AUSTRALIAN HIMALAYAN FOUNDATION

AHF Health Sector Strategy

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Cover Image: Mark Morrissey

Image: Mark Morrissey

Introduction

Inspired by the humanitarian work of Sir Edmund Hillary and our passion for the Himalayan region and its people, AHF was founded in 2002 with a mission to improve the quality of life for those most in need in remote Himalayan communities. Working in partnership with local non-government organisations, communities and governments in hard-to-reach areas of Nepal, India and Bhutan, our work focuses on supporting four foundational aspects of development: health, education, climate adaptation and conservation, and arts and culture. In addition, our strategic plan prioritises safeguarding vulnerable groups and promoting gender equality, and strengthening the capacity of our partners to implement best practice and sustainable development programs and to respond to crises.

Improving access to basic health services and health outcomes in the Himalaya has been a strategic goal for the Foundation since our inception. We began our first health-focused development program in Zanskar, India in 2005. Other than in emergency response (Nepal earthquakes and COVID), our health programs have primarily centred on women and children. In this AHF Health Strategy, we outline some of the main health challenges currently faced by communities in the region and present our strategic approach to strengthening Himalayan community health outcomes.

Why Health?

a. Good health is foundational for a quality life

Most people can intuitively appreciate the fundamental importance of good health. Physical and mental health provide a solid foundation for enabling individuals, families and communities to accomplish and experience a quality life. Whilst there is a moral imperative to ensure all people can access healthcare, our AHF community is also driven to improve health and well-being from a rights-based perspective (Article 25, Universal Declaration of Human Rights).

> **Universal Declaration of Human Rights - Article 25**
> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
> Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.
> (The United Nations, 1984)

In recent decades, health-related goals have featured prominently within multilateral global development agendas. Of the eight Millennium Development Goals (MDGs), four focused on improving health outcomes and reducing hunger. Subsequently, the United Nations Sustainable Development Goals (SDGs) continue to foreground improved health outcomes as a critical element of our shared global action plan – the global Agenda 2030. Specifically, SDG3 is to "Ensure healthy lives and promote well-being for all at all ages". This goal is underpinned by 13 specific targets addressing wide ranging issues such as reducing maternal and infant mortality, infectious disease, and non-communicable disease (NCD), and improving reproductive health and mental health and well-being (for a full set of SDG3 targets and indicators see Annex 2 – Sustainable Development Goal 3 – Healthy Lives).

Improving health is a fundamentally important collective global goal, and one that AHF aims to contribute to in the Himalaya.

b. The state of global health

Globally, much progress has been made in relation to a wide variety of health outcomes over the past 50-100 years. This progress comes thanks to a range of factors including better living conditions, improved sanitation, and targeted disease eradication and immunisation campaigns.

Some key indicators of progress include:

- **Longer life expectancy** - Over the past 50 years, global life expectancy has increased by 10 years, and importantly, the disparity in life expectancy between high- and low-income countries has also declined (BBC 2013).
- **Reduced rates of maternal and child mortality** - Today, children are far less likely to die before their fifth birthday than was the case 50 years ago. Indeed, the UNDP Human Development Report 2020 highlighted that: "The chance of a child dying before age 5 has declined five-fold since 1950, and the number of women dying in childbirth has been almost halved globally since 1990." (UNDP 2020).
- **Elimination or significant reduction in infectious disease-related deaths** - the global incidence of tuberculosis and HIV have declined (UNDP 2020, UN 2021) smallpox has been eradicated and Polio is close behind - cases have decreased by 99% since 1988 (WHO 2020).

