrity. The following program elements have already

been integrated into a virtual platform: (1) Remote technical assistance to some of the local municipality offices throughout their annual health planning and budgeting processes; (2) Remote coaching and mentoring was provided to rural SBAs; (3) Rural Ultrasound training follow-up: This was offered as a follow-up activities for SBAs who had previously undergone the government ultrasound training; (4) Quality of Care follow up visits for BC: While the initial visit is done in-person, follow-up visits have been implemented virtually.

- **Social Media support group for Rural SBAs:** Rural SBAs were already isolated prior to the pandemic. The pandemic only made things more difficult for them. Many of our SBA trainees expressed their wish to be connected to other health professionals practicing in similar conditions. To this effect, we created a dedicated private group on Facebook for our SBAs. Facebook is quite popular in Nepal as its widespread use has been noted in recent studies, and it is easily accessible through computer, laptop, and small portable devices (tablets and smartphones). Admission to this group is vetted by an OHW staff serving as group moderator and is responsible for posting relevant information and updates. Members are encouraged to share their challenges/experiences and supportive dialogues/discussions are fostered. We plan to invite MNH experts to present new data and provide feedback as needed.
- **Ensuring availability of life-saving drugs:** Availability of essential obstetric drugs such as Oxytocin, Magnesium sulfate (MgSO4), and Misoprostol in the rural birthing centers is crucial to prevent maternal deaths. Additionally, the birthing centers staff are required to provide misoprostol to female community health volunteers (FCHVs) to distribute to all pregnant women. The OHW staff is reaching out to healthcare providers to review their available stock of essential drugs and facilitate the procurement of missing items with the relevant municipality level government authorities. The team also ensures that all FCHVs are provided with adequate supplies of misoprostol, and that they are distributing misoprostol to every pregnant woman at 8 months in their gestation period, along with appropriate counseling for birth preparedness and tracking all maternal deaths.
- **Maternal and Newborn Health (MNH) Emergencies Helpline:** Developed in collaboration with the GoN and the Nepal Society of Obstetricians and Gynaecologists (NESOG) to assist rural MNH services providers in clinical decision-making during the COVID-19 pandemic, this program was designed in anticipation of scenarios where rural providers might be faced with an MNH emergency in which referral to a higher facility might be delayed or not be possible at all given the impact on travel accessibility due to the pandemic.
- **Telehealth Program for Rural Health Facilities:** This program supports Skilled Birth Attendants in adapting their pre-COVID in-person consultations to cellphone-based consultations for pregnant women (antenatal care) and recently delivered women (postnatal care). This ensures that pregnant and postpartum women can still receive the health education and support they need during this vulnerable period while limiting unnecessary potential exposure to COVID for themselves or their providers. We are very excited to report that the Government of Nepal has decided to scale our telehealth program throughout Nepal for the duration of the pandemic. They have integrated our protocol in the interim RMNCH (Reproductive, Maternal, Neonatal and Child Health) service delivery government guidelines (guidelines on how to provide appropriate MNH services during the pandemic). As such the government is now mandating that all health facilities nationwide provide our telehealth program during the pandemic.
- **Development of COVID-related information materials:** With the approval from the National Health Education, Information, and Communication Center (NHEICC), we translated and adapted 6 infographics and 3 videos developed by Noora Health, to the Nepali language/context. These materials focus on COVID-19 related topics, such as home isolation, breathing exercises, and care for the elderly, high risk individuals, and COVID patients. Our team printed and distributed 2,200

sets of infographics, 1700 were distributed to health facilities in our program districts, and 500 were included in the isolation kits we developed for COVID positive pregnant women or recently delivered women in home isolation. Additionally, these materials were shared on OHW's Facebook page and made available on the government's website.

- **Radio messaging for pregnant women:** We used local FM radio stations in our program districts to broadcast messaging specifically designed for pregnant and new mothers (danger signs, service use reminder, service use at the time of COVID and COVID prevention message). Each radio station broadcasted at least 10 messages per day.

