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Annual Report

2010-11

Rural Health Development Project (RHDP)
ग्रामिण स्वास्थ्य विकास परियोजना
Government Of Nepal / Swiss Agency For Development And Cooperation

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Executive Summary

This Annual Report presents the outcomes and outputs achievement for the Rural Health Development Project (RHDP) during the period of 16 July 2010 to 15 July 2011. The report is mainly based on the data and information collected from the RHDP internal outcome monitoring system and Government's Health Management Information System (MIS). The RHDP is a bilateral project between the Governments of Nepal and Switzerland. The goal of RHDP Phase VII is "improved the overall health of the Nepalese (especially women) who are disadvantaged and living in poor and remote regions of the country. To contribute to achieving the Health Millennium Development Goals (MDGs), RHDP works closely with various stakeholders: such as the District Health Office (DHO), Health Facilities (HFs) and communities, as well as the Ministry of Health and Population /Department of Health Services (MoHP/DoHS), Family Health Division (FHD) and other central partners.

During this period, RHDP continued to support the Health Mothers Group (MG), the MG Network, the Female Community Health Volunteers (FCHVs), Adolescent Clubs, local health workers, and the Health Facility Operation and Management Committees (HFOMC). This project has contributed in improving health and behaviour, and in providing quality health services at the local level. There is a significant increase in the 4th Antenatal Care (ANC) visit from 50% to 73%, one Postnatal Care (PNC) visit to 70% from 49%, and health worker delivery to 93% (an increase from 50% last year). Of those beneficiaries, 60% are Disadvantaged Group (DAG) mothers. The Contraceptive Prevalence Rate (CPR) has remained at 29% against the target of 42% for 2013. 74% of MGs and HFOMCs have implemented micro-health projects such as upgrading delivery and ANC rooms, toilet and drinking water schemes, roofing and health facility building maintenance and stretchers - with the RHDP contribution being 50%. All HFOMCs have a functional Emergency Health Fund (EHF), and 772 people have benefited from this fund.

In addition, 95% of MGs organize regular meetings and discuss maternal and neonatal health issues. As a result, the majority of MG members are aware of the negative effects of Gender based violence (GBV) on the health of women and children. 64% of adolescent clubs have developed peer educators, and are now able to make other adolescents aware of the HIV and AIDS problem. Moreover, 24 Uterine Vaginal Prolapsed (UVP) screening camps and 4 surgery camps were organized in coordination with DHO and various hospitals that provided technical support - ultimately benefitting 3,738 clients. 41 health facilities have a functional 24-hour delivery service, including a Sub Health Post (SHP) for health workers, delivery in the presence of a Skilled Birth Attendant (SBA) with adequate rooms and equipment, and with both ANC and PNC services provided.

The project spent NRs 69.83 million (97.5%) of the total budget of NRs 71.6 Million.

RHDP successfully phased out from Dolakha in July 2011. The DHO, DDC and other stakeholders from the district appreciated RHDP contributions in Dolakha, and extended their commitment to sustain some activities i.e. 24 hours birthing centres, emergency health funds. During this phasing out, the major lesson learnt is that by involving concerned partners and stakeholders a smooth implementation of the phase-out plan can be accomplished and ownership and commitment for health be strengthened. The phase-out planning and documentation were done in a rather human resources and time intensive way.

Outcome Monitoring Summary

GOAL: Improved overall health status of people, especially of women, disadvantaged and poor of remote areas of Dolakha, Ramechhap and Okhaldhunga Districts.

