



# **Support to Safe Motherhood Programme, Nepal**

**A part of the Government of Nepal's National Safe Motherhood Programme**

## **REVIEW OF THE EQUITY AND ACCESS PROGRAMME**

By Deborah Thomas



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## ACRONYMS

AA	ActionAid
AAN	ActionAid Nepal
AI	Appreciate inquiry
ANC	Ante-natal care
ANM	Auxiliary Nurse Midwife
BCC	Behaviour change communication
BEOC	Basic essential obstetric care
CBO	Community based organisation
CHD	Child Health Division
CDO	Chief District Officer
DDC	District Development Committee
DFID	Department for International Development
DHO	District Health Officer
DHS	Demographic and Health Survey
DOHS	Department of Health Services
DPHO	District Public Health Officer
EAAG	Equity and Access Advisory Group
EAP	Equity and access programme
EASO	Equity and access support organisation
EOC	Emergency obstetric care
FHD	Family health division
FUG	Forest user group
GON	Government of Nepal
HFMC	Health facility management committee
HMIS	Health management information system
KAP	Knowledge, attitudes and practice
LSI	Livelihoods and social inclusion
MNH	Maternal and newborn health
MOHP	Ministry of Health and Population
NGO	Non-governmental organisation
NHEICC	National Health Education, Information, Communication Centre
NPC	National Planning Commission
NSMP	Nepal Safe Motherhood Programme

PRRP	Participatory review and reflection process
RBA	Rights based approach
RHCC	Reproductive Health Coordination Committee
SBA	Skilled birth attendant
SDIP	Safe delivery incentive programme
SMNH	Safe motherhood and newborn health
SMIEC	Safe Motherhood Information, Education and Communication
UMN	United Mission Nepal
TA	Technical assistance
VDC	Village Development Committee
WDO	Women Development Officer

## EXECUTIVE SUMMARY

The purpose of this review is to assess the strengths and weaknesses of the Equity and Access Programme (EAP), and the viability of the model for scaling up. The review was undertaken two and a half years after project launch and with a final year of implementation remaining ; priority actions for the remainder of the project period can be found on pages 25-27.

The EAP aims to empower women, their families and local stakeholders to secure maternal and newborn health rights. Its design is founded on learning from the Nepal Safer Motherhood Programme, and in particular, the ineffectiveness of service strengthening and untargeted access promoting interventions to impact on the emergency obstetric care seeking behaviour of poor and excluded groups. EAP explicitly targets the poor and excluded. In focal districts, the programme works in selected disadvantaged VDCs and within these, disaggregated caste and ethnicity data and social mapping have been used to identify target communities and households to ensure that the programme works with and for the poor and excluded.

The Equity and Access Programme is fully on track for achieving its objectives and contributing to the national maternal and newborn health long-term plan. It is successfully “getting below”, reaching poor and excluded groups, increasing their knowledge and demand for maternal and newborn health, and affecting health behaviours.

“Before the women’s group everyone delivered at home and no-one knew the danger signs and the importance of going to a health facility for delivery.”

“Even elderly people are now advising pregnant women to attend for ANC.”

“We have learned knowledge and it has helped us. People are now going for ANC check-up, people know about SDIP Rs. 1000.”

Malika Women’s Group, Dalit Community, Piple VDC, Myagdi District

There are several key factors behind the programme’s success:

- A rights based approach and its explicit targeting of the poor and excluded.
- A “tried and tested” package of inputs that work together: women’s groups, community based emergency funds and transport schemes, mass communications, and the mobilisation of local structures and decision-makers.
- Social empowerment of women through women-led mobilisation that has encouraged women to identify and act on the underlying causes of maternal and newborn illness and death.
- The focus on local capacity building to foster local change agents, to support local governmental and non-governmental organisations, and strengthen existing structures.
- A networking approach to connect stakeholders and foster coalitions for change at district levels and below; including health officials, district administration, village development committees, NGOs, CBOs and women’s groups.

The result is that women and communities are engaging with local health providers and local officials to demand more responsive services, tackle social injustices, and claim accountability.

“After the network went to the health post to introduce ourselves we have seen that the health staff are more interested in us women, extending their opening time to 3 o'clock when they used to close at around 1 o'clock; previously they were not bothered about us.”

Dadarberiya Women's Network, Morang District

A detailed analysis of the strengths and weaknesses of the programme is presented in the main section of this report. Overall this review has found that the programme has taken the learning from NSMP and made important strides in increasing access and equity in MNH. A number of issues and challenges around how to operationalise rights based, social mobilisation for MNH exist, and there are areas of the programme that need sustained attention over the remainder of the project, including advocacy, qualitative social monitoring, and social inclusion audits. However, overall the EAP model has shown that it can be effective in empowering poor and excluded groups to increase their knowledge and change MNH behaviours. EAP provides a firm foundation for taking rights based, demand side interventions for reproductive and MNH to scale.

In considering future plans for EAP and scaling-up of the model, there are several strategic issues that should be taken into account. Firstly, EAP was designed as a demand side project dependent on existing health services in the focal districts. Management of the demand-supply side equation so fundamental to improving EOC utilisation was compromised, and in some places health services lacked the resources, particularly staff, to respond to increased demands and nurture community trust. In designing a future programme, management of the demand-supply side balance requires a more explicit and better coordinated approach.

Secondly, maternal and newborn health issues, be they socio-cultural or service-related, are closely linked to reproductive health and family planning. Addressing MNH within a broader reproductive health paradigm makes conceptual and programmatic sense at the community level and in health service delivery and management. It is recommended that any future programme takes a broader reproductive and MNH approach.

Enabling social empowerment and the redefining of social norms that underpin pregnancy and childbirth in Nepal is a long-term process. EAP has shown that women can be empowered to address the social determinants of MNH but effective social mobilisation takes time and needs to cover a critical mass of the poor in programme areas. Coverage of EAP was heavily impacted by DFID's budget capping in years 1 and 2. Sustaining achievements will require ongoing support and facilitation in many of the EAP focal areas, especially as many groups will have received less than two years of support by project end. Future investments in social mobilisation need to take a longer term horizon.

The programme's inclusion of community financed emergency funds has highlighted the difficulties of reaching the most highly disadvantaged and income poor. Further research is planned to better understand the causes and levels of self-exclusion from the programme. Future programmes need to consider alternative programmatic designs to reaching the most highly disadvantaged and the cost and capacity implications.

Implementation of EAP through a contracted agency outside of Government with a policy advisory group including senior officials from health and social welfare has worked well. Implementation has been efficient and linkages between NGO implementing partners and district government agencies have generally been closely developed. Looking to the future, the new political environment presents hope and opportunity. However the institutional home for demand side, social empowerment approaches for reproductive and MNH within Government remains unclear. Capacity of district and local government structures to absorb management of the EAP model is also weak and governance deficits in district contracting are widespread.

In the short to medium term the risk seems too high to attempt to institutionalise management and implementation of the programme within Government. To sustain the benefits of the programme and take it to scale, it seems necessary to maintain management and implementation outside of Government, perhaps opening up a 'pool fund' for EAP that multiple donors may want to join. As with other high priority programmes such as HIV/AIDS, a high level multi-stakeholder policy and oversight committee could be established to oversee and direct the programme and ensure compliance with Government policy and coordination. As local government capacity and transparent systems develop it would be appropriate to transfer local management of the programme to district and local government authorities; benchmarks could be set which trigger transfer of responsibilities.

Many development programmes are anchored in women's or community groups, and it is a valid question to ask whether EAP's women's groups should be harmonised with others. The strength of the EAP model is its focus on the poor and excluded and on MNH rights. Harmonisation runs the risk that the target focus will be watered down or evaporate if subsumed into multi-sectoral groups without the capacity or structures to promote equity and access to MNH. To protect and promote MNH and reproductive health as priority development objectives, it is recommended that a narrow focus is retained to the women's groups until such time that policy coherence and institutional capacity and systems exist to promote reproductive and MNH through multi-sectoral community group structures.

The Equity and Access Programme is contributing to the equitable achievement of MDGs 4 and 5, and building social capital and voice for improved local governance. Such a strategic development intervention has the potential to inform health systems reform and broader health and social development programmes.

## **ACKNOWLEDGEMENTS**

Many thanks are due to the Equity and Access Programme Team and EAP implementing partners who enthusiastically participated in, and facilitated this review. Special thanks also to Hom Nath Subedi who worked tirelessly to support the review and generously shared his insights. Thanks also to the many national, district, VDC and village stakeholders who gave their valuable time to share experiences, views and suggestions.

## INTRODUCTION

This report documents the findings and recommendations of a participatory review of the Equity and Access Programme implemented by ActionAid Nepal and New Era<sup>1</sup>.

The review of the Equity and Access Programme (EAP) which is entering its third and final year of operation had two key objectives:

- To assess the strengths and weaknesses of the programme, and agree priority actions critical to achieving project objectives.
- To consider key issues surrounding the viability of the model for scaling up.

The review was led by Deborah Thomas<sup>2</sup> with the full participation of the Kathmandu based EAP team and support of the SSMP-Options Equity and Access Adviser. The team reviewed key documents, visited Myagdi, Baglung and Morang districts, and consulted a range of national and local level stakeholders from Government, civil society, and development partners, including Ministry of Health, the Department of Health Services, National Planning Commission, and DFID.

The review was undertaken concurrently with a review of JHU-CCP's support to the National SMIEC Strategy. Although each review had a distinct focus, running them concurrently brought out important linkages between them and allowed for broader geographical coverage and stakeholder consultation, it provided added triangulation of data, as well as efficient use of staff time.

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<sup>1</sup> See annex 1 for terms of reference.

<sup>2</sup> Consultant provided by Options Consultancy Services, London.