ORGANIZATIONAL MILESTONES:

1. PROGRAM SCALE-UP:

Over the next two years, continue scaling our program in Nepal to reach another 154,000 pregnancies (71,000 in 2020 and 83,000 in 2021):

In 2020, our combined programs exceeded our expected target and reached 77,622 pregnancies while focusing on ensuring the continued provision of quality MNH care during the ongoing COVID-19 pandemic. Though COVID had a direct impact on the delivery of our regular programs due to lockdowns, OHW leveraged relationships with other NGOs/INGOs and our strong partnership with the government to adapt our existing programs. We also provided additional support to health providers so that they could meet the unique challenges of the pandemic. Our COVID response activities were rolled out across our program districts and included the distribution of PPE and essential drugs (such as misoprostol) to all of the health facilities in each district to ensure continued MNH service delivery for pregnant women and their newborns. In Q3 and Q4, with the national lockdown lifted but localized travel restrictions still in place, the OHW team expanded the rollout of our COVID-specific activities and resumed most regular program operations with added precautions (i.e. fewer trainees per session, mandatory PPE, and distancing).

In 2021, progress towards program targets in our active districts has been steady despite the lockdown in Q2, thanks to the strong efforts of the program team during Q1. Lessons learned from 2020's experiences adapting to a variety of new and difficult working conditions have laid the groundwork for improving efficiency in terms of program rollout. We were able to optimize efforts by reducing field travel through bundling and integrating field-based interventions and digitizing many of our internal processes to avoid administrative delays. With the lower numbers of COVID cases in Q1, these added efficiencies translated into better achievements for our field teams. As the team watched the rise in COVID cases in neighboring India due to the spread of the Delta variant, knowing that vaccination efforts had only just begun, we began expanding our remote options for program delivery, an area we are continuing to develop to improve implementation long-term. Despite the subsequent national lockdown in Q2 and devastating second COVID wave across Nepal, our team continues to leverage what we have learned to grow our impact and keep us well on track to achieving our impact targets for this year.

Continue to seek opportunities for partnerships, alignment, and collaboration with other national or international INGOs with whom we could partner to improve our model or increase our capacity to scale.

The COVID pandemic has actually strengthened OHW's opportunities for partnership and collaboration

with other national and international INGOs. Within Nepal, OHW plays a leading role within the Association of International Nongovernmental Organizations (AIN) and influences national health policies and practices while serving on the national government taskforce. We ensure an effective and coordinated COVID-19 response plan at the policy level and provide technical support to working groups under the Ministry of Health and Population, the Social Welfare Council, and the AIN. In addition to providing policy guidance, we collaborated with the AIN to initiate a joint procurement effort of personal protective equipment (PPE) to maintain health services during the initial scarcity. As we expand our virtual suite of tools, we are exploring leveraging collaboration through existing resources such as the Safe Delivery app to increase our capacity. In the most recent wave, we partnered with Direct Relief and DAK to deliver $2m of emergency COVID relief not only to our districts, but others outside our usual coverage.

Start the process to adapt the Network of Safety model to the Terai context:
OHW is piloting our model in the Terai, a new region for our programmatic work in Nepal located in the southern plains of the country. We just started our pilot district (Sarlahi) to test how our model works in this region. The results from a series of needs assessments our team has completed in Sarlahi are showing us a very different local landscape including a much higher population density and comparatively fewer available birthing centers (as compared to the mountains/hill areas). One definite advantage of expanding our programs to the Terai is that more women can be served. While access to MNH care may be geographically easier, many deeply rooted cultural issues limit access to care for pregnant women and newborn infants resulting in almost double the national average of unattended home deliveries:

- Among pregnant women, prevalent risks factors include low status of women resulting in their inability to seek care without permission; higher rates of teenage pregnancies and lower female literacy rates as compared to national averages
- Among the local communities, factors include more traditional views on pregnancy and childbirth and widely prevalent harmful practices toward mothers and newborns (restricting access to certain foods, restricting access to healthcare, violence, …); a high proportion of lower caste populations and a very prevalent caste system which marginalizes them; a high prevalence of gender-based violence; local populations speaking only local dialects; low awareness of MNH issues and birth preparedness; no functional health mother groups; and inactive FCHVs - no link between health facilities and communities.
- Among the local health facilities, our results show easier physical access (decent road system); better building structures and adequate space available, however the service readiness is very poor due to lack of adequate equipment, supplies and essential drugs; poorly trained healthcare providers; poor management of existing resources, and lack of quality assessment/improvement systems.
- Among local authorities, factors include a lack of support from local municipalities - MNH is not a priority; poorly trained local officials; non-functional health facility management committees; and a general lack of coordination between district health offices, municipal health offices and health facilities.

Our results revealed an increased need for community mobilization programs preferably implemented by a local entity, familiar with local culture and language to address these specific socio-cultural factors as well as technical support to improve local governance and accountability, all while in a higher population density region. Going forward, our team will be working on identifying a local NGO in each of our new districts. This additional requirement from the SWC will be key to achieve lasting results in the Terai.

2. SYSTEMS

Adapt our internal processes to the changing landscape of Nepal:
A crucial landscape change for OHW in Nepal is the ongoing COVID pandemic which is likely to impact our programs for several years. In response, our team has developed several new policies to improve our internal processes to deal with the landscape changes resulting from the pandemic. We implemented strict COVID-safety measures for our staff, digitized our hiring system, streamlined our procurement processes, and moved to a fully online banking platform in Kathmandu.

Explore partnerships with local NGOs as sustainable implementation agents for the Network of Safety:
As we initiate the renewal process of our 5 year project agreement with the Social Welfare Council (SWC), we have been asked to incorporate local NGOs into our implementation process. To conform to this new mandate, we developed guidelines to identify appropriate NGO partners for our program districts and we have published a formal expression of interest to seek out these new partnerships. By the end of the year, we aim to identify an appropriate local NGO to support our community-based work in each of our 15 additional districts. This new mandate will be very helpful in the Terai where our initial assessment recommended additional community-based activities, preferably conducted by local teams more familiar with the local cultural landscape.

Complete our Ehealth pilot study:
DHIS-2 is the electronic version of the current aggregated service delivery data collected in each health facility. In partnership with the government of Nepal and GIZ, OHW has completed the DHIS2 training in three of our current districts (Sindhupalchok, Sankhuwasabha, and Terhathum) in 2020 despite the pandemic. We have trained a total of 368 health workers. Now, each health facility and municipal health office of these 3 districts have at least two trained health workers on e-reporting of service statistics and all of the health facilities are now equipped with at least one computer for reporting purposes. Post-training, we conducted routine monitoring visits and training follow-ups with all of the health facilities enrolled in our program. By the end of 2020, 100% of the facilities were using the new DHIS2 platform to report their service statistics despite the challenges of often limited internet connectivity in the more remote areas. We also saw significant improvements in their reporting quality (increases in accuracy and timeliness) as compared to baseline in 2018. As of January 2021, the government of Nepal has completed the roll-out of this program in all the palikas (municipalities) nationwide.

HMIS 3.6.1 is a OHW pilot project for an individual patient record system that does not aggregate the service delivery data. We had planned to have completed this pilot project by the end of 2020. As with many other research projects, our project was delayed by the COVID pandemic. We have completed all the training and now have a total of 86 trained nurses across all 40 health facilities in Sankhuwasabha (including the district hospital) trained in the use of HMIS 3.6.1. As of April, 100% of the health facilities were digitally recording data via HMIS3.6.1. This is an exciting new program that has many of our government partners very interested in our results. Next year, we hope to be able to take our final results to the Federal Government for potential scale-up at the National Level with funding support from a large bilateral agency.