Outcome 1: Community, Especially Women And Disadvantaged Groups, Positively Change Their Health Seeking Behaviour And Contribute To The Health System At Local Level (Demand Side)		
Indicators	**Baseline, Phase Target**	**July 2010 - July 2011 Achievements/Comments**
47% of deliveries conducted by health workers: Auxiliary Nurse Midwife (ANM), Staff Nurse or Doctor, DAG clients, etc. increased up to 44%	Baseline: 38.5% Phase Target: 47%	**Achievement:63%** (n=349 mothers of 33 Ilaka HFs) **Comment:** The trend of deliveries assisted by health worker has increased from 50% to 63%. The delivery of DAG has also increased from 42% to 60%. Health workers, FCHVs and MGs have played an important role as health promoters to increase awareness, resulting in behaviour change among pregnant and disadvantaged mothers. 24-hour and well-equipped birthing centre with a trained SBA has also contributed to increase the health workers delivery.
80% of mothers have completed at least 4 ANC check-ups	Baseline: 55% Phase Target: 80%	**Achievement: 73%**(n=349 mothers of 33 Ilaka HFs) **Comment:** Despite significant achievements, the target is still a challenge. 4th ANC check-up sharply increased from 50% to 73%. Birth Preparedness Package (BPP) training to FCHVs, MGs and DAG, coupled with innovative practices (KosheliBhet, BhotoTopi to new baby, greeting cards and green flag to pregnant women), along with the regular presence of female staff and privacy maintained for ANC checkups, are all key factors for the increase in the 4th ANC visit. RHDP will continue support for this.
50% of postnatal mothers have obtained at least one PNC	Baseline: 44% Phase Target: 50%	**Achievement: 70%** (n=349 mothers of 33 Ilaka HFs) Comment: The 1st PNC visit increased from 49% to 70%. 36% of mothers were of the Brahmin, Chhetri, Thakuri (BCT) caste, the majority were from ethnic groups such as Janajati (JJ) (32%), Newar (14%), Dalit (17%) and 1 from other caste and ethnic groups. This progress is attributed to the increase in the number of birth centres and a favourable environment: government maternity incentives, maintained privacy and skilled health personnel for ANC and PNC Check up.

The CPR has increased to 42%	Baseline: 35% Phase Target: 42%	**Achievement: 29%** (n=131045 expected numbers of Married Women of Reproductive Age (MWRA)) **Comment:** 29% of couples have adopted family planning devices. Depo Provera is preferred (42%) as it lasts for 3 months. The other preferred family planning devices are pills and condoms. The target to meet CPR still remains challenging despite of several efforts and intervention. Labour migrations, unavailability of implant and under reporting are the main reasons for low CPR. RHDP will work closely with DHO to improve the supply and reporting system.
60% of communities have implemented micro health projects, with RHDP contributing 50%	Baseline: 60% Phase Target: 50%	**Achievement: 74%** (n = 162 VDCs) **Comment**: MGs and HFOMCs have implemented various micro-health projects in coordination with RHDP, VDC, DDC and other development agencies. The micro-health projects include improvement of the delivery / ANC room, toilet and drinking water systems, roofing and building maintenance, placenta pit, incinerators and stretchers.
At least 80% of HFOMCs have a functional emergency health fund, including GoN maternity incentive schemes that have been utilized, and benefiting at least 2 persons per VDC	Baseline: NA Phase Target: 80%	**Achievement: 99%** with 772 beneficiaries (n= 161 VDCs in all three district) **Comment:** EHF is established at all VDCs of Dolakha, Ramechhap and Okhaldhunga districts. Altogether, 772 people have benefitted from EHF during this period. Of those beneficiaries, 67% were female of various castes such as BCT (26%), JJ (43%), Newar (13%), Discriminated Newar (3%) and Dalit (15 %.) Progress is attributed to the priority given to DAG and safe motherhood-related cases through effective rules developed by HFOMCs.