Yet, despite these positive trends, numerous significant health challenges remain. Malnutrition and maternal and child health require further attention to meet global goals. Many infectious diseases continue to present major threats and the incidence of some has plateaued or is increasing. As we are presently dramatically reminded, global populations are still vulnerable to pandemics, with SARS, MERS, COVID-19 all presenting recent examples. COVID-19 has resulted in over 5.6 million deaths and 370 millions cases globally (January 2022 - WHO) and these figures are likely to be significant under representations of actual case and mortality rates due to challenges in global surveillance, reporting and limited access to diagnostic tools. Furthermore, they reflect the direct impact of the disease only. The pandemic has had wide-ranging indirect negative effects into other areas of health and wellbeing as a result of factors such as reduced access to regular health services, isolation, and economic hardship (Kaczorowski 2021). Impact and public health responses vary from month to month, and nation to nation. We address COVID-19 in the Himalaya in more depth below.

It is also important to recognise that as we live longer and more successfully tackle infectious diseases, the nature of the health challenges we face is gradually changing. In both high- and low-income settings, NCDs (chronic illnesses such as cardiovascular and respiratory diseases, cancers, diabetes), alongside accident and injury, mental health and wellbeing, have emerged as areas of significant concern. NCDs now represent 71% of all deaths globally. A majority (77%) of these deaths are occurring in low- and middle-income countries (Holmes et al 2017, Shrestha 2014, WHO 2021). Accidents are the eighth leading cause of death globally and similarly disproportionately impact those living in the global south, killing and 3.5 times more people in low-income countries than high-income countries (CDC 2020). These shifts place additional burdens on the health systems of developing/LMICs countries, as they simultaneously work to address communicable and non-communicable diseases and other health issues (US Department of Health and Human Services 2014).

Within this broader global public health context, an area of particular concern, and an important strategic focus for AHF, is maternal and child health. Fortunately, as in other areas, we have seen progress in past decades, including within the geographic regions where AHF works. The WHO reports that the number of maternal deaths per 100,000 live births has dropped by about 38% worldwide between 2000 and 2017, and that Southern Asia has achieved the greatest overall reduction: a decline of nearly 60% (WHO 2019). Nonetheless, women and children remain some of the most vulnerable people, and health challenges are compounded for those living rurally, those with less education (Ashworth et al 2019), and those affected by humanitarian crises (Schmied et al. 2020) – all factors facing the communities in AHF project areas.

Image: Mark Morrissey

For AHF, securing a better future for children has always been and continues to be a core focus of our work and our health programs are largely maternal and child health focused.

c. Health gains at risk - COVID-19 pandemic

In 2020, COVID-19 tore our world apart, pushing millions into uncertainty and fear. The pandemic has been widely acknowledged as threatening to undo some of the critical education, health and environmental gains achieved over the last two decades.

Covid-19 in Nepal

Data on the impact of COVID-19 is constantly evolving. Globally, those with underlying health conditions have been more susceptible to severe illness and death from COVID-19 and early research indicates this is the case in Nepal also - those already living with NCDs or other underlying conditions such as asthma and diabetes have been more vulnerable to serious illness and death from COVID-19 (Rayamajhee et al 2021)

The lockdowns and response to the pandemic continue to disrupt other essential health services, including childbirth, pre and post-natal care, treatment and screening for TB; HIV, hepatitis B and C; malaria, NCDs such as cancer, rollout of childhood immunisations, access to family planning and contraception; provision of dental care (UN 2021). The pandemic has led to increases in food prices, difficulty in accessing food and medicines, restricted movements of patients and healthcare workers, and flow-on effects on mental health are yet to be fully understood.

> **"The lockdown measures due to COVID-19 have jeopardized Nepal's decade-long significant progress, especially in the areas of maternal and child health, for example, maternal mortality and neonatal deaths have suddenly increased by more than three folds during the pandemic [13].** Childbirth at home in the absence of skilled health care workers and the prevalence of morbidities associated with other communicable and non-communicable diseases have also significantly increased after the COVID-19 outbreak in Nepal [8, 13]. The COVID-19 pandemic is anticipated to further worsen the availability and utilization of health services in both urban and rural areas of Nepal."
> (Singh et al 2021).