## REVIEW OF THE EQUITY AND ACCESS PROGRAMME

Despite the armed conflict and political instability since the mid-1990s, Nepal has made important gains in maternal and neonatal health. The maternal mortality ratio is estimated to have halved between 1996 and 2006, to 281 maternal deaths per 100,000 live births. Family planning use has risen sharply from 29% in 1996 to 48% in 2006; as has the use of antenatal care. Behind these encouraging figures however, lies increasingly hard evidence of the caste, ethnic and regional inequities in maternal and neonatal health. From 2006 DHS data we see that while ante-natal care (ANC) has increased across the country, among Muslims (32%), Janajatis (34%) and Dalits (40%) it is much lower than among more advantageous groups such as Hill Brahmins (76%) and Newars (68%)<sup>3</sup>. Identity also impacts on a woman's likelihood of delivering with a skilled birth attendant. The DHS found that 70% of Terai/Madhesi Brahmin/Chettri women delivered with a skilled birth attendant (SBA) but only 5% of Terai/Madhesi Dalit women did.

Lessons learned from the Nepal Safer Motherhood Project (NSMP) showed that the strategy of service strengthening and untargeted access promoting interventions could not effectively reach poor and excluded groups to increase their use of EOC. The weaknesses of the NSMP approach led to the design of the Equity and Access Programme (EAP) under SSMP. EAP explicitly targets poor and excluded women and their families, and aims to empower them to overcome the many additional barriers they face in accessing maternal and newborn health care and improving their health seeking behaviour.

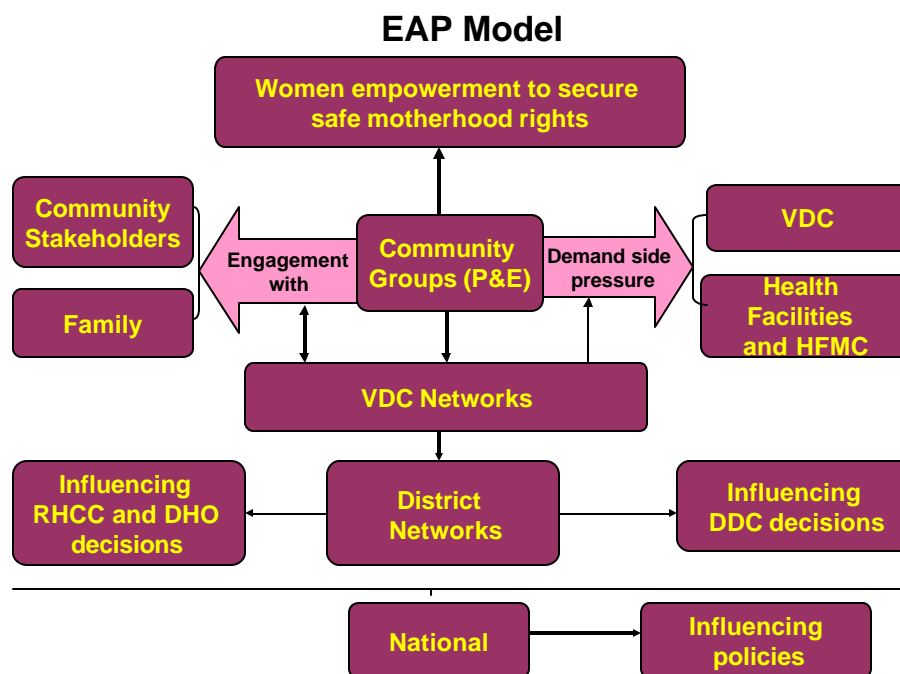
As the GON's attention is increasingly drawn to the equitable achievement of the MDGs, the achievements, weaknesses and potential of the EAP is well positioned to feed into policy and programme development for the equitable achievement of MDGs 4 and 5. This report aims to feed into policy and programme dialogue by taking a critical review of the programme and drawing out lessons for scaling up.

### 1. The EAP Approach

EAP aims to empower women, their families and local stakeholders to secure maternal and newborn health rights; its target is the poor and excluded. It engages with poor and excluded women through local women's groups, and mobilises support from family members and the local community. Through information and group mobilisation the programme seeks to empower poor and excluded women to seek appropriate MNH care, demand their MNH rights and seek accountability of local health providers and duty bearers. Alliances between women's groups and networks strengthen women's and community voices for MNH and increases their influence on health providers and local and district authorities for better and more responsive MNH services. Advocacy at local, district and national levels for MNH is a core pillar of the programme.

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<sup>3</sup> See Lynn Bennett and Dilli Ram Dahal, 2008, "Preliminary Exploration of Caste/Ethnic and Regional Identity Dimensions of the Nepal 2006 Demographic and Health Survey".



**Diagram 1: The EAP Model<sup>4</sup>**

## 2. Coverage of EAP

EAP covers 10 districts in total, 8 with both community engagement and mass communications, and 2 districts with only mass communications inputs. Only one of the EAP districts is a SSMP supply side strengthening district. The districts were selected as representative of hill and terai ecological zones, with a high density of disadvantaged Janajatis, Dalits and other marginalised groups, and with functioning BEOC services; this was essential given that EAP included no significant support for the supply side. Dandeldhura, Dailekh and Parbat have relatively low proportions of disadvantaged Janajatis, Dalits and other marginalised groups but are characterised by poor access to services due to remoteness and physical barriers.

Implementation of group activities began in September 2006. The community programme covers a varying percentage of the VDCs in a district, and a percentage of the poor and excluded in each VDC; mass communications are district-wide. The programme has used ethnicity as a proxy for poverty and with local stakeholders selected VDCs with large Janajati and Dalit populations. Budget capping in year 1 and 2 due to DFID's country wide financial shortfalls has heavily impacted on coverage of the programme. As shown in table 1 below, coverage of the poor and excluded in terai districts is low and increased numbers of social mobilisers per VDC would be required to boost coverage levels. At present the programme operates on the principle of one social mobiliser per VDC for terai and hill areas which doesn't reflect the much larger population of the terai. Any future programme will need to give stronger weight to higher coverage in the terai. Similarly in hill and mountain VDCs

<sup>4</sup> Provided by EAP

where physical mobility is particularly difficult one social mobiliser may not physically be able to cover the geographical area and additional mobilisers may be necessary.

**Table 1: Estimated coverage of the poor and excluded in women’s groups**

Districts	Total Population <sup>5</sup>	Number of women of reproductive age (15-49) <sup>6</sup>	% of population poor and excluded <sup>7</sup>	Estimated number of poor and excluded women of reproductive age	Total number of EAP group members <sup>8</sup>	Estimated coverage of poor and excluded women in groups
Morang	843,220	238,004	67.65%	161,010	15,170	9.42
Chitwan	472,048	131,976	46.75%	61,699	17,371	28.15
Nawalparasi	562,870	153,553	70.51%	108,270	10,529	9.72
Rupandehi	708,419	192,558	70.04%	134,868	10,064	7.46
Parbat	157,826	44,161	33.68%	14,873	6,178	41.54
Myagdi	114,447	32,049	73.80%	23,652	9,153	38.70
Dailekh	225,201	59,386	35.33%	20,981	10,340	49.28
Dadeldhura	126,162	34,321	28.32%	9,720	7,365	75.77

### 3. Social Mobilization: An effective package of activities

EAP’s demand side package fits well with good practice and builds on the successes of NSMP:

- group mobilisation,
- home visits and family interaction,
- community based emergency funds and emergency transport arrangements,
- strategic mass communications,
- linkages to the supply side and local government.

<sup>5</sup> Mapping Nepal Census Indicators 2001 & Trends, ICIMOD and CBS/HMGN, 2003.

<sup>6</sup> Estimated Target Population by National, Ecological, District, Municipality and VDC for Fiscal Year 2005/2006, HMIS, DoH/MoH.

<sup>7</sup> EAP, untitled.

<sup>8</sup> Equity and Access Programme, 2008, “Biannual Report 5 – January to June 2008”.

### **3.1 Group Mobilisation and Face-To-Face Interactions at the Community Level**

Women's groups form a central pillar of the social mobilisation process. The initial mobilisation approach aimed at delivering information on MNH topics, and linking this to information on women's rights. Communities and health providers in Myagdi claim that the women's groups raised awareness and knowledge of danger signs, initiated emergency funds and community transport arrangements, and prepared families for what to do in an emergency. The response from the groups was reportedly mixed with varying levels of participation in group meetings and signs of group fatigue. While the health and rights information giving style was effective in providing information, mobilising women to contribute to emergency funds and place pressure on health providers, it was relatively weak at empowering women to challenge the social norms that underpin MNH.

**Malika Women's Group, Dalit Community, Piple VDC, Myagdi District**

"Before the women's group everyone delivered at home and no-one knew the danger signs and the importance of going to a health facility for delivery."

"Even elderly people are now advising pregnant women to attend for ANC."

"We have learned knowledge and it has helped us. People are now going for ANC check-up, people know about SDIP Rs. 1000."

**Sub-Health Post in-charge, Piple VDC, Myagdi District**

"Awareness of MNH has increased since EAP, more women know of the danger signs."

"There is now 100% achievement of first time ANC, this was 27% before the women's groups. Women have been raising awareness and now everyone comes, before it was just the elite."

"Earlier few people knew about iron tablets but now there is a strong demand for them."

"Free essential health care has increased the number of patients per day to over 40 from 20."

The EAP logical framework has steered the programme's focus towards quantitative changes in health knowledge and practice and not the social aspects of change and the empowering processes that enable better health seeking MNH behaviour. EAP has performed extremely well against the logical framework fulfilling all output indicators that are currently measurable. But, the logical framework and the timeframe have hampered the innovative potential of the programme. It was not until late 2007 that the weaknesses of the "information giving" mobilisation approach started to be addressed as programme staff shifted towards stronger rights based and socially inclusive programming. This delay in developing a more innovative and empowering group mobilisation approach reflects the weak involvement of AAN in implementation.

In 2007, Morang District pioneered the adaptation of AA's flagship REFLECT model to the EAP and introduced a blended group mobilisation approach combining REFLECT methodologies that promote women-led and issue-based reflection and action with MNH themes. The result has been very positive. The two women's networks in Morang visited

during the field visit<sup>9</sup> were powerful, articulate and cohesive, supporting better MNH services and demanding social justice. Although these networks are likely to be some of the most active in the district, testimonies from women members, social mobilisers, EASOs and EAP District Coordinators vouch for the stronger effectiveness of the REFLECT -EAP model over that of the earlier information-giving approach in terms of the level of group participation, strength of group cohesion, and examples of women's empowerment and practical action for MNH.