Increase the government cost-share component of our model at the municipality level:
As part of our scale-up strategy, OHW aims to transition our partners at the municipal level (local) government into an increased payers' role, with OHW shifting into a more technical advisory role with limited funding expectations. In 2020, we **achieved a total of $201K in government contribution** to our programs (almost 10% of our program expenses), mostly to our BC renovations ($120K) but also to

medical equipment for BCs ($37K) and training costs ($44K). Despite the strain on local funding caused by the COVID pandemic, local municipalities in our program districts in 2020 were able to provide an average of 47% of the BC renovation costs. The local municipalities had to put funding towards COVID prevention and management and as a result, only 72.6 % of all municipalities were able to prioritize MNH by setting aside budgets specifically earmarked for that purpose in 2020.

3. **IMPACT:**

External Program Impact Evaluation:
As the government implemented a national lockdown to curb the spread of the virus, field work for the evaluation was paused for about six months in 2020. This led to a change in study approach from direct person-to-person interviews to phone interviews for data collection. In the reporting period, 448 participants (199 from the intervention sites and 249 from the control sites) were interviewed remotely for the quantitative part of the study. Preliminary analysis of the quantitative survey has been completed and further analysis of the findings is ongoing. The preliminary findings of the survey were used in the selection of the key informants for the qualitative part of the survey. In-depth interviews of key informants - new mothers and their caregivers - have also been completed. We expect the external evaluation process to be completed by the end of 2022, provided the study does not encounter more COVID related delays.

Promote best practices, research, and training in maternal and newborn health:
We continue to explore and pilot new developments/advances in maternal and neonatal health in order to incorporate MNH best practices into the Network of Safety and use results to drive policy change in Nepal. Many of our projects encountered delays due to COVID.

- ***Continuum of care simulation based mentorship for SBAs:*** OHW is working to implement this research-based intervention in four of our current working districts of Udayapur and Dolakha in 2021 and Sarlahi and Myagdi in 2022. Since this program requires in-person training and hands-on practice, project implementation was delayed due to COVID and the subsequent lockdown, However, work was able to restart in Q1 of 2021. Two skills labs were set up, one in Udayapur and the other in Dolakha. Our team completed the baseline assessments for 33 mentees from 8 birthing centers in Udayapur and 5 mentees from 3 birthing centers in Dolakha. Monthly mentoring sessions were started, 11 (3 of them remotely) were conducted in Udayapur and 5 (2 of them remotely) in Dolakha.
- ***Rural Ultrasound (RUSG) Training site for SBAs:*** To strengthen the local training capacity and better meet the growing training needs for ultrasound training in rural areas, OHW has been working in partnership with one of the largest maternity hospitals of Nepal, the Paropakar Maternity and Women's Hospital (PMWH) in Thapathali, to establish their facility as a second official RUSG training center. PMWH is a tertiary-level hospital with 24,000 deliveries per year, centrally located in Kathmandu (Province 3). It is also one of the primary maternal and newborn health training sites in the country with a highly qualified team to run the USG training program. This new training center now doubles the country's capacity to provide ultrasound training each year.
- ***RUSG program evaluation:*** In 2020, we completed the evaluation of the rural ultrasound training program initiated in 2019. Based on the recommendation from the study, we began to revise the current training package to make a competency-based standard curriculum in order to improve the quality of service delivery. We are working in partnership with the National Health Training Center (NHTC) to revise this curriculum so the government takes ownership of the program once revision is completed. This process was further delayed by the pandemic, but we

expect the curriculum revision to be completed by the end of 2021.