Sadly, there have already been several reports of specifically worsening outcomes for mothers and children in Nepal: *".. since the start of the pandemic, maternal deaths have soared. According to the department of health, 258 women died as a result of pregnancy or childbirth between March 2020 and June 2021. Thirty-three women had Covid-19. In the year before March 2020, the country recorded 51 maternal deaths. Neonatal deaths have also increased, from 13 deaths per 1,000 live births before lockdown to 40 deaths per 1,000 live births during the first lockdown. Health workers fear that the second wave of infections could see maternal death rates reach levels not seen in the country this century"* (Adhikari jn The Guardian, 2021). Considering these factors, there have been calls in Nepal for more targeted communications, specifically focusing on vulnerable populations, older people, people with NCDs, and pregnant women, as well as calls for the reinstatement of other health services and activities as soon as possible (Adhikari, 2021, Neupane et al 2021, Rayamajhee et all 2021, Singh et al 2021).

Images: Action for Nepal

Covid-19 in Bhutan

COVID-19 has caused a major socioeconomic impact on the lives of people in Bhutan, but despite resource limitations, Bhutan quickly achieved control of the pandemic in 2020, building on the country's well-established primary healthcare and vaccination systems (Dorji et Tamang, 2021). The country was fast to implement effective public health measures including initial lock downs. Vaccines, once they became available, were rolled out in an impressively rapid and comprehensive vaccination campaign - by August 2021 over 90% of the eligible population (those over 12) had been fully vaccinated (The World Bank in Bhutan) By global comparison, to date COVID-19 case numbers have remained low for the duration of the pandemic. However, because Bhutan still imports about 50 percent of its total food consumption, food prices have increased by approximately 15 percent over the last year and have cast a shadow on food security and livelihoods of vulnerable people. FAO Bhutan's Assistant Resident Representative, Chadho Tenzin noted that: 'the outbreak of COVID-19 and a lack of decent work opportunities in many parts of the region, alongside significant uncertainty of food systems and markets, has led to a worsening of inequality, as poorer families with dwindling incomes further alter their diets to choose cheaper, less nutritious foods" (FAO-UNICEF-WFP-WHO 2021)

Image: Heather McNeice

COVID-19 crisis has also heightened the risk factors generally associated with poor mental health – financial insecurity, unemployment, fear – while protective factors – social connection, employment and educational engagement, access to physical exercise, daily routine, access to health services – fell dramatically. This has led to a significant and unprecedented worsening of population mental health. A study identified increased prevalence of stress, anxiety and depressive symptoms during the initial stage of COVID-19 pandemic in Nepal (Devkota, et al 2021). UNFPA in Bhutan reported a surge in both gender-based violence and mental health concerns (UNFPA 2020).

Children and young people are particularly impacted and could feel the impact of COVID-19 on their mental health and well-being for many years to come warned UNICEF in the report: 'The State of the World's Children 2021; On My Mind: promoting, protecting and caring for children's mental health'. This is UNICEF's most comprehensive look at the mental health of children, adolescents and caregivers in the 21st century and it highlights that even before COVID-19, children and young people carried the burden of mental health conditions without significant investment in addressing them.

Image: Ramona Codd-Miller

According to the latest available estimates, more than 1 in 7 adolescents aged 10–19 is estimated to live with a diagnosed mental disorder globally. Almost 46,000 adolescents die from suicide each year, among the top five causes of death for their age group. However, only 2 per cent of government health budgets are allocated to mental health spending globally. (UNICEF 2021)

The state of health in Nepal

Nepal is among the least developed countries in the world, with about one-quarter of its population living below the poverty line. The country is ranked 142nd out of 177 in the UNDP's Human Development Index (HDI) in 2020.