Outcome 2: Local Health Service Providers/Promoters In Collaboration With Local Bodies, Respond To The Priority Health Needs		
Indicator	**Baseline and Target**	**July 2010- July 2011 Achievements/Comments**
24-hour delivery service available in 36 health facilities in three districts, delivering quality services (12 in each district)	Baseline: 9 (4 in Dolakha, 4 in Ramechhap, and 1 in Okhaldhunga) Target: 36	**Achievement: 100%** (n= 41 HFs) **Comment**: 24-hour birthing centres are established and well operated at 41 HFs including 5 SHPs. One additional AMN in each centre is hired either by VDC or DHO on a contract basis in all birthing centres. RHDP has provided SBA training to 21 ANMs for effective delivery services. In addition, the project has given support to centres constructing delivery rooms, and supplied basic equipment and capacity building of HFOMC through AI-based training.
20% increase in the service recipients (from all the health facilities)-all from discriminated communities	Baseline: 76.5% (Women, JJ, Dalit) Target: 20% increase from baseline	**Achievement: 82%** (n=112000 OPD Clients) **Comment:** Altogether, 112000 clients received health services in all three districts. Of which, the % of discriminated people who received these services increased (gradually) from 76% to 82% this year. RHDP will continue creating awareness among DAGs to seek free health care services from government HFs, as well increase access to the HFs.
All HFOMC plans are reflected in VDC plans in all three districts	Baseline: NA Targets: 100%	**Achievement: 94%** (n= 162 HFOMCs) **Comment**: 94% of HFOMCs plans are reflected in VDCs annual plans (out of 162 VDCs in all the 3 districts). HFOMC, in coordination with MG, MG Network and FCHVs, have formulated participatory plans. The health plans include: 24-hour birthing centres, hiring ANM staff for birthing centres, maintenance of physical infrastructures, as well as a FCHV allowance and innovative activities for safe motherhood promotion through MG and MG Networks. A total of NRs 25,473,012 was allocated for health from the VDC budget in all the three districts.
Two DDCs to include a health plan with RHDP that reflect good practices in their five-year plan	Baseline: NA Targets: 2	**Achievement: Under progress** **Comment**: All Three DDCs have incorporated RHDP good practices in the DDC's policy. One of the most highlighted aspects is the gradual expansion of 24-hour birthing centres throughout the district. RHDP has started consultation and interaction programs with DDCs, DHOs and other stakeholders in order to incorporate the health plan as a sectoral plan for DPP.

3. Basic Information

3.1 Background

The Rural Health Development Project (RHDP) is a bilateral project between the Governments of Nepal and Switzerland. RHDP began its work in the Dolakha district in 1991 as the Primary Health Care, Mothers and Child Health and Family Planning Project (PHC/ MCH/FP), which was renamed the Rural Health Development Project in 1997. RHDP coverage grew into Ramechhap in 1996 and into Okhaldhunga in 2006. The last phase VII started in July 2009. RHDP phased out of Dolakha on 15th July 2011 and will be phased out of Ramechhap and Okhaldhunga in the beginning of 2013, as the whole RHDP project will have to be closed by mid-July 2013. The components of the project (Phase VII) are aligned with the priority programs of the Ministry of Health and Population (MoHP)/ Family Health Division (FHD). The focus of the project is to empower women and DAGs in regards to maternal and child health, and to support local governments in the promotion of local health governance.

The expected outcomes of the project are:

1. To positively change the community in regards to their health seeking behaviour and to contribute to the health system at a local level, especially for women and disadvantaged groups **(DEMAND).**

2. To help local health service providers and promoters, in collaboration with local bodies, respond to the priority health needs of the population **(SUPPLY)**.

3.2 The Socio-Political Context

The sustained volatile political situation is due to a lack of national consensus when addressing key aspects of the peace process and in the drafting of a new constitution. Frequent changes in the central government and in the overall political equation have had a spill over effect in district and village-level politics. However, the political situation in all three of the target districts has remained rather positive. Local Peace Committees (LPCs) have been formed in all three districts. In five of the VDCs for Ramechhap, VDC-level LPCs have also been formed and initiated dialogues for the peace process. There is good participation of all political parties when it comes to RHDP-supported activities. In addition, the support of political parties and local bodies that manage health and health-development activities has increased. This positive change is the result of effective lobbying for health-related community groups.
Labour migration is an issue in the RHDP working districts. National census 2011 revealed that around 6% (Male: 5% and Female 1%) of the total population are abroad in 3 districts, which has impacted also in the Contraceptive Prevalence Rate (CPR) to be low in the district.