The REFLECT methodology is in the process of being scaled up across all EAP districts except in Rupendehi where an alternative approach is being tested, the "dialogue method"; as with REFLECT this is also a more interactive, issue-based and empowerment focused approach.

Monitoring and evaluation of the new group mobilisation approaches vis-à-vis health and empowerment indicators is a priority. Early experience with REFLECT is very encouraging and needs documenting so it can be shared across and beyond EAP.

Monitoring of community activities has till now been directly linked to logical framework requirements and attention to groups has focused on the social identity of leaders with encouragement for those from poor and excluded backgrounds. No monitoring tools for groups have been developed. To start to address this gap it is recommended that EAP support the networks in Morang to develop a simple monitoring tool that will support them in sustaining membership interest and contribute to their advocacy activities. Based on field experience this tool can be adapted and scaled up. Indicators may include those linked directly to MNH outcomes and services such as number of maternal and newborn deaths, reports of drug stock-outs, as well as numbers of women participating in meetings, and actions taken and results achieved.

#### **Baijantimala Women's Network , Bairban VDC, Morang District**

Formed from 21 women's groups that are overwhelmingly made up of poor and excluded women, the network is well-organised, has strong leadership and is functioning with minimal support from the local NGO, UPKAR .

During a meeting with the Health Facility Management Committee of Bairban Health Post it was the network framing the agenda; constructively highlighting shortfalls in equipment and staff, recognising the contribution and service of the health staff present, and debating the challenges the network face in motivating women to deliver at the facility given supply side gaps and traditional beliefs around pregnancy and delivery.

The network has skilfully built on the momentum and positive will created by appreciative inquiry (AI) workshops by pressurising stakeholders for 24 hour delivery services while also offering their support. The AI workshops used AI techniques to ignite commitment and cohesion for change among health staff and local stakeholders and led to their specific commitment to introducing 24/7 delivery services. With two ANMs, one locally hired by the HFMC, the facility is now providing 24 hour delivery services but at a stretch. The network was quick to point out that equipment promised by SSMP had still not arrived, and to note that one of the ANMs had been absent one day on training when a delivery case came to the

<sup>9</sup> Baijantimala Women's Network and Dadarberiya Women's Network

centre. This absence provoked heated but constructive debate highlighting how even temporary staffing gaps can quickly deter women from using services as they are perceived as unreliable. It was agreed that in future the network should be informed of any planned absences so that they can advise women seeking delivery care or experiencing complications to go direct to the nearest hospital rather than to the Health Post.

Through the women's groups and now the network the women reported how they have found their voice. The Secretary said "before I couldn't speak my name in front of others now I am a leader."

By meeting once a month the network connects together the women's groups in the area and regularly engages with the HFMC and VDC. It is also fostering linkages with other organisations, advocating for MNH and its capacity as a community based organisation. With an emergency fund of Rs. 200,000 and a network of hundreds, it is locally perceived as an honest broker and is being called on to resolve local disputes.

In Darbesha VDC a local police officer sexually harassed a local girl. The Bairban Women's network heard of the incident and decided to act. They went to the local police post and complained to the in-charge but he did nothing. The women then went en masse with male members and pressurised the in-charge. Finally he relented and assured the group that he would take immediate action against the responsible officer. He also apologised publicly.

The network has also won a local contract from Rural Reconstruction Nepal RRN (a National NGO) worth Rs. 97,000 to manage road gravelling to a local health facility and more recently a contract worth Rs. 150,000 to manage the construction of market place stalls.

The network has tremendous capacity to lead and mobilise women behind various development agendas, and champion social change for MNH.

Additional community activities led by social mobilisers are (i) home visits to poor and excluded families that are not attending group meetings, discussed in more detail in the next section, (ii) mother-in-law and daughter-in-law interactions, and (iii) interaction with a range of community stakeholders including FCHVs and local leaders, and organisation of local events such as street drama. Facilitators are the key drivers of change.

#### **Mothers -in -law**

"Before the women's group we didn't know the danger signs. Now our mothers-in-law know them and they allow us to attend group meetings."  
Baijantimala Women's Network,  
Bairban VDC, Morang District.

Testimonies were given by various stakeholders - women's group members, elderly men interviewed in the communities visited, social mobilisers and EASOs - of changes in mother-in-law and daughter-in-law relationships during the project period. Many examples were given in Myagdi and Morang of mothers-in-law encouraging daughters-in-law to attend ANC, identifying danger signs and referring daughters-in-law to hospital. Asked how to increase institutional deliveries the first response from the Baijantimala Women's Network was to scale up mother-in-law and daughter-in-law interactions.

### **3.2 Community based emergency funds and emergency transport schemes**

EAP's latest biannual report<sup>10</sup> suggests that the programme is well on track for achieving the logical framework indicator that *“at least 70% of groups have emergency funds and transportation scheme with 50% of utilisation by poor and excluded groups by November 2008”*.

For the period January to June 2008, 95% of community groups had emergency funds with 70% utilisation by poor and excluded. For the same period 48% of groups had emergency transport schemes with 76% utilisation by the poor and excluded.

One of the main reasons for the lower rate of transport schemes is the large scale labour migration of men out of rural Nepal; the villages visited in the hills were almost empty of working age men. The full implications of male labour migration out of rural areas for MNH emergencies needs further review and analysis. The preparation of a briefing style report to inform policy-makers is recommended.

A more qualitative assessment suggests that the emergency funds are perceived as a central part of the women's groups, even to the extent that they are seen by some as the key purpose of the group. We heard reports of some women depositing their monthly Rs. 5 payment and not staying to attend the meeting, or sending children to the meeting with the payment.

*“some women are left out from groups, some say they have no time...all do not participate equally, some pay and leave and cannot learn.”* Baijantimala Women's Network.

Such examples are to be expected from any group mobilisation programme, but are likely to be more common if women find the group discussions repetitive and/or of limited benefit to their livelihoods, particularly so for very poor women.

A common feature of women's savings schemes across the region is the challenge of including the very poor. Although it is not mandatory for a monthly donation to the savings fund to participate in the EAP women's groups, the shame and embarrassment of not donating money often translates into self-exclusion. In both the Myagdi and Morang communities we visited we heard how the women's groups encouraged the ultra poor to attend meetings and undertook home visits to share information and keep them connected. In Dadarberiya the network was prepared to subsidise the monthly donations of the ultra-poor but still some chose not to come to meetings, others drop out and rejoin depending on their ability to pay.

This raises several issues. First that the process of group mobilisation needs continuing review and development to ensure it remains meaningful and beneficial to women from different backgrounds. The move to more interactive and women-led approaches should help stimulate group participation.

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<sup>10</sup> Equity and Access Programme, 2008, “Biannual Report 5 – January to June 2008”.

Second, that the **group and savings approach may not be suited to the needs of the ultra poor**. Further investigation is needed by EAP to examine the extent to which poor and excluded women are not participating in groups, including the very poor and socially marginalised from higher castes such as unmarried mothers. This could be done in a sample number of VDCs across the programme areas and will act to validate the extent to which the group approach is socially inclusive. Experience from Myagdi, suggests that the programme is including the majority of the poor and excluded in groups in areas where it is working with the exception of the most highly disadvantaged and income poor; the emergency fund is a barrier for these women.

#### **Counting self-exclusion of the ultra -poor and higher castes**

In ward 7 of Piple VDC, Myagdi District there is 75 households. Two women's groups are made up of members from 45 households, one Dalit group representing 25, and a second mixed caste group of 20. Out of the remaining 30 households, women from 10 households have joined a women's group in ward 5, and women from 5 other households have joined a group in ward 6. The remaining 15 households are not members of any group, 10 are higher caste and do not want to join a group, and 5 are Dalits.

Home visits to disadvantaged women who are non-group members has been a reasonable response from the programme and enabled information to be taken down, but is clearly much less empowering than group participation. Although the programme is at a late stage of implementation, it is recommended that EAP work with the highly disadvantaged to explore alternative methods of including them in the programme. This line of enquiry will help to define the boundaries of social inclusion of programmes such as EAP, and be particularly relevant for any future programme. Clearly reaching down to the most highly disadvantaged has cost and capacity implications, and may in future require programming through alternative routes such as livelihoods and social protection. Experience from Bangladesh of targeting the ultra-poor shows that holistic interventions are more effective for ultra-poor families to build their capacity and livelihood security and enable them to participate in broad community development interventions.

### **3.3 The supporting role of strategic mass communications**

Mass communications through radio, drama, pamphlets and posters have worked synergistically with community engagement in 8 districts; and implemented on their own in Baglung and Surkhet. Less precise in targeting and reaching the poor and excluded than community engagement, mass communications have played an important role in creating mass awareness of MNH across all socio-economic groups.

Various strategies have been adopted to reach and appeal to the poor and excluded. All media are localised. Radio programmes use the language, accents and life stories of the poor and excluded, and in Rupandehi broadcasting is in the local language. Drama uses

local folk stories to convey MNH messages and print media draws on images of local people from poor and excluded backgrounds.

JHU-CCP's support has been pivotal to the development and implementation of the mass communications element of the social mobilisation package. The flexible and synergistic working relationship between EAP and JHU-CCP has produced high quality products with JHU-CCP providing BCC expertise and EAP providing programmatic expertise in targeting the poor and excluded and taking a rights based approach, as well as disseminating messages and monitoring and follow-up.

JHU-CCP provided technical assistance to the development of the radio programmes funded by EAP. JHU-CCP has developed the capacity of multi-stakeholder radio production district teams including the District Health Office, NGOs, and radio stations. Systematically produced to quality standards the radio production process has helped local NGOs and radio producers build their capacity and credibility to produce quality programmes that target the poor and excluded. In Baglung, Chartare Youth Club (CYCs) has used the methodologies and techniques to develop a radio programme on soil management. The BCC capacity, interest and commitment developed in the EAP districts means that given future funding, they are well-prepared to develop and implement technically sound, localised BCC.