The policy landscape

The Nepali Constitution (2015) has enshrined free basic health care as a right. Following the decentralisation of the government, the Nepali healthcare system is structured in three tiers (federal, provincial, and local), with a measure of autonomy delegated to the local (municipality or ward) levels (Singh et al 2021). Health policy has been guided by a range of key instruments including, most recently, the national Health Insurance Act (2017) regulating provision of social health insurance (Ashworth et al 2019), the Nepal National Health Sector Strategy (2015-2020), and prior to this the National Safe Motherhood policy (1998), the current Safe Motherhood and Newborn Health Long Term Plan (2006-2017), the National Policy on Skilled Birth Attendants (2006), and the Aama Programme (2009) providing free delivery care in health facilities and cash incentives to access anti and post-natal care, as well as cash payments to cover transport costs and funding for health facilities.

Constitution of Nepal
Article 35. Right relating to health:
(1) Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services.
(2) Every person shall have the right to get information about his or her medical treatment.
(3) Every citizen shall have equal access to health services.
(4) Every citizen shall have the right of access to clean drinking water and sanitation.
(GON 2015)

Local Government - health management, targets and roles

Over the past two decades, responsibility for the functioning of healthcare facilities (health posts and primary health care centers) has been increasingly devolved to local government bodies and is primarily managed by the Health Facility Operation and Management Committee (HFOMC), which is a legitimate body formed locally at each health facility.

Capacity strengthening of those local health facilities and the local governance structures is a well documented priority for many of the Rural Municipalities and Local Governments and necessary for the sustainability of health projects in Nepal. Good management, monitoring and supervision of the health facility by HFOMC is important for it to function efficiently. The government has outlined minimum standards and guidelines for HFOMC management. Guidelines stipulate the member make-up of HFOMCs with participation and diverse representation of the community. These standards and guidelines provide a solid and meaningful base to assessing capacities of HFOMCs and shaping programmatic interventions.

Health Outcomes

Whilst Nepal has made good progress towards addressing many of the MDG and SDG targets, this progress is not equally experienced across different segments of the community. A range of outstanding health issues remain to be addressed including malnutrition, maternal mortality, anaemia, access to reproductive health facilities, hepatitis, water-borne diseases.

GoN SDG Baseline Report (2017)
"..Nepal remains as one of the few countries having accomplished an impressive record of human development during the last two decades (UNDP, 2014). But having started with a very low base, Nepal still remains as a country with low human development status. …".
".. these improvements have not been uniform across ethnic groups and geographical regions, as disparities exist between rural and urban areas and among eco-geographical regions and social groups (NPC, 2016)"
(GoN National Planning Commission, SDG Baseline Report, 2017)

Health System and Geographic Challenges

Considering health system and population factors, other documented health system challenges in Nepal include a shortage of healthcare workers: "As of September 2016, the number of total health care personnel including doctors, nurses, and midwives in Nepal was 3.15 per 1000 population" (Neupane et all 2021), as well as a deficit of earthquake resistant hospitals and facilities (WHO). Health care services are also impacted by underlying contextual and community factors such as poverty, illiteracy, attitudes towards medical professionals, geographic distribution, lack of infrastructure, security concerns of healthcare professionals, government policies or physical barriers.

Challenges in accessing basic, quality healthcare in Nepal are particularly pressing in the remote mountain areas of the country such as Solukhumbu, where AHF works, or in other remote areas such as those recently surveyed by AHF in West Nepal. Physical distance and lack of infrastructure such as limited motorable roads connecting remote regions mean that people are also less likely to access healthcare that may be available in regional centres. Ashworth et al (2019) note that "*Approximately 22 million people have difficulties accessing healthcare in rural Nepal" and that "Rural populations in particular have been identified as being vulnerable to inequitable healthcare access. The rural population in South Asia faces accessibility issues related to geography, cultural factors and gender. These factors are of particular importance in Nepal, where a variable geography, natural disasters and unstable political history have contributed to widening equity gaps in accessing care.*"