3.3 About Stakeholders

The District Health Office (DHO) is the main collaborating partner for the implementation and monitoring of project activities, while DDC, VDC and NGOs are supporting partners for issue-based activities. Moreover, MGs, MG Networks, HFOMCs, FCHVs, adolescents, teachers, and traditional health-care practitioners are the key project partners. DDC and VDC' support to the health sector is crucial.
Spending budget of NRs 69 million, RHDP contributed to GoN strengthening of the health sector and achieving the Health MDG's at district level in Dolakha, Ramechhap and Okhaldhunga.

4. Outcomes Achieved

Outcome 1:
Community, especially women and disadvantaged groups have positively changed their health seeking behaviour and contributed to the health system at local level (Demand)

The overall achievement on the "demand side" of interventions is positive. The RHDP sample monitoring survey shows that delivery conducted by skilled health workers has increased from 50% to 63% this year. Of which, delivery received by DAG clients (assisted by health workers) has increased from 42% to 60% this year. The percentage of at least 4 ANC Check up has also increased from 50% to 73% this year, against a target of 80% for 2013. Similarly, the percentage of post-natal mothers obtaining at least one PNC visit has increased from 49% to 70% this year. The percentage of communities (MG, HFOMC) who have implemented Micro Health Projects (MHPs) has increased from 65% to 74%. This progress is attributed to the active involvement of VDCs in the implementation of MHP-related activities. These projects include the upgrading of delivery and ANC rooms, toilet and drinking water systems, better roofing and building maintenance, and in providing more stretchers for patients.

HFOMCs have managed an Emergency Health Fund (EHF) combined with the GoN maternity incentive scheme, and has benefited 772 people. Both print and broadcast media are used to provide adequate information about the EHF among the target population and throughout the district. Contraceptive Prevalence Rate (CPR) remained at 29% against the target of 42%. The data for CPR was obtained from the HMIS. The main reasons for this low CPR in the districts are under reporting, labour migration and limited choices for family planning. RHDP is working closely with DHO in making available more family planning devices (implants and condoms) and in supporting an improved reporting system.

The access to health services has increased - especially for women and DAGs - during this period. RHDP inputs to the capacity building of MG, MG Networks, FCHVs, Adolescents and HFOMCs as health promoters, has played a vital role within the community. RHDP has enabled women and DAGs to actively participate in the planning, implementation and monitoring of their own activities through a participatory approach. The interaction among inclusive MG Networks, FCHVs and HFOMCs has also helped to bring about a positive change in health seeking behaviour.

Outcome 2:
Local health service providers/promoters, in collaboration with local bodies, have started responding towards priority health needs of people, mainly women and disadvantaged (Supply):

The capacity of local health service providers and promoters has increased, mainly in the areas of maternal health. The health plans prepared by MGs, MG Networks and HFOMCs that are focusing on maternal and child health have been incorporated into the plans of respective VDCs, such as establishment of 24-hour birthing centres, hiring of ANM staff, a material incentive for FCHVs, support for women through health MG Networks, and the maintenance of health facilities. Such planned interventions helped to increase basic health services in the VDCs, for example, the number of 24-hour birthing centres has increased up to 41, from 19 from last year. In most of the VDCs, additional ANMs are hired locally for the running of birthing centres at most levels. The DDCs of the three districts have also agreed to gradually establish and manage 24-hour birthing centres in their respective districts.

RHDP provided SBA training to locally hired ANMs in coordination with the National Health Training Centre (NHTC). In addition, needs-based training to health workers (such as

training on implant and misoprostol) has increased the capacity of health workers while providing quality health services. This resulted in better identification of complications and emergency referrals. The project has also provided essential equipment and materials to SHPs, allowing them to run ANC and PNC services more effectively. A capacity building training for HFOMCs (based on an AI model) helped formulate a five-year vision that included detailed objectives. In addition, RHDP field staff has strongly facilitated the preparation of VDC-level annual health plans based on the five-year vision. A significant number of female participants, led by MG Networks and HFOMCs, participated and endorsed their health plans during the VDC council.