No impact evaluation of the mass communications programme is planned. A rapid assessment of the effectiveness of the radio programme, Aama, by JHU-CCP and district radio teams, plus testimonies from a range of stakeholders during our visit, suggest that it has been successful. Feedback and participation by the audience in quizzes show high audience levels in all areas. In Baglung, Aama is the station's number 1 programme and other stations want to air it. The end line KAP survey planned for 2009 will measure changes in SMNH knowledge and source of SMNH information; given the success of the radio programmes, increased reference to radio as a source of information is expected. Demand for drama was reported to be high by district-level and community stakeholders and is an important component of the BCC portfolio.

The division of EAP districts into 8 with community engagement plus mass communications and 2 with only mass communications would suggest scope for comparison of their respective effectiveness. However, randomised controlled conditions were not established. Baglung and Surkhet were also not included in the EAP baseline survey on knowledge, attitudes and practices, and both were NSMP districts. It will therefore not be possible to compare the outputs of the two approaches. Moreover, the two approaches are complementary and designed to work together to reach the poor and excluded. Mass communications alone will have much less impact on improving the MNH of the poor and excluded than where it is strategically programmed alongside community engagement. Judgement on whether the right balance across the BCC portfolio was achieved will require more in-depth analysis as part of the SSMP evaluation.

### **3.4 Linkages to the supply side and local government**

EAP is designed so that community level activities (women's groups, women's networks, social mobilisers) link up and work with FCHVs, health providers, HFMCs and VDCs. The programme is also designed so that local NGO partners foster relations and work closely with District Health Officers, District Development Committee (DDC), Women Development Officers and other members of the District level Reproductive Health Coordination Committee (RHCC).

Involvement of FCHVs and local health providers throughout the project process, including training and orientation has fostered their interest and laid the foundations for future sustainability. FCHVs are generally group and network members and often closely working alongside social mobilisers. In Myagdi the Piple Sub-Health Post in-charge felt that FCHV training had improved their knowledge and motivated them to carry out their voluntary work. Myagdi CDO, LDO and DHO consider FCHVs as possible actors for sustaining community activities once the programme ends. But as the DHO pointed out this will require incentives and recognition, as well as training and preparation for them to take on this role. The Rs. 50,000 FCHV endowment fund to be allocated to each VDC from the 'red book' (GON budget) may be a means of supporting activities in the future. It is recommended that further discussions with RHCCs and FHD are pursued to establish a plan of action for fostering this linkage.

The programme emphasised the need to work closely with health providers and HFMCs, and social mobilisers have been key to enabling this. In most of the working VDCs social mobilisers are nominated as invitee member of HFMCs. In both Myagdi and Morang districts, good working relationships appear to have been nurtured with health providers, although this has required continuing effort, and there are reports of friction during the initial phase of the programme as demand increased and new pressures were placed on providers. Such tension is to be expected given that the programme had no significant supply side inputs and was unable to support local providers respond to increased demand.

#### **Rising patient numbers**

The Assistant Health Worker in Bairban Health Post attributed massive increases in general patient numbers to the awareness raising of the women's network and free health care, rising from 500 in 2006-7 to 1700 in 2007-8.

The HFMCs met during the visit were appreciative of the programme and recognised the contribution of the women's networks. During meetings with two HFMCs both seemed to be led by the health workers in-charge, and it was the women's networks that voiced community concerns and steered discussion. Considerably more capacity building would seem to be needed to strengthen the functioning of the HFMC as a joint facility-community management body. At present, the women's networks are performing a valuable voice function that the HFMCs can benefit from and are less well structured to absorb themselves.

Where appreciative inquiry has been implemented, women's networks appear to have grasped the opportunity to support facility staff to implement changes.

Linkages with VDCs have been actively forged and EAP has well exceeded the logical framework targets that "at least 50% VDCs contributed to emergency funds managed by community groups" and "SMNH activities are included in at least 25% VDCs and all DDCs plan by December 2007". According to EAP's latest biannual report:

For the period January to June 2008, 60% of VDCs contributed to emergency funds managed by community groups, and 40% of VDCs and 50% of DDCs included MNH in their plans.

Contributions from VDCs typically fall in the range of Rs 20,000 to 50,000 per year.

#### **4. District coordination and linkages with other agencies**

The degree of coordination at district level varies. For example in Myagdi the programme has developed exceptionally close working with key district stakeholders and involved both the CDO and the DHO in joint monitoring of the programme; building understanding and ownership. In Morang the programme has less clout with district officials, and weak ownership by the DPHO. The district set-up may in part affect district government relationships with EAP Coordinators; in places housed in the DHO premises, AAN regional centres, or independently. However, judging from differences in Myagdi and Morang the key factors behind stronger district ownership seem to be strong CDO leadership, a committed LDO and DHO, the skills of the District EAP Coordinator, and less, competing donor presence.

In both Myagdi and Morang the district government is looking to the women's networks to enable and support implementation of its health programmes, including SDIP, free Essential Health Care (EHC), and immunisation. In Myagdi, district stakeholders are also actively looking to see how they can absorb and sustain the networks, and draw lessons from them. For example, the Women's Development Officer, LDO and CDO are keen to introduce EAP methodologies and topics to the WDO groups. From our meeting with the RHCC it was clear that the district NGO partners, the Equity and Access Support Organisations (EASOs) are valued sources of information and opinion; providing field insight and ground testing of government decision-making. In Morang, the district public health officer is less experienced and engaged with the programme, this together with the abundance of development agencies operational in the district has led to less knowledge transfer than in Myagdi. Additional support from the central team to help build linkages with the RHCC and the district health office in particular is justified and arguably should have been initiated earlier. It is strongly recommended that the central EAP team give enhanced attention to supporting District Coordinators develop effective linkages with district stakeholders in all EAP districts.

In addition to working with Government, local partners appear well networked with other agencies. In Myagdi, EASOs are working closely with Forest User Groups (FUGs) who are providing a separate incentive of Rs. 100 to women who have an institutional delivery. Similarly, the Bairban VDC women's network has been able to convince the local FUG to provide Rs. 500 incentive to local women who delivered in health institutions. The women's networks are viable platforms for a wide range of development initiatives. Recognising their

potential the Grameen programme has funded EASOs to scale up the EAP approach to an additional 10 VDCs in Myagdi. In Morang, women's networks are actively networking. For example, Daiderbaira Women's Network has presented its activities and achievements to Plan International and Women Rehabilitation Centre – WOREC (an NGO working in women's issue); while SIDC intends to use the women's groups as a vehicle for implementing an ADB agricultural programme.

At present there are multiple women's groups attached to different line departments and programmes. As a step towards better coordination, in Rooma VDC, Myagdi District, EAP is coordinating its group facilitation with 2 other programmes, Village Development Programme (VDP) and the Women's Development Programme. This innovative approach has been introduced in a few VDCs and needs to be closely monitored and scaled up if effective.

## **5. Getting the demand-supply balance right**

EAP was designed as a demand side project dependent on existing health services in the focal districts. This has had its drawbacks particularly due to service gaps resulting from staff shortages. Raising demand without improving services has impacted on community confidence building, and placed additional pressure on health workers. SSMP-Options advisers have mediated support from FHD to EAP areas, including for example implementation of appreciative inquiry. Separated supply and demand side districts under SSMP has reduced the impact of interventions and programme learning; a better coordinated approach to getting the demand and supply balance right is needed in future.

SSMP has focused on MNH and not broader reproductive health and family planning. Given the interconnectedness it is recommended that any future programme take a broader reproductive health perspective. This argument was also heard in Myagdi where family planning acceptance is slipping and the number of repeat abortions increasing.

### **How to encourage more institutional deliveries?**

Asked what we need to do to encourage more institutional deliveries...the women's network in Piple VDC said "more interaction programmes with mothers-in-law, engage male youths, appoint skilled health workers in every health facility and prove that they are working well."

The ANM said "punish home deliveries, fine families if they deliver at home".

CICI in Surkhet is taxing women who deliver at home.

## **6. Rights based development: social inclusion, participation and empowerment, voice and accountability**

EAP is founded on the principles of a rights based approach. It targets the poor and excluded; aims to inform and empower women to seek and demand better MNH care; and mobilises communities and local stakeholders to engage with health providers and local officials to place pressure for more responsive and accountable services. In practice however, it has taken EAP and its partner's time and field experience to embrace the potential of a rights based approach and grasp the multiple dimensions for translating this

through the EAP. Training on rights and social inclusion to core EAP staff and EASOs was reported to have been central to strengthening rights based programming. Further opportunities to build rights know-how and capacity remain but at this stage in the programme the emphasis needs to be on consolidation and lesson-learning. Stronger involvement of AAN in the programme or on-going rights based technical assistance may have increased the pace of progression.

### *Social inclusion*

Targeted at the poor and excluded, the programme operationalised this to mean Dalits, disadvantaged Janajatis and religious minorities. This classification fitted the widespread understanding of the poor and excluded at the beginning of the programme, and was based on DFID's LSI monitoring framework. More recent caste, ethnicity and regional analysis of health indicators allows a more refined definition of health disadvantage which will aide future programming.

The programme took a transparent and pragmatic approach to targeting the poor and excluded in the designated districts which were selected by Government. In coordination with the D/PHO and RHCC, focal VDCs were selected with a high population of Dalits and disadvantaged Janajatis and low development indicators. Within each of the focal VDCs, participatory social mapping with a cross-section of stakeholders identified poor and excluded villages. More precise vulnerability mapping or wealth ranking of households was not undertaken, in part due to the time constraints and pressures to implement, but also because the EAP team felt that social mapping was sufficiently robust to capture the poor and excluded. As discussed earlier, barriers to inclusion of the most highly disadvantaged are apparent and a social audit of the extent of exclusion within the project is recommended. This exercise will provide a measure of the limitations of the programme's group mobilisation and savings approach to include the most disadvantaged, including those that may not fit the "Dalit, disadvantaged Janajati and religious minority" classification. The findings of the social audit will provide evidence of the magnitude of error by using less time-consuming but blunter targeting instruments. It will also contribute to analysis of the cost and coverage implications of the existing approach. Reaching down to the most highly disadvantaged will increase costs and likely require a different programme approach, this will need to be factored into future plans.