Health Care Accessibility in the Rural Plains of Nepal

"The 2011 Nepal Living Standards Survey (Central Bureau of Statistics) reports that 41% of rural households do not have access to a health post or sub health post, and that 79.6% do not have access to a public hospital within 30 min of their home. Overall, Nepal's rural populations take a mean of 135 min to access a health post or sub-health post. In 2012, Paudel et al. noted that this was a major reason why rural populations did not seek healthcare when needed; 92% of rural households in Nepal cannot access healthcare via a personal automated vehicle and instead rely on cycling or public bus (40%), or as pedestrians (50%). The mode of transportation, distance crossed and time travelled often lead to fatalities from preventable illness or treatable emergencies such as snake bites. Understanding these accessibility issues allows for redevelopment of healthcare deployment in Nepal and similar nations." (Ashworth et al 2019)

Health challenges faced by rural women

Women living in rural areas are less likely to receive reproductive health services than their urban counterparts. For the proportion of the population living in remote and mountainous regions, long distances to health facilities and lack of transport makes seeking maternal care difficult (Nguyen, 2020). "*Research literature on healthcare accessibility in Nepal has focused on women's knowledge and attitudes towards accessing healthcare, and indicate that women face challenges with longer travel times, variable transportation modes, financial issues and embarrassment…*" (Ashworth et al 2019)

Image: Trevor Harrison

A prominent public health issue in very remote parts of Nepal, eg in Bajhang District in Far West Nepal is the ancient tradition of Chhaupadi. This practice banishes young girls and women from their homes to a mud hut or shed ("Chhau-") for the entire duration (and sometimes longer) of their menstruation and in childbirth. It is believed they will bring their family bad luck, or ill health, if they are not banished. Despite Nepal's Supreme Court banning chhaupadi in 2005, and the government criminalising it since 2017, Chhaupadi is still commonly practised in some remote areas of Nepal. Forcing girls to live in Chhaupadi huts during the menstrual period violates human rights, including health, gender and education rights (Thakuri et al 2021).

Government of Nepal targets

Despite some positive trends, it is evident that continued effort and support is needed if Nepal hopes to achieve the Sustainable Development Goal (SDG) targets including reducing MMR to less than 70 per 100 000 live births, under-five mortality to at least as low as 25 per 1000 live births, and NMR to at least as low as 12 per 1000 live births, all by 2030. The issue of inequality in health care access and outcomes between socioeconomic and geographical groups will also need to be addressed (Nguyen, 2020). The GoN National Planning Commission has laid out a set of specific targets in this regard, reflecting Nepal's approach to integration of the SDGs (see text box).

Nepal's National SDG Targets (selection)
Nepal has established numerous health related national targets, aligned with the SDGs. Some of these targets include:

SDG2:

- reduction in prevalence of undernourishment (measure of sufficiency of access to food at country level) to 3%
- reduction in prevalence of underweight children under five years of age to 9% in 2030
- reduce prevalence of anaemia among women of reproductive age and children to 10% and 10% respectively in 2030.

SDG3:

- reduction of MMR to less than 70 per 100 thousand live births by 2030, in line with the global target.
- reduction of preventable deaths of newborns and children to less than 1%
- for overall newborn and U5 mortality rates, the target is to reduce them from 21 and 38 per thousand live births to 12 and 20 respectively by 2030
- almost elimination of the prevalence of HIV, TB, Malaria and other Tropical Diseases, and water borne diseases
- reduce NCDs to one–third of existing levels
- raise the proportion of births attended by SBA to 90%
- increase institutional delivery to 90%
- provide postnatal care for 90% of mothers.
- reduce suicide mortality rate from 17.8 per 100,000 in 2019 to 4.7 in 2030

SDG 6:

- Basic water supply coverage to 99% of households
- Piped water supply and improved sanitation to 90% of households
- Reach 95% of households with improved (household) sanitation facilities
- Ensuring 98% of the population use latrines

(GON Voluntary National Review 2020)

The state of health in Bhutan

Bordered by the world's two most populous nations, India and China, Bhutan is home to one of the region's smallest, with a population of less than 800,000 people, and a landmass of 38,117km2 - about one third the geographic size and a fraction of the population of Nepal. The country is ranked 129th out of 177 in the UNDP's Human Development Index (HDI) 2020, and is expected to transition out of the United Nations' 'Least Developed Country' status by 2023.