- ***Establishment of Sick Newborn Care Units (SNCU):*** OHW has purchased and received all of the equipment needed for the Special Newborn Care Units in both of our district hospitals in Ilam and Sankhuwasabha. The space for the units have been refurbished, the equipment set up and the units are now fully set up and ready to be used. In collaboration with the government of Nepal, OHW trained 16 healthcare providers at the district-level hospitals in Ilam and Sankhuwasabha. Four doctors from each hospital were trained on how to use the equipment supplied in the SNCUs (including radiology equipment) and how to improve the screening and management of sick newborns. Four nurses from each hospital were trained on holistic newborn care, including how to identify and assess signs of health deterioration in newborns and how to respond and manage the first phases of a health crisis in newborns. Furthermore, OHW trained 10 medical providers in Health Facility Based Integrated Management of Newborn and Child Sickness (HF-IMNCI). Because of COVID, the training of the mentors was delayed to 2021. The 3 mentors completed their training to provide HF-IMNCI follow-up training and onsite coaching and mentoring and are now providing coaching and mentoring sessions to all of the rural healthcare providers in both districts.
- **Rural Maternal and Newborn Health (RMNH) service utilization study:** Data collected during the last lockdown in 2020 (April-June 2020) in 268 rural birthing centers of the OHW program districts reported a 23% increase in institutional deliveries, a 10% increased in antenatal care visits and a 29% increase in postnatal care visits as compared to same period in 2019 (before COVID). Comparatively, in non-OHW districts, a study conducted by the Center for Research on Environment, Health and Population Activities (CREHPA) for UNFPA covering 424 HFs all over the Nepal reported 19 percent decline in institutional delivery, 30% decline in ANC and 11% decline in PNC during last year's' lockdown (March-August) as compared to the corresponding period in the previous year. Qualitative data from healthcare providers and patients in the OHW districts indicated that COVID related travel restrictions resulted in pregnant women opting to use nearby birthing centers for their pregnancy-related needs instead of using larger referral facilities further away.

M&E system revision and current program indicators

We are currently reviewing our M&E plan and expect to finalize this document by the end of October. This process was delayed from 2020 to 2021 due to the onset of the pandemic. Our M&E team wanted some time to assess the impact of the pandemic (if any) on our data collection processes and our program indicators. We have introduced appropriate safety protocols to ensure that the pandemic would not unduly affect our abilities to assess our results. We have also identified several new indicators, mostly on quality of care and government participation to incorporate into our plan.

Proxy outcome indicators (as of December 2020, impact is measured yearly):

Our goal is 30% observed (and maintained) increases in births attended by a trained health care provider, and institutional deliveries in districts which have completed phase 2 (program implementation). We have achieved this goal in all districts where phase 2 (implementation) of our program has been completed. We measure this percentage by comparing our baseline assessment data with data as of December 2020. Proxy indicator progress from districts that have not completed phase 2 is presented in **APPENDIX 1.**

Proxy Indicators in districts which have completed phase 2 (program implementation):

DISTRICTS	SBA deliveries Baseline - Actual	Institutional deliveries Baseline - Actual
Dhading*	2014=44% - 2020=64 % **46% increase**	2014=44% - 2020=66% **50% increase**
Sindhupalchok*	2015=19% - 2020=45% **137% increase**	2015=21% - 2020=48% **129% increase**
Bhojpur	2015=23% - 2020=52% **126% increase**	2015=26% - 2020=61% **135% increase**
Terhathum	2016=26% - 2020=46% **77% increase**	2016=27% - 2020=50% **85% increase**
Panchthar	2016=43% - 2020=56% **30% increase**	2016=44% - 2020=58% **32% increase**
lam	2017=22% - 2020=50% **127% increase**	2017=21% - 2020=50% **138% increase**

*Dhading and Sindhupalchok's program set-up were interrupted by the 2015 earthquakes; in both districts, activities focused into earthquake relief for a couple of years, effectively delaying regular program roll-out by one and a half years.

Maternal and Newborn Mortality (as of December 2020):

Our goal is at least 50% observed (and maintained) declines in maternal and neonatal mortality in completed districts (6+ years after program initiation). Both Baglung and Dolpa (our completed pilot districts which have undergone the final endline survey) have been fully transitioned and locally led for 3 years and continue to do well in terms of maternal and newborn mortality. Dhading, which only completed transition in December 2020, is continuing to make progress and is scheduled to undergo the endline survey at the end of 2021. Mortality measurements from active program districts (internal monitoring data) is presented in **APPENDIX 2**

MMR (Maternal mortality ratio) per 100,000 live births:

	Baseline	Endline* (2019) Variance with baseline	2020** Variance with baseline
BAGLUNG (2011)	374/100,000	39/100,000 **90% decrease**	15/100,000 **96% decrease**
DOLPA (2011)	1,663/100,000	192/100,000 **88% decrease**	0 **100% decrease**
DHADING (2014)	77/100,000		38/100,000 **51% decrease**