### *Participation and empowerment*

"now we are organised and can benefit by getting better services." Women's Network  
Baijanitimala Bairban VDC, Morang District

“before if there was a problem during childbirth we went to the traditional healer now we go straight to hospital.” Women’s Network Dadarberiya VDC, Morang District

### **Tackling social injustice**

The Dadarberiya Women’s Network from the terai brings together 20 women’s groups from poor and excluded backgrounds. Since the women’s groups became active they have seen many changes in women’s knowledge of MNH and practice. ANC has become systematic, mothers-in-law no longer stop daughters-in-law from visiting the local health post, women go to hospital rather than traditional healers if there is an emergency, and the health post stays open until 3 o’clock rather than 1 o’clock. The women feel that through the network they have collective power to deal with problems. As one woman said, “women are no longer alone with emergencies because the network takes action to get her to hospital”.

The women see MNH as intricately related to the wider social injustices and disempowerment they face in life, and through the REFLECT mobilisation process have identified specific issues for action. One such issue was a case of child marriage. The network members heard that a girl of 14 was due to be married to a boy from India. The girl’s mother was not happy with the decision and went to group leader to stop the marriage. The women went to the house of the girl to urge the father not to go through with the marriage, explaining the impact this would have on her life and that it was illegal. After a long discussion the father agreed to postpone the marriage and the girl has been readmitted into school.

A second issue acted on was a planned case of polygamy which attracted considerable local media attention. In this case a man was planning to marry a second wife on the grounds that the first had not brought a dowry. First the women went to the man’s house and called him to a community hearing to discuss the situation. The reaction from the men in the village was that this was “men’s business” and the women had no right to get involved. The following day the man absconded from the village and the women decided to protest. They convinced the local brick factory owner to support them and blockaded the main road in front of the kiln. The road block drew a lot of attention and police force was used to clear the road and take the women to the CDO. The women resisted and demanded that the man planning polygamy should also go to the CDO. Seven women were taken to the CDO by the police and 30 others followed by bus to support them. The man was also found and taken to the CDO. The CDO filed the women’s complaint and cautioned the man. The women’s network rightly feels that this was a major achievement; they stopped a polygamy case, demonstrated their strength to the community and

There is abundant qualitative, triangulated evidence that the social mobilisation package has informed and enabled women and their families to know, recognise and react to danger signs and seek emergency care. The focus of the logical framework on health outcomes and the design of the monitoring system to feed the framework means that there is no systematic monitoring of social empowerment by programme implementers. Social change is being captured by the voice study but this is implemented almost in parallel to the field programme and though its findings have been used by programme managers’ in planning and management, use of the findings in advocacy efforts have been slow to materialise.

Evidence of different degrees of social empowerment lie beneath the surface of much of the EAP reporting and concerted effort needs to be given over the remainder of the programme period to capture stories and make best use of the voice study material; technical assistance may be necessary. However, two years of implementation is too short a time-frame to expect

to see widespread changes in power relationships, and the long term nature of enabling changes to harmful social and cultural practices that continue to persist in Nepal, such as chaupadi cannot be over-emphasised. That said there are plenty of examples from across EAP that suggest that the sort of socially inclusive social mobilisation package that EAP has delivered can stimulate social change. Where women are more empowered, such as the Dadarberiya VDC women network there is clear evidence that they are tackling entrenched practices and injustices, and claiming accountability from duty-bearers. Benefits from the social mobilisation package extend far beyond MNH.

Although the networks are at varying stages of development, they clearly have the potential to be champions of local change and a platform for broad socially inclusive development.

### *Voice and accountability*

“After the network went to the health post to introduce ourselves we have seen that the health staff are more interested in us women, extending their opening time to 3 o'clock when they used to close at around 1 o'clock; previously they were not bothered about us.” Dadarberiya Women's Network

EAP has mobilised and helped organise groups of poor and excluded women to find and articulate their voice. To place pressure on local health providers, have their voices heard by district officials, and support and demand better, more responsive services. Many of the examples of voice have not been reported nor systematically fostered by the programme as “voice initiatives” but have arisen as part of the result of social mobilisation and good district level management. Strong EAP staff, partners and social mobilisers working together have been key to this process with district EAP coordinators and local NGOs lobbying district stakeholders and reinforcing demands made at the local level by women's networks and social mobilisers.

#### **The perceived positive effects of monitoring health staff attendance**

In Myagdi, some women's groups are monitoring health staff attendance. The reported effect has been increased staff attendance at Baranja Sub-Health Post, and more outreach clinics at Kunhu, Darbang, Dagnam and Baranja Sub-Health Posts.

Mass communication and community engagement have worked together to disseminate information about SDIP and free Essential Health Care. All the women we met during our visit knew their SDIP entitlement and were aware of free EHC, and many reported how they have claimed for these benefits. The additional analysis of the SDIP Survey of Women by Tim Powell-Jackson et. al. confirms that EAP has had a significant impact on knowledge of SDIP in VDCs where EAP is working at the community level, particularly among the poorest and through women's groups.

The lack of functioning decentralisation in the health sector means that citizen pressure on health providers can get trapped at the local level. With limited control over resources, health providers have been poorly placed to respond to increased demands. For remote health and sub-health posts isolation and lack of support from the district headquarters is more severe. In this context, getting the balance right between citizen pressure and citizen support to

health providers is extremely challenging. Apart from a small number of incidences where citizen protest and anger have spilled over, reports from EAP staff and partners suggests that generally groups and networks are pursuing non-threatening lines of engagement. The fact that health providers have an overwhelmingly positive perception of the networks and groups, and that district officials consider them key instruments for supporting implementation of various health initiatives reinforces this view that voice is currently rather 'soft' in nature.

Advocacy events at both district and national level have been minimal to date though influencing through EAP's relationships with district stakeholders has been ongoing. Advocacy expertise is thin within the programme and building the advocacy capacity of networks and local NGO partners is a priority. The EAP central team has used international forums to disseminate EAP experiences and lessons, and with the SSMP-Options technical team has raised the profile of EAP among the Ministry of Health, the National Planning Commission and development partners. As the programme enters into its final year and as more evidence is collected and documented, including the end line survey, much more emphasis must be given to advocacy and dissemination. More hard-hitting advocacy and the opening up of space for policy dialogue at local, district and national level is likely to push the comfort levels out, and it is proposed that AAN directly engage in managing and enabling more contested debate.

#### *The voice capture study*

Experience with the voice capture work stream has been mixed. Key informants have produced rich material but the in-house capacity to use this to best effect is lacking. EAP has also collected information through client exit interviews, in depth interviews, case studies and suggestion boxes. The parallel arrangement of having separate Voice Capture Organisations to local implementing EASOs, has not worked well. In the first round of the voice study the EAP team and EASOs felt the voice study was monitoring their own performance and purposefully had little contact with the VCOs. This undermined any sense of ownership of the voice data by the EAP district team including the implementing partners, and strangled their use of the material for advocacy or programme development. Although this misunderstanding has now been rectified, reports from EASOs is that they are using the voice capture material but not in a planned or systematic way. This sub-optimal use of the voice material reflects weak ownership of the voice capture study across the programme, and the lack of expertise to analyse and draw out material for use by women's networks, EASOs, and the national EAP team in their respective advocacy efforts. The high level technical expertise needed to analyse and use the voice study data has made it dependent on external consultants and therefore relatively expensive.

The priority focus for the second round of the voice study is to mine the data and maximise use of the information for district and national level advocacy. Recent technical support will be important in shaping material and developing more powerful forms of engaging district stakeholders in its dissemination; such as involving key informants in sharing meetings and broadening out participation to include a wider selection of civil society groups.

One of the downsides to the parallel voice capture study has been that it has tended to squeeze out attention to other forms of voice within the programme. The logical framework indicators around voice and accountability are tied to the voice study. This has downplayed

EAP's attention to how women's groups and networks engage with HFMCs, voice their demands to VDCs and district officials, although voice at all levels is taking place.

Looking to the future, key informant monitoring methodology or PEER does have a valuable role to play in programming but needs to be designed as an integral part of programme design, planning and implementation. The technical demands of the tool make it unsuited to large scale replication as a monitoring tool and any future roll-out should ensure appropriate research capacity is locally available to utilise the rich material it provides. Subsequently, other tools for capturing voice for advocacy, both visual and audio, need to be considered by EAP. The recent inputs from Undercurrents to develop a short video are likely to make a significant contribution.

## **7. Institutional Arrangements**

AAN and New Era have been almost silent partners in the programme. Apart from their involvement in advisory group meetings there is very little evidence of their technical influence and support to programme implementation. The one exception to this has been AAN's guidance and support to adapting REFLECT to MNH. This is particularly disappointing given AA's global standing as a leading rights and advocacy organisation and the potential read across to EAP. Till date AAN appears to have struggled with finding the mechanisms by which it could institutionalise the project within its country programme. This will be hastened if the new AAN Country Programme includes the right to health, but still it is recommended that some concrete outputs from AAN are defined and agreed for the final year of implementation. Three priority areas of support for consideration are: measuring and documenting social empowerment; strengthening the advocacy capacity of partners and networks and developing strong national and district level advocacy materials; forging links between EAP's networks and groups and those connected to AAN's broader development portfolio. Any similar institutional arrangement in the future should include specific knowledge transfer deliverables from the NGO(s) awarded the management contract.

The Equity and Access Advisory Group (EAAG) forms the main linkage between EAP and line ministries. After a slow start the EAAG has become a useful forum for bringing key stakeholders together and sharing progress and issues. The Family Health Division's (FHD) decision to scale up EAP to 2 districts with financial aid funds is one concrete output from efforts to promote EAP achievements. Once implementation starts EAP relations with the Division are expected to solidify, and open up space for stronger programme and policy influencing. SSMP-Options' advisers have connected EAP to developments within FHD and facilitated discussions to strengthen supply side gaps in EAP areas. Recognising the importance of balancing demand and supply initiatives it will be critical that any future EAP programme develops strong and transparent institutional relationships with DHS (FHD and CHD) to coordinate and monitor the demand-supply side equation.

Strong, high quality and flexible support has been provided by JHU-CCP and NHEICC to the programme. JHU-CCP's support for mass communications (especially Aama radio programme) filled important gaps in EAP's scope of work. Any future scaling up of EAP will need to ensure that mass communications expertise and funds are available to the programme either through NHEICC or contracted in.