With respect to health outcomes, the country has demonstrated strong progress over the past decades. In this century, life expectancy has increased by 10 years, from 60.2 years in 2000 to 70.6 years in 2016. Infant mortality has steadily declined from 102.8 per 1000 live births in 1984, to 26.7 in 2019. Several infectious diseases such as measles have been eliminated (2017) or near-to eliminated, an evolving vaccination program is in place (Dorji, 2021) and targeted long-term campaigns have effectively addressed malaria.

However, while the country has achieved many significant health developments, in recent decades new challenges such as the burden of non-communicable diseases, healthcare workforce skills levels, and mental health concerns have emerged as new focal areas. Pre COVID-19 pandemic reports indicated that non-communicable diseases are the leading cause of death across all age groups, accounting for 53% of all deaths (Yangchen et al)

The policy and infrastructure landscape

Since 2008, Bhutan has been a constitutional monarchy, and the Constitution of the Kingdom of Bhutan mandates the state to provide free basic public healthcare. Bhutan is also well known internationally for its innovative Gross National Happiness (GNH) Index, which provides the central framework for government planning and investment. The GNH index includes 12 National Key Result Areas, including one focused on a 'Healthy and Caring Society' (number 14), and nine domain areas, one of which is psychological health.

> *"The State shall provide free access to basic public health services in both modern and traditional medicines"* Constitution of the Kingdom of Bhutan (2008), Article 9, Principle 21

National planning aligned with the GNHI is delivered through concurrent five-year strategic plans. The current plan, the 12th Five Year Plan (2018-2023), details 11 health-specific indicators. Public health strategy is further detailed in the National Health Policy (2011). As may be expected given the holistic nature of each framework, the GNH Index and ensuing national policies are well aligned with the SDGs.

Healthcare is predominantly provided via the public system, rather than via very private sector alternatives. Structurally, Bhutan's national commitment to the provision of free basic healthcare is delivered via 209 'Basic Health Units', 28 district hospitals, two regional hospitals and a national referral hospital – a three-tiered system (Wangmo et al, 2018) This configuration is complimented by the services of Village Health Workers at the grassroots level, and the 'referrals abroad' of complex technical medical cases to India (IMS)

> Bhutan utilizes a system of universal free healthcare, which it finances with approximately 3.5% of its GDP. There have been many significant health breakthroughs in Bhutan, between the near-eradication of vaccine-preventable diseases and the provision of an equitable healthcare supply. Modern health struggles have accompanied Bhutan's modernization; instead of malaria and polio, Bhutan now faces addiction, mental illnesses, HIV/AIDs and other serious problems. Specifically, the three most pressing concerns are systemic healthcare problems, noncommunicable diseases and mental health issues. Bhutan's healthcare system faces challenges itself. Most prominent is a lack of proper recordkeeping, unequal access to care (despite having equal supply) and inadequate providers.
> (Sam Konstan, Optimism Regarding Healthcare in Bhutan (2021))

Mental Health

It has been widely reported that in Bhutan, suicide ranks as the sixth most dominant cause of death (preceded by alcoholic liver disease, other circulatory diseases, cancers, respiratory diseases, and traffic accidents) (MoH, 2018, Nirola, 2019) Concerns around the status of mental health in the country were amplified after the completion of the nation's first comprehensive suicide survey in 2014, the 'STEPwise Survey for Non Communicable Diseases Risk Factors' The government has since introduced a number of prevention programs in response, including most recently the 'Suicide Prevention in Bhutan – A Five Year Action Plan (2018 – 2023)'.