NMR (Neonatal mortality rate) per 1,000 live births:

	Baseline	Endline* (2019) Variance with baseline	2020** Variance with baseline
BAGLUNG (2011)	36/1,000	3/100,000 **92% decrease**	2/100,000 **94% decrease**
DOLPA (2011)	108/1,000	21/100,000 **81% decrease**	6/1000 **94% decrease**
DHADING (2014)	6/1,000		5/1,000 **17% decrease**

*Endline data for Baglung and Dolpa in 2019 was obtained via external sample based surveys conducted by an external Nepali research team (MITRA SAMAJ)

**2020 data was obtained from HMIS data

APPENDIX 1: ACCESS TO CARE IN PHASE 2 DISTRICTS:

	SBA deliveries Baseline - Actual	Institutional deliveries Baseline - Actual
Taplejung	2016=30% - 2020=55% **83% increase**	2016=32% - 2020=55% **72% increase**
Khotang	2016=18% - 2020=54% **200% increase**	2016=23% - 2020=58% **152% increase**
Okhaldhunga	2017=54% - 2020=77% **43% increase**	2017=55% - 2020=76% **38% increase**
Sankhuwasabha	2017=39% - 2020=60% **54% increase**	2017=42% - 2020=64% **52% increase**
Ilam	2017=22% - 2020=50% **127% increase**	2017=21% - 2020=50% **138% increase**
Ramechhap	2018=29% - 2020=48% **66% increase**	2018 =29% - 2020=49% **69% increase**
Nuwakot	2018=34% - 2020=66% **94% increase**	2018=35% - 2020=67% **91% increase**
Solukhumbu	2018=25% - 2020=51% **104% increase**	2018=26% - 2020=54% **108% increase**
Dolakha	2019=45%- 2020=65% **44% increase**	2019 =46%- 2020=67% **46% increase**
Kavre*	2019 =18%- 2020=22% **22% increase**	In target palikas 2019=19%- 2020=24% **26% increase**
Udayapur	2019=35% - 2020=53% **51% increase**	2019=38% - 2020=59% **55% increase**

*In target palikas only

APPENDIX 2: MORTALITY DATA IN ACTIVE PROGRAM DISTRICTS WITH 2+ YEARS OF PROGRAM IMPLEMENTATION:

	MMR (per 100,000 live births)	NMR (per 1,000 live births)
Sindhupalchok (earthquake)	2015=112 - 2020=31 **72% decrease**	2015=12 - 2020=6 **50% decrease**
Bhojpur	2015=153 - 2020=29 **81% decrease**	2015=15 - 2020=12 **20% decrease**
Panchthar	2016=200 - 2020=46 **77% decrease**	2016=14 - 2020=8 **43% decrease**
Terhathum	2016=127 - 2020=44 **65% decrease**	2016=21 - 2020=8 **62% decrease**
Khotang	2016=116 - 2020=52 **55% decrease**	2016=19 - 2020=10 **47% decrease**
Taplejung	2016=237 - 2020=140 **41% decrease**	2016=29 - 2020=16 **45% decrease**
Okhaldhunga	2017=142 - 2020=0 **100% decrease**	2017=13 - 2020=7 **47% decrease**
Sankhuwasabha	2017=83 - 2020=117 **38% increase***	2017=11 - 2020=11 **no change**
Ilam	2017=77 - 2020=30 **61% decrease**	2017=9 - 2020=5 **44% decrease**
Ramechhap	2018=42 - 2020=21 **50% decrease**	2018=9 - 2020=8 **11% decrease**
Nuwakot	2018=78 - 2020=32 **59% decrease**	2018=10 - 2020=5 **50% decrease**
Solukhumbu	2018=306 - 2020=137 **55% decrease**	2018=17 - 2020=11 **35% decrease**

*mortality takes time to be significantly affected. During program implementation, we often see numbers increase and decrease. We therefore look at trends over time instead of year to year changes for the first 6 -7 years