Even the SHPs have started to provide quality health services in the districts, since the status of HFs has improved. For example, 31 deliveries were conducted in Rampur Ilaka health facilities and 86 deliveries were conducted in Namdu Ilaka. RHDP's continued efforts resulted in a significant increase in the utilization of the health care services in the three districts. Among the 112,000 end-users, 82% were from discriminated communities (Women, Janajati, and Dalit). A further breakdown reveals 47% were BCT, 27% were Janajati, 14% were Newar, 14% were Discriminated Newar, 10% were Dalit, and 1% came from other castes and ethnicities.

The incorporation of health plans in DDC five-year plans in Okhaldhunga and Ramechhap is work in progress. In Okhaldhunga, a collection of health related information with stakeholders has been completed. The health sector plan will be incorporated in the main plan of the DDC periodic plan. At present, RHDP good practices are reflected in the DDC annual plan in Dolakha, Ramechhap and Okhaldhunga.

5. Outputs Achieved and Performance, Partners

Output 1:
Communities, especially women and DAG are capacitated to increase their access to improved maternal health care and family planning services

366 Mother Groups were monitored, and findings show that the composition of MGs is inclusive and reflects the demographic profile of the districts. 73% MGs have prepared a constitution for their groups. MGs, MG Networks and FCHVs capacities were improved with local initiatives like *Sutkeri Kosh* and *Kosheli Bhet,* and *with the* distribution of Information Education Communication (IEC) materials (flags, leaflets and greeting cards) to all pregnant women. The purpose of such was to increase knowledge on the importance of ANC check-ups, deliveries assisted by health workers, complications during pregnancy, and delivery and emergency preparedness.

FCHV providing Kosheli Bhet to a Mother

Flags containing safe motherhood-related messages were kept at houses of pregnant women so that health workers and concerned people could easily identify and provide necessary health education. In addition, equipment and materials were supplied to Illaka-level health facilities and primary health care facilities to establish 24-hour birthing centres.

Output 2:
Adolescents are aware of Adolescent Sexual Reproductive Health (ASRH)

The monitoring data of 45 secondary school adolescent clubs in three districts show 64% of adolescents have developed peer educators, 86% have organized bimonthly meetings, and 72% can describe signs and symptoms of HIV/AIDS correctly. The target for 2011 was 99%, however, 80% described the mode of HIV transmission correctly. A total of 113 adolescent clubs and school teachers have received Life Skills training, which have empowered them to share knowledge about sexual reproductive health with their peers, thus decreasing the culture of silence. In addition, these activities have enhanced leadership skills and local resource mobilizations.

Adolescent Club Members Conducting a Session

25% of health facilities have established "adolescent corners" in health facilities, and youth-friendly services are now available in Okhaldhunga and Ramechhap. The DHO in Dolakha has also introduced this concept within the district. In addition, refresher trainings to Adolescent clubs and supports to organize extracurricular activities in school have also contributed to enhance the capacity of Adolescents.

Output 3:
Mothers Group are able to deal with Gender Based Violence and Uterine Prolapsed Issues

MGs are very much aware of the impact of domestic and gender-based violence on the health of women and children. Similarly, MGs are able to handle UP issues at the local level. A sampled survey shows that 74 % of MG members (targeted 25%) understood the negative effect of violence on the health of women and children. 44% of the community was aware of domestic violence and referral possibilities by MGs. 52% of MG networks had organized campaigns against domestic violence. 82% of those surveyed of reproductive age are able to identify the causes and preventive measures of UVP. 46% identified as 3rd degree UVP cases have received surgery services, against the target of 50 % by 2013.