Suicide can be linked to diverse social, cultural, economic and environmental factors, however in Bhutan some have suggested the relatively fast rate of modernisation may be one underlying factor, and specifically the introduction of the internet and television as recently as 1999 (Dorji in Johnson, 2018). Others point to the very minimal access to psychiatric or therapy services. (Konstan, 2021) Cultural factors, alongside high rates of alcoholism and domestic violence, present further challenges; "*seeking medical treatment for mental illness is a brand-new idea for many Bhutanese; most are more likely to complain of being afflicted by deities than depression and would rather visit a shaman than a psychiatrist*" (Johnson, 2018, Yangchen et al). In their analysis of the 2014 study, Dendup et al noted correlations to factors such as age, gender, family history employment status and poverty: "*female gender, being unemployed, low and middle household income than high household income, and having a family history of suicide were associated with higher odds of having suicidal ideation. Younger age and alcohol consumption were associated with both suicidal ideation and suicide attempts. While those from the middle-income group compared to those in the high-income group had reduced odds of attempting suicide*" (Dendup et al, 2020).

Interestingly, one advocate pointed to the challenges of language, highlighting how the Bhutanese language lacks nuanced vocabulary for discussing mental health; "*You can say you've experienced depression and anxiety in English — now, how do you translate this into Dzongkha? If you translate it, it's like, 'you're mentally ill.' That's it. There's no way to describe it further.*" (Zam in Johnson, 2018).

Bhutan does not have any mental health legislation to protect the rights of people with mental illness, and low financial resources, scarcity of mental health personnel, facilities and medicine, presence of conflicting healing systems and the stigma of seeking help for the mentally ill are additional issues to address (Rinchen 2012).

AHF Response

AHF experience and achievements

AHF has been delivering targeted health programs for over 16 years, working in collaboration with a range of local partners and governments in the Indian Himalaya and Nepal. See Annex 4 for a short history of *AHF Health Programs*.

Since our first program in 2006, we have refined our approach and focus areas, however health remains central to AHF's Strategy (2020-2025).

Some of our key health achievements include:

- Provide mother and child health care, train the traditional health practitioners (Amchis) and Auxiliary Nurse Midwives to use modern medical care practices, and provide medical health services through targeted and intensive health camps, in partnership with Servants of Society and Ladakh Institute of Prevention, Ladakh (2006-2017)
- Cervical and breast cancer screening and prevention programs in Nepal, including the provision of the HPV vaccine to girls and education for women on vaccines, early detection and cervical and breast cancer in partnership with the Nepal Network for Cancer Treatment and Research (NNCTR) and the Nepal Australia Cervical Cancer Foundation (NACCF) (2009-2013).

Nurses for Nepal Program

- Enhanced effectiveness of service delivery following the recruitment and training of two Nurses to support health posts in two wards in Lower Solukhumbu to complement and assist existing health staff as part of the 'Nurses for Nepal' (NFN) Program (2017-2021).
- Increased knowledge and practice of school students on hygiene and sanitation, handwashing techniques, adolescent sexual and reproductive health and other social issues following the regular health awareness programs run in schools.
- Improvement of the competency of the Female Community Health Volunteers (FCHVs) after being trained by the nurses, which increased their ability to run mothers' group meetings.

Nurses for Nepal Program

- Positive changes of women's health behavior observed as women sought necessary health care services and adopted healthy behaviors. Women were reported to have sought increased health check-ups during pregnancy, to have consumed nutritious food and an increase in institutional delivery was reported. The active involvement of women in mother's groups and the different health sessions provided within the mothers' groups are also reported as having empowered the women and having helped them make the right decisions about their health.
- Capacity strengthened of local community Health Facility Operation and Management Committees to manage the health posts effectively and to promote sustainability.

COVID-19 Responses:

- In 2020 and 2021 AHF worked with Action for Nepal to source and distribute vital Personal Protective Equipment (PPE) and medical equipment and supplies to the remote hospital and five health posts in Mahakulung Rural Municipality in Solukhumbu.
- As a result of this initiative:
  - » 30 health staff were trained in COVID-19 prevention and treatment
  - » 168 health staff benefited from improved protection
  - » More than 54,000 people indirectly benefited from the equipment provided to diagnose, treat and manage COVID-19.