The BCC working group has also been a valuable forum through which EAP has networked and coordinated with other agencies, and through which it has shared EAP expertise and experience on targeting the poor and excluded.

EAP has benefitted from a generous level of SSMP-Options' Equity and Access (EA) adviser time, this was particularly useful at the beginning of the programme in bringing across NSMP experience. The EA Adviser has also been instrumental in promoting EAP in the Ministry of Health and NPC.

Options TA to EAP has brought important technical expertise particularly around the voice capture study but arguably more was needed given the technical demands. In the absence of support from AAN, enhanced support to rights based programming would have been beneficial.

## **8. Management capacity and costing issues**

Due to the tight timeframe of the review very limited attention was given to management and costing issues and further analysis is required.

### *Management*

A comprehensive organisation and management needs assessment and review of EAP's implementing partners has been undertaken. This report provides a good basis for assessing the strengths of each of the EASOs, the gaps, and documents all of the capacity building and training provided by EAP. The assessment concludes that all of the implementing partners have the organisational capacity to implement EAP and meet adequate standards in terms of governance, financial policy/procedures, personnel management and organizational sustainability.

One of the main challenges for the remainder of the programme will be retaining district EAP coordinators as the programme starts to exit, and covering gaps as they inevitably arise; two coordinators have already resigned to take up new posts. This will be particularly difficult given the thin management tier within the overall programme. One criticism from EASOs is that programmatic and strategic monitoring has been weak, and there is a need for more thematic and in-depth monitoring of issues by the central team. This seems a fair comment and highlights the fact that the central team, managing and supporting implementation in 10 districts, although highly competent, is made up of only 4 professional staff. If the programme is taken to scale the introduction of regional resource centres would seem to be necessary.

### *Costing*

SSMP-Options' Finance and Administration Manager and the EAP Finance and Administration Officer initiated costing analyses of EAP during the review, see tables in annex 2. Currently cost data is not disaggregated by district or EASO. Further work is required to answer key cost questions, such as the relative cost of the programme per district and population covered. This analysis will help to develop future costing scenarios for different patterns of roll-out.

Cost-effectiveness analysis will not be possible but a disaggregated cost analysis will help to benchmark the relative cost of elements of the EAP approach to that of similar programmes such as MIRA, which as a research project has collected harder evidence of impact.

## **9. Sustainability**

“social mobilisation is not an easy task. It is hard to justify such an investment if only for 2-3 years as changes may not be sustained.” VDC Secretary Myagdi District

The implementation timeline shows that phase 1 groups were initiated in September 2006 and phase 2 groups in April 2007. This means that phase 1 groups will have benefitted from support for 2.5 years before exit, and phase 2 groups, 23 months. Such a timeframe maybe sufficient to increase MNH knowledge and increase ANC, but is likely too short a period to achieve the social empowerment and redefining of MNH to tip the balance for institutional deliveries; especially given the DHS 2006 finding that 73% of women do not consider it necessary to give birth in a health facility.

The short implementation timeframe means that no process of graduating groups and networks has been developed under the programme, this is a major shortcoming both in terms of sustainability but also for programme learning. Women’s networks and health cooperatives are the two strategies being promoted by EAP to sustain the social infrastructure and change process. So far all women’s networks have been registered with VDCs and efforts are planned in the coming 6 months to promote linkages amongst the VDC networks and with line ministries and other agencies. Some level of continuing support and facilitation will be needed to realistically sustain the networks and technically support the health cooperatives. Possible sources of future support for facilitation include VDCs, FCHVs, WDOs and local NGOs. Some of the NGO partners have plans to sustain the networks by absorbing them into other development programmes, but principally this depends on the availability of funding. Some of the NGO partners (Nawalparasi and Chitwan) have already received new commitments from other donors to run community mobilisation programmes in EAP VDCs.

NHEICC has included funding for radio and BCC materials in its 08-09 Annual Work Plan and Budget and assuming the timely availability of funds at district level, the production of localised materials should continue.

Planned financial aid funding of EAP implementation costs in 2 districts for 08-09 is a milestone. However, funds are unlikely to flow before the end of the year and technical assistance from the central EAP team will taper off in mid 2009 as DFID’s support closes down; FHD is unable to contract an international NGO directly. Unless a successor to EAP is established in time for a smooth transition of operations the FHD funded districts are unlikely to receive the level of TA they require, and benefit from this potential learning and policy influencing experiment will be very limited.

## **10. Impact and Learning**

Comparison of the baseline and endline survey will be the primary tool for measuring changes in health KAP in the programme districts, attribution of change will not possible. The

baseline survey collected information from across each of the districts and did not target EAP focal VDCs with community engagement activities. It will not be possible to isolate the comparative changes in KAPs of women in EAP focal VDCs to those outside.

Preliminary analysis of the SDIP's household Survey of Women implemented between January and March 2008 shows that EAP has had a positive impact on women's knowledge of the incentive programme especially among Dalit women and through women's groups; this confirms what we would expect, that EAP's women's groups are an effective vehicle for transmitting information to poor and excluded women. The analysis also found that EAP has not had a significant impact on the rates of institutional deliveries among poor and excluded women in EAP areas. Although there is no question over the robustness of the SDIP methodology used, one constraint vis-à-vis using the data to measure the impact of EAP is the timing of the survey. Implemented between January and March 2008 it would have questioned women in EAP phase 1 groups some 14-16 months after the groups were formed. Women in phase 2 groups would only have been part of the groups for 7-9 months. Bearing this in mind, the institutional delivery finding articulates what we would expect that changing non-emergency delivery practices of poor and excluded women in Nepal requires significant time and effort and that 14-16 months and 7-9 months of group engagement is too short a timeframe to impact on the demand for non-emergency institutional deliveries. If funding permits a repeat of the Survey of Women in mid 2009 should be considered.

Using health facility records of institutional deliveries, EAP has attempted to collect institutional delivery data from each of the health facilities in the programme's focal VDCs. The data collection exercise produced data that was at odds with that recorded in the HMIS, this could be due to lapses in EAP's data collection, errors in health facility recording, or lapses in reporting deliveries at health posts and primary health care centres to the district level where data is compiled for the HMIS. The HMIS data provides a district aggregate and does not allow for disaggregation by ethnicity, caste or residence. Assuming that health facility records are reliable and are available from 2005 they could provide insight into facility delivery rates according to caste, ethnicity, and residence in EAP vs non-EAP sites. The quality of the data is the key issue.

It is recommended that further analysis of the reliability of the records is undertaken in a sample site before a full scale data collection exercise is launched. EAP is already aware of districts with poor records and these should be excluded. If the data is found to be reasonably reliable, analysis in selected districts could help triangulate the findings to be collected through the endline survey and help explain the findings of the Survey of Women analysis. Bearing in mind that the endline survey will not provide comparative data on the rate of facility deliveries among women living in EAP and non-EAP VDCs, the analysis of the health facility records, if reliable, would provide a more complete picture of the pace of change in institutional deliveries among women residing in EAP's focal VDCs. In addition, this assessment could shed light on discrepancies with the HMIS and help identify areas for improvement. Undertaken in coordination with the RHCC, the assessment could be used as another entry point for supporting DHOs mainstream equity into their management of the sector by providing a practical tool for benchmarking equity in institutional deliveries in their districts; ideally this exercise would be linked to forthcoming SSMP-Options' technical assistance to support district health teams mainstream rights and social inclusion.

The programme monitoring system doesn't measure the social impact of the programme, although the voice study will provide rich material to help fill this gap. Concerted effort is required over the next 6 months to collect and document qualitative evidence of social

change through programme staff. Documentation of process and development of manuals and guidelines for scaling up also need to be produced. By the end of the project EAP should be aiming to have a resource bank on rights-based and socially inclusive mobilisation for MNH including case studies, impact analysis of shifting from information-giving mobilisation to reflective and issue based mobilisation, and practical manuals that other organisations can use for replication.

Learning priorities over the next 9 months are:

- evaluation of the impact of the REFLECT group mobilisation methodology,
- social audit of the extent of exclusion from the women's groups and networks,
- exploratory programming of methodologies for targeting the ultra poor and highly marginalised.

## **11. Scaling-up: the issues**

*The strengths of EAP: reasons for scaling up*

EAP is:

- "getting below".
- Informing and raising demands of poor and excluded women .
- Increasing knowledge and use of MNH services among the poor and excluded; particularly knowledge of danger signs for pregnant and delivering women and newborns, birth preparedness, use of ANC and iron-folic tablets, attendance at health posts.
- Enabling women's empowerment, generating voice, increasing short and long-route accountability at district level and building upward pressure on government systems.

*Factors for success: what is making the difference?*

- Rights based approach explicit targeting of the poor and excluded.
- A solid package of inputs working together: group mobilisation, emergency funds, emergency transport schemes, mass communication, and links to local structures and decision-makers.
- Empowerment with focus: information is not enough to change deep socio-cultural beliefs on what is appropriate for MNH. Reflective, women led mobilisation encourages women to identify and act on the underlying reasons for maternal and neonatal illness and death.
- Local capacity: local change agents, local NGOs and local staff.
- Good linkages with local stakeholders (VDCs, CBOs, NGOs) and coordinated working with district health services and officials.

*Main constraints*

- Weak health services without the capacity to respond to increased demands and build community trust.
- Short time-frame and low coverage levels.

- Political instability and lack of elected representation in local government (DDC/VDC)

*Key questions to consider for the future*

- To maintain the focus on MNH or spread wider to health and other social sectors?
- To institutionalise the programme within Government or keep implementation led by NGOs?
- Long-term investment or more of the same?
- To continue working with the existing organisational structure or start from scratch and create a new one?

*The policy and operating context*

The new political environment presents much hope for the future and uncertainty. It is unknown what the federal structure of the country will be; how the division of labour among line ministries will shake out; and the timing of local elections and future national elections. New policies will take time to develop.

The current capacity of district and local government structures is weak. Political pressures on all levels of government remain high and district officers are reluctant to expose themselves to political forces. Government contracting out of work at district level currently suffers from bureaucratic delays, lack of transparency, political pressure to award contracts to certain parties, and open carteling and corruption. In Mygadi, NGOs cited several examples of incompetence and patronage that undermines implementation of work contracted out by Government.