RHDP continues to incorporate the topic of UP, domestic violence and GBV in all capacity building trainings for HFOMC, MGs and other local partners, thus generating awareness at the grassroots level. With the joint efforts of DHO and RHDP, 24 UVP screening camps were organized benefiting 3738 clients (JJ-41%, BCT-35%, JJ-N-9% and Dalit-15%). Similarly, 4 surgery camps were organized that benefited 242 clients.

Output 4:
Local Health Promoters are incorporated within the Health System

More local health promoters were found active in the local health system during this reporting period. A sampled survey shows that 92% of MGs and 95% HFOMCs have conducted regular meetings, where they discussed health-related topics and have made functional partnerships with VDC and other local agencies. Likewise, a total of 139 MG Networks[1] were established and are now functioning. 3-day leadership skill training was provided to 674 members of 54 MG Networks. MG Networks are now able to guide MGs and

[1] 40 in Dolakha, 53 inRamechhap, 46 in Okhaldhunga.

support HFOMCs in improving health access and quality health service. MG networks are implementing a VDC budget that includes funds for safe motherhood. BPP & Misoprostol training was provided to 29 health workers in Ramechhap. 190 health staffs were trained on infection prevention. For quality health service, SBA training was also provided to 21 ANMs in coordination with the NHTC.

Output 5:
Local Bodies pursue Local Health Governance Approaches as envisaged by MoHP& MoLD

In general, local bodies are responsible for the health of people. This year, funding from local bodies for local health system has reached to a total of NRs. 27, 891012. The fund was allocated for promotion of 24-hour birthing centres in local health facilities, safe motherhood and neonatal health services and sanitation in Ramechhap, Okhaldhunga and Dolakha.
A sampled survey shows that 72% of health posts have at least one ANM hired by local bodies for operating a 24-hour birthing centre. 82% of sampled HFOMCs have planned activities with VDC/DDCs through MG Networks and HFOMCs in phased-out VDCs. 82% sampled HFOMCs have received financial support from agencies other than RHDP. 80% of HFOMCs have utilized VDC funds ranging from NRs 45,000 to NRs 75,000 for local health initiatives. This progress is attributed to the implementation of various activities within HFOMCs, MG Networks and VDCs for example, with the implementation of an Appreciative Inquiry training model and with regular monthly meetings.

Output 6:
RHDP Approaches are consolidated in a sustainable way

RHDP continues to consolidate approaches in all three districts during the last phase of the project. RHDP approaches are spread and emphasized during various coordination meetings at the VDC and the district level, and stakeholders have recognized RHDP's working approaches and good practices.

In Dolakha, a systematic phase out process was completed during this reporting period. The findingsand lessons learnt of the phase out were disseminated at the Ilaka levels. The participation and commitment of stakeholders in the phase-out workshop was encouraging. The participants appreciated RHDP's contribution in the Dolakha district, and pledged commitment for the continuation of health activities initiated by the project.

6. Project Management and Financial Resources

The Fund Flow Analysis 2010-11 shows that RHDP spent NRs 69.83 million out of the NRs 71.60 million allocated (97.5%) for the project. This funding has benefited 19% DAGs and 19% non-DAGs, with the remaining 62% being spent on general project costs. Gender-wise, 65% female and 35% male benefited from RHDP interventions.

RHDPproject staffing in the beginning of year 2 of phase VII was 54 according to the Project Document. It is also important to note that career development trainings were provided for staff during the project phase out from the Dolakha district.

7. Lessons Learnt and Issues

The major lessons learnt of this year are linked to the phasing out process in Dolakha:

- Constant coaching, facilitation and lobbying with MGs, HFOMCs and with VDC-level political leaders have made a difference in the allocation of the VDC budget for health care.

- Maintaining a common understanding among stakeholders ensured the effective participation of community and partners during planning, implementation and monitoring of project activities. In addition, these efforts generated a feeling of accountability and ownership, as seen with stakeholders during the exit process.

- The MG network plays a vital role in coordination with all VDC-level MGs and lobbying with the VDC and political leaders to approach the VDC fund for women and targeted groups. They have properly usedthe VDC fund for capacity building activities.

- Human resources management is crucial during phasing out and has to consider program priorities.

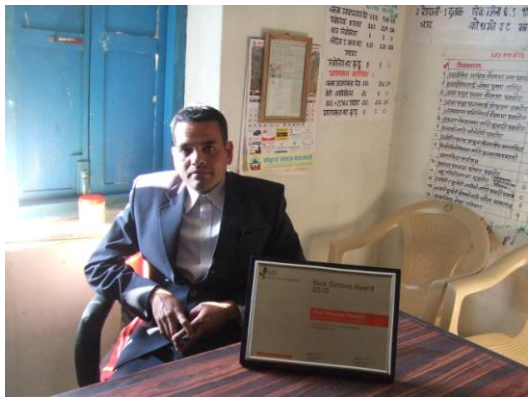
- Project activities need to be implemented as soon as possible in order to phase out and close the project on time.

- An early planning and lean approaches are needed for the documentation and capitalisation of experiences in order to guarantee quality as well as timely communication.

8. Appendices

Annex A. Award Story

Deurali Sub-Health Post Receives Nick Simon's Award-2010



The Deurali Sub-Health Post (SHP) received the prestigious **Nick Simon's Award 2010** for its outstanding contribution in the field of safe motherhood, and in the substantial decrease of Deurali VDC maternal and child mortality. For this outstanding achievement, SHP In Charge Mr. Ram Sharan Poudel was awarded a Certificate of Appreciation by DHO and with a cash prize by the DDC.

Mr.Poudel is quoted, "Hard work pays in life and today I have realized this fact. Today, I am very much happy because Deurali SHP is now know across Nepal...Now our health facility looks like a big hospital with all quality equipment made possible with RHDP contributions, and there is high flow of pregnant mothers coming for ANC checkups."

The Deurali SHP was established in 1996, and since strived to make the post a model SHP, with 24-hour delivery service becoming a reality on 17th July 2010. The 24-hour birthing centre is run in coordination with various organizations following MoHP guidelines.

During the first year of operation, 37 deliveries were conducted successfully. The four-room building was constructed with the help of the Poverty Elevation Fund. RHDP helped by providing a drinking water supply, toilet construction, solar system, other essential furniture and instruments for treatment. RHDP also provided SBA training to ANMs hired by the HFOMC.

For effective running of this SHP, HFOMC, FCHVs, MGNs and local health workers are all actively involved

Annex B. Abbreviations

AI	Appreciative Inquiry
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
ASRH	Adolescent Sexual and Reproductive Health
BCT	Brahmin, Chhetri Thakuri
BPP	Birth Preparedness Package
CPR	Contraceptive Prevalence Rate
DAG	Disadvantaged Group
DDC	District Development Committee
DHO	District Health Office/ District Health Officer
DoHS	Department of Health Services
EDP	External Developmental Partners
EHF	Emergency Health Fund
FCHV	Female Community Health Volunteer
FHD	Family Health Division
GoN	Government of Nepal
GBV	Gender Based Violence
HFOMC	Health Facility Operation and Management Committee
HP	Health Post
HF	Health Facility
IUCD	Intra Uterine Contraceptive Device
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
IEC	Information Education Communication
JJ	Janajati
MoLD	Ministry of Local Development
MDG	Millennium Development Goals
MG	Mother's Group
MHP	Micro Health Project
MoHP	Ministry of Health and Population
MWRA	Married Women of Reproductive Age
NGO	Non Governmental Organization
NHTC	National Health Training Centre
PHC	Primary Health Care Centre
OPD	Out Patient Department
PNC	Postnatal Care
PPH	Port Partum Haemorrhage
RHDP	Rural Health Development Project
SBA	Skilled Birth Attendant
SDC	Swiss Agency for Development and Cooperation
SHP	Sub- Health Post
UVP	Uterine Vaginal Prolapse
VDC	Village Development Committee

Annex C. Budget and Expenses