“politics in the UK or neighbouring countries influences policy, in Nepal politics also influences implementation.” CDO Myagdi district.

Harmonising women’s and community groups and networks with overlapping mandates makes sense if the benefits of harmonisation outweigh the losses. With increasing discussion over the implications of decentralisation and jockeying for positions among government departments, this debate is heating up. Experience from EAP shows there is demand and scope to roll-out the group methodologies and messages of EAP through non-health community groups, however the viability of doing so depends on the capacities of those groups and programmes and available TA to support the process. The trade-off of integrating MNH into multisectoral groups and networks could be a weakening of the emphasis on empowerment for MNH.

*Initial thoughts for scaling up*

EAP fits the long term development objectives of increasing equity and social inclusion in Nepal, strengthening local governance, supporting voice and increasing the responsiveness and accountability of public services, as well as addressing MDG 5. Women’s groups are a strategic development intervention.

In the short to medium term the risk seems too high to attempt to institutionalise management and implementation of the programme within Government. There is at present no obvious government department home for the programme or capacity to take on this responsibility.

To sustain the benefits of the programme and take to scale it seems necessary to maintain management and implementation of the programme outside of Government, perhaps opening up a 'pool fund' for EAP that multiple donors may want to join. As with other high priority programmes such as HIV/AIDS, a high level multi-stakeholder policy and oversight committee could be established to oversee and direct the programme and ensure compliance with Government policy and coordination. As local government capacity and transparent systems develop it would be appropriate to transfer local management of the programme to district and local government authorities; benchmarks could be set which trigger transfer of responsibilities.

Policy consensus on whether to harmonise women's and community groups is unlikely in the short-term. To protect and promote MNH and reproductive health as priority development objectives it is recommended that a narrow focus is retained to the women's groups until such time that policy coherence and institutional capacity and systems exist to promote reproductive and MNH through multi-sectoral community group structures.

Lessons from EAP suggest that any future social mobilisation programme needs to commit for the long-haul, and aim to cover a critical mass of the poor and excluded in programme areas. Empowering women to claim their health rights, and challenge and redefine social norms around pregnancy and childbirth is a long-term venture.

## **SUMMARY OF RECOMMENDATIONS**

To address key issues and gaps in the existing programme the following recommendations are made:

### *Social mobilisation*

- The effect of the two new mobilisation approaches, REFLECT and the 'dialogue method' on the performance of the groups in terms of both health and empowerment indicators be monitored and evaluated.
- Early experience with REFLECT needs documenting so it can be shared across and beyond EAP.
- EAP support the networks in Morang to develop a simple monitoring tool that will support them in sustaining membership interest and contribute to their advocacy activities. Based on field experience this tool can be adapted and scaled up.

### *Social inclusion*

- A social audit of the extent of exclusion within the programme is undertaken in a sample of VDCs.
- EAP work with highly disadvantaged families that are not participating in community group activities to explore alternative forms of empowering engagement.

### *Participation and empowerment*

- Concerted effort needs to be given over the remainder of the project to capture stories and make best use of the voice study material; this may require engaging technical assistance.

### *Voice and accountability*

- Key informant monitoring methodology does have a valuable role to play in programming but needs to be designed as an integral part of programme design, planning and implementation. The technical demands of the tool make it unsuited to large scale replication as a monitoring tool and any future roll-out should ensure appropriate research capacity is locally available to utilise the rich material it provides.
- Opportunities to be seized for using audio visual media to capture voices for advocacy.
- As the programme strengthens its focus on advocacy in its final year, it is proposed that AAN provide direct support in managing and enabling more contested debate.

### *Institutional arrangements*

- Concrete knowledge transfer deliverables from AAN to the programme are defined and agreed for the final year of implementation. Three priority areas for consideration are: measuring and documenting social empowerment; strengthening the advocacy capacity of partners and networks and developing strong national and district level advocacy materials; forging links between EAP's networks and groups and those connected to AAN's broader development portfolio.

### *Costs*

- Further work is required to answer key cost questions, such as the relative cost of the programme per district and population covered.

### *Sustainability*

- Further discussions with RHCCs (especially with cooperatives, women development officers, forest user groups) and FHD are pursued to establish a plan of action for defining and preparing the future facilitation role of FCHVs vis-à-vis women's networks and groups.
- Monitoring and documentation of key sustainability strategies taken by EAP; women network and health cooperatives.

### *Impact and learning*

- If funding permits a repeat of the Survey of Women in mid 2009 should be considered to measure the impact of EAP and SDIP.
- Further analysis of the reliability of the health facility records to analyse trends in institutional deliveries is undertaken in a sample site before a full scale data collection exercise is launched.
- By the end of the project EAP should compile a resource bank on rights-based and socially inclusive mobilisation for MNH including case studies, impact analysis of shifting from information-giving mobilisation to reflective and issue based mobilisation, and practical manuals that other organisations can use for replication.

In considering future *scaling-up* of the programme it is noted that

- Women's groups are a strategic development intervention – targeted interventions are an essential complement for achieving Nepal's universal health coverage goals.
- Given the policy vacuum and governance uncertainties in the short to medium term, sustaining the benefits of the programme and taking it to scale will mean maintaining management and implementation of the programme outside of Government. As local government capacity and transparent systems develop it would be appropriate to transfer local management of the programme to district and local government authorities; benchmarks could be set which trigger transfer of responsibilities. This would allow the programme to respond to district governance capacities and pursue a range of implementation modalities.
- In order to protect and promote MNH and reproductive health as priority development objectives it is recommended that a narrow focus is retained to the women's groups until such time that policy coherence and institutional capacity and systems exist to promote reproductive and MNH through multi-sectoral community group structures.
- Any future social mobilisation programme needs to commit for the long-haul, say 10 years, and aim to cover a critical mass of the poor and excluded in programme areas.
- Future programmes will need to take into account the respective contexts of each district, such as the larger populations in the terai, and develop context specific operational approaches. The standard of one social mobiliser per VDC needs review if coverage is to be enhanced, this has obvious cost implications.
- Given the interconnectedness of MNH and broader reproductive health and family planning, a broader reproductive health perspective is recommended in future.

- Strong, transparent institutional relationships between the demand side programme and Department of Health Services (FHD and CHD) need to be created to better coordinate and monitor the demand-supply side equation.

## **ANNEX 1**

### **Support to the Safe Motherhood Programme, Nepal (SSMP)**

#### **Terms of Reference**

#### **Review of the Equity and Access Programme and JHU-CCP's Support**

##### **1. Background**

The National Safe Motherhood Programme (SMP) is a priority within the Nepal Government Health Sector Strategy which works towards meeting the Tenth 5-year Plan/PRSP and the health sector targets as set out in MDG5 – “to reduce the maternal mortality ratio by three quarters between 1990 and 2015”. The National Safe Motherhood Plan 2006-2017 provides the implementation framework for the SMP and has the goal of: “Improved maternal and neonatal health and survival especially of the poor and vulnerable”, and the purpose: “Increased healthy practices and utilisation of quality maternal and neonatal health services, especially by the poor and vulnerable, delivered by a well managed health sector”.

In July 2004, DFID committed £20 million over 5 years to the National Safe Motherhood Programme through the Support to the Safe Motherhood Programme (SSMP). Inputs were designed with the Ministry of Health and Population, the Department of Health Services, other government departments and non-governmental partners to the national programme.

##### **2. Context**

The Nepal Tenth 5-year plan/PRSP (2005) sets out clear policy commitments to social inclusion, equity, voice, accountability and rights through improvement in targeted and mainstream programmes to improve service delivery and efficiency. A major challenge to maternal health in Nepal is the extent to which this policy framework is reflected in programming throughout the National Safe Motherhood Plan. The SMP suggests that utilisation of maternal and neo-natal services has not proportionately benefited women from poor and marginalised communities. For this reason, SSMP places an explicit focus on equity i.e. increased access for marginalised groups and operates in 19 districts through a wide range of implementing partner agencies including Unicef, UMN and ActionAid.

The primary “access” implementation input in this area is made by ActionAid which manages an “Equity and Access Programme” focusing primarily on community level interventions and voice capture in poor VDCs of 8 districts of Nepal. In addition, EAP undertakes mass communications work (principally radio programming) in a further two districts, supported by NHEICC/JHU. EAP activities are reported to have led to significant increases in deliveries in public institutions in these districts.

In addition to targeted interventions through EAP, SSMP-Options supports implementation of MoHP's Safe Delivery Incentive Programme (SDIP). This provides incentives to women, service providers and institutions for institutional deliveries and

incentives to service providers alone for home deliveries. Findings from the recent impact evaluation indicate that the SDIP is having a positive impact on service utilisation – particularly among women from poor and marginalised groups.

Furthermore, Johns Hopkins Bloomberg School of Public Health/Centre for Communication Programmes (JHU/CCP) is an SSMP associate partner whose main purpose is to provide technical support for the IEC/BCC component of the SSMP programme and, in particular, to support major stakeholders: DoHS; NHEICC; the EAA and other programme partners including UNICEF and UMN in planning, implementing and monitoring the Safe Motherhood IEC Strategy.

Specifically, JHU-CCP is responsible to 1) strengthen the capacity of partners to design BCC programmes; 2) plan, design, produce and distribute national SMNH media and materials; 3) support their localisation e.g. Local “Aama” Radio Programmes, and 4) strengthen NHEICC’s ability to provide BCC leadership at national and district levels, including in SSMP working districts.

### **3. Purpose**

The purpose of the assignment is to undertake participatory reviews of (a) SSMP's Equity and Access programme, and (b) the technical support provided by JHU-CCP to the national SMIEC Strategy.

Although the focus of each of the reviews is distinct it is expected that running them concurrently will draw out the linkages between the sub-programmes and makes for efficient use of adviser and EAP field staff time.

The Equity and Access Programme is now in its third year of operation and the time is right to undertake a critical review of the programme to help guide the final year of implementation and to ensure robust learning mechanisms are in place to capture key evidence for national policy and programme development. Earlier reports have identified a range of achievements and issues critical to the success, sustainability and scaling-up of the programme. Drawing on the EAP's ToR, existing evidence and documentation, this review will work with EAP and AAN to assess the merits and weaknesses of the programme and agree priority actions over the remainder of the project that are critical to achieving project objectives.

The review will give particular attention to issues that underpin the viability of the EAP approach as a cost-effective model for scaling up. This includes:

➤ Social mobilisation approach (SMA):

- Is the social mobilisation approach using current good practice, what are the key factors for being effective, what have been the major constraints? What methods and tools are being applied? What monitoring and evaluation mechanisms are in place, and will they deliver the evidence necessary for demonstrating impact particularly around behaviour change and service utilisation? Is the approach well documented for taking to scale? How is the SMA used to establish linkages among different levels of networks and how are these networks mobilised?
- How has EAP contributed to SDIP promotion?

➤ Communication approach

- What is the evidence that EAP's communication approach in 8 districts and its intensive mass communication approach in 2 districts are having an impact? What are the key issues and constraints? How has EAP work been influenced by JHU-NHEICC inputs? What measures need to be established to prepare for comparison of the effectiveness of the communication vs. social mobilisation approaches?

➤ Rights and social inclusion

- What is the evidence that the approach is reaching poor and excluded groups? What needs to be done to meet shortfalls in evidence? What is the experience around socially inclusive community mobilisation and emerging lessons for the programme and broader policy?
- What evidence is there that the programme has led to social empowerment and increased women's and men's participation in claiming MNH and broader rights? What evidence is there of voices being raised and demands being met? How can gaps in evidence be addressed?
- Has the programme delivered effective advocacy at district and national level? What systems have been established and what policies formed or changed in favour of the poor and excluded? What have been the constraints, what needs to be done over the remainder of the project.
- What initiatives have been taken to hold duty bearers accountable?
- Has the voice capturing contributed to improving accountability, transparency, acceptability and quality of services?

➤ Linkage and coordination with other agencies

- Has the programme developed linkages and coordinated with other agencies to create synergies in producing outputs?

➤ Linkages with the supply side

- What are the linkages between the various levels of the programme (women's groups, networks, social mobilisers, EASOs, district coordinators) and the health service and how effective have they been in influencing health services, including improving referrals? What systems, structures and mechanisms are in place to further strengthen the linkages? What has worked well and how have community groups seized supply side initiatives such as appreciative inquiry; what is the evidence? What have been the constraints, what are the priorities over the remainder of the project?

➤ Impact

What measures (studies, data collection) are in place or planned for measuring the outcomes of the programme? What are the findings of studies done (e.g. TPJ work), what are the implications? Do any additional instruments need to be developed?

Discuss the national and international significance of programme findings.

- Technical and management capacity
  - Has adequate support been provided to develop the capacity of district level institutions (EASOs and RHCC) and managers (DEACs and EASO managers) to effectively manage the programme and sustain the initiative beyond the project?
  - Has adequate technical support been provided by AAN and Options, what have been the gaps, what are critical requirements for the remainder of the project?
  - What mechanisms are developed to ensure accountability and transparency of the programme?
  - What are the monitoring and evaluation approaches and tools in place to track the progress of the projects?
  
- Cost
  - Have any costing analyses been undertaken so far? What is planned and what more needs to be done to develop evidence of the cost-effectiveness of the approach for scaling up?
  
- Institutional arrangements
  - What have been the strengths and weaknesses of the institutional arrangements vis-à-vis AAN, Options, FHD, NHEICC, DFID? What are the lessons for the future?
  
- Sustainability
  - What structures and mechanisms have been developed for the sustainability of EAP results?

### JHU-CCP

Technical assistance from JHU-CCP is drawing to a close in September 2008 and while key experts are still in post now is timely to review and document the experience, achievements and impact of this stream of technical support.

#### Specifically the review will address:

- How has JHU worked to strengthen national BCC capacity through NHEICC including the leveraging of additional resources (e.g. from NFHP, GTZ and NHEICC)
- How has JHU worked with EAP, Unicef and UMN and others to strengthen BCC programme capacity? Has JHU contributed to EAP's ability to reach out to marginalised populations?
- What evidence is there that capacity has been strengthened and has been able to effect improvements in BCC planning, implementation and monitoring?
- What have been the major achievements of JHU's support and the constraints faced?
- What evidence is there of the impact of JHU's support? Are additional measures needed to measure impact?
- What is the likely sustainability of JHU's support, what are the key factors on which

sustainability will depend?

- What is the learning to be drawn from JHU's support to guide NHEICC and the MOH in future policy and programming.

**Key areas of responsibilities:**

**The lead consultant will provide support in the following key areas:**

**a) Desk review:**

Review related documents appropriate to equity and access programme and communication programme by JHU.

Access and review international journals and literature and project/programme related document to gain and feedback international prospective and learning in similar area.

Discuss with Timothy Powell-Jackson' who is analysing Relative Contributions of EAP and SDIP on Deliveries in Public Health institutions in Equity and Access Districts.

Consult/discuss with Options team members Ben Rolfe & other appropriate person about programme.

**b) In country visit:**

- Briefing from SSMP/Options on EAP and JHU-NHEICC development and current status.
- Discuss and clarify, as required, the role of the communications consultant.
- Help plan, coordinate and compile inputs of the communications consultant.
- Meet with the EAP team (including ActionAid's Country Director) to discuss programme achievements based on the EAA's TOR.
- Carry out as required, individual and/or focus group discussions with the EAP and SSMP teams.
- Meet with government and donor/INGO counterparts – DOHS, FHD, CHD, NHEICC, MOHP, NPC, UNICEF, UMN, SMNF, Save the Children, DFID and other appropriate stakeholders at central level.
- Meet Mary Manandhar who is doing voice capturing support to EAP.
- District visits as appropriate:
  - Visit at least two districts (one remote rural and one terai) for following purposes. District will be selected in consultation with SSMP-Options.
  - Meet district stakeholders – District RHCC, D/PHO, Local Development

Officer at DDC, Women Development Officer and District Education Officer, FM Radio Station Chief and other as appropriate

- Make community visits, observe and interact with community and health institution staff and health facility committees, and meet individual beneficiaries of the programme
- Conduct focus group meeting with EASO members and staff,
- Interview with EAP district coordinators.

C) Report writing:

- Present preliminary findings and debrief Options/SSMP, EAP and JHU team as appropriate prior to departure.
- Work with the Communications Consultant to ensure a consistent level of presentation, analysis and clarity in the final report.
- Compile the review report to include separate sections on programme achievements, gaps and future recommendations and submit to Options.

**The communications consultant will provide support in the following key areas:**

- Briefing from SSMP-Options on the concept, design and implementation of JHU's communication inputs with particular reference to NHEICC and the Equity and Access Programme.
- Work closely with the lead consultant to design the review framework.
- Meet NHEICC staff and the JHU team to discuss programme activities, achievements and challenges based on JHU TOR and agreement.

Carryout individual and/or group meetings with SSMP-Options, SSMP-UNICEF, SSMP-UMN and EAP team as required.

Meet with other government and donor/INGO stakeholders including FHD, CHD, SMNF, NFHP, and appropriate stakeholders at central level.

- Visit at least two districts and meet with EAP field facilitators, health post staff and community groups as appropriate.
- Meet radio production and airing teams in districts.
- Support the lead consultant in preparation of the final review report.
- Provide support to the lead consultant as requested.

**4. Outputs**

The lead consultant shall submit the draft review report in electronic (Word) format to Options/SSMP. The report should include a statement on the extent to which the TOR have been met and the degree to which the review process proved successful in producing findings and recommendations.

## **6. Timeframe**

- In-country work from 13-22 August, 2008.
- Report to be finalised in September 2008

## **7. Reporting**

SSMP-Options' Deputy Team Leader Mr. Greg Whiteside will be the focal person for this review consultancy. But consultants will work closely with Equity and Access Adviser Mr. Hom Nath Subedi in practical level. Similarly the international consultant will also work closely with the Options based technical lead Louise Holton and Ben Rolfe as required.

## ANNEX 2

### Equity and Access Programme (EAP) Summary of Costs

Cost Details	Cost (NPR)			TOTAL COST (NPR)	TOTAL COST EQUIVALENT GBP
	February 2006 to March 2007 #	April 2007 to March 2008	April to June 2008 (3 months)		
<b>PROGRAM COSTS #</b>	<b>21,401,370</b>	<b>59,004,699</b>	<b>7,145,540</b>	<b>87,551,609</b>	<b>667,472</b>
KNOWLEDGE ENHANCEMENT	5,416,934	21,970,602	3,146,944	30,534,480	232,787
ENABLING ENVIRONMENT CREATION	8,688,319	15,667,487	134,854	24,490,660	186,711
PARTNER'S CAPACITY BUILDING	5,877,757	7,768,968	639,324	14,286,049	108,913
VOICE OF Rightholders & SERVICE PROVIDERS	1,387,955	2,376,679	804,788	4,569,422	34,836
NGO MANAGEMENT+ Consultancies	30,405	11,220,963	2,419,630	13,670,998	104,224
					-
<b>MANAGEMENT COST</b>	<b>16,315,388</b>	<b>14,428,339</b>	<b>3,252,232</b>	<b>33,995,959</b>	<b>259,177</b>

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District and Central Level Remuneration and Travel Cost	9,502,150	10,124,313	2,510,189	22,136,652	168,764
Central Office Support Staff Cost and Travel	1,314,680	1,411,356	319,073	3,045,109	23,215
Capital and Running Cost	5,498,559	2,892,670	422,969	8,814,198	67,197
<b>Institutional Overhead, ActionAid/NewERA</b>	<b>1,885,838</b>	<b>3,671,652</b>	<b>519,889</b>	<b>6,077,378</b>	<b>46,332</b>
					-
<b>TOTAL</b>	<b>39,602,596</b>	<b>77,104,689</b>	<b>10,917,661</b>	<b>127,624,947</b>	<b>972,982</b>

Equivalent GBP	292,101.47	596,270.70	84,609.47	972,981.64	
Weighted Average Rate £=NPR	135.58	129.31	129.04	131.17	

# NGO management cost apportioned to output 1-4. Programme cost recorded in accounts from May 2006 only.

### Programme Cost (EAP)