Waku Construction Project

- Supported the construction of a Health Post building in the remote ward of Waku, with the full support the community who donated their best piece of land for the project. This was implemented through Action for Nepal in collaboration with the local government and One Heart Worldwide who also contributed financially to the project. This local facility, which includes a birthing centre, will benefit around 4,800 people in Waku, particularly women.

AHF program delivery approach

Signature elements of our approach include:

- **Strong collaboration with and capacity strengthening of local partners**

AHF works exclusively with local organisations that have strong links with the communities they serve and that share our vision, purpose and goals. Since 2017, AHF has worked in close partnership with Action for Nepal (AFN) to develop and implement the Nurses for Nepal, COVID-19 responses, Waku Construction Project and now the new Solukhumbu Women's Health Program (2021-2025). These programs engage ward health staff to strengthen their capacity in a range of areas, leverage local resources, ensure program activities complement government priorities and coordinate effectively with local authorities. AHF has supported our long-term education partner, REED Nepal, since 2005, including in the delivery of health and hygiene awareness sessions for students, and our partner in Bhutan, RENEW for over ten years to support children mostly survivors of abuse and violence.

- **A commitment to long-term engagement**

AHF holds a predominant place as one of the leading development aid agencies in areas such as the Lower Solukhumbu in Nepal, where we have provided sustained, practical assistance for many years. We have a long-term commitment to our local partners and the communities they work with to ensure sustained improvements to health outcomes.

- **Responsive adaptation**

We adapt our response to challenges such as the Nepal Earthquakes and COVID-19 to honour our commitments, support partners and communities at times of crisis.

- **Safeguarding, Inclusion and Equality**

We actively mainstream gender, child safeguarding and disability inclusion approaches within our health programs, as well as the inclusion of other vulnerable and disadvantaged groups[1], reflecting development sector best practices as outlined in the ACFID Code of Conduct. Many of our health activities are specifically targeted to address health concerns for women and children.

We work closely with our partners to strengthen their capacity to safeguard children, as well as to prevent discrimination and sexual abuse and exploitation. We are committed to providing disability-specific initiatives to support the empowerment of persons with disabilities, as well as integrating disability-sensitive measures into the design, implementation, monitoring and evaluation of AHF policies and programs.

[1]Women, children, female or child-headed households, people with disabilities, the poor, the elderly, indigenous peoples and ethnic minorities, religious and linguistic minorities, lesbian, gay, bisexual, transgender and/or intersex people, people dependent upon the land of others for livelihood or residence.

- **Continuous improvement and learning**

In addition to strong collaboration and frequent communication, AHF and our local partners share a commitment to evidence-informed programming and ongoing learning arising from research, monitoring and evaluation.

- **Sector integration across projects**

AHF's primary programmatic sectors (Health, Education, Environment) buttress one another. For example, health programs delivered in schools enhance students' knowledge and practice of good hygiene and sanitation, handwashing techniques, adolescent sexual and reproductive health and other social issues. Better student health outcomes in turn facilitate better school attendance and participation – a foundation for improved education outcomes and reversely. From interviews with children in Bhutan, AHF support for their education seems to have a positive impact on their wellbeing. In West Nepal, AHF is exploring how health and education programs may intersect particularly in relation to the discouragement of Chhaupadi.

In future, it is expected that climate change will also increasingly present a challenge to health in the region, and the burden of climate change is expected to fall disproportionately on the poor, the less educated, those that rely on weather dependent agriculture for their own food safety and to generate resources to cover other living expenses (UNDP 2020). AHF is committed to growing its environment and climate change response programs in our 2020-25 Strategic Plan and beyond.

Image: Ramona Codd-Miller

Image: Mark Morrissey

AHF has the relationships, knowledge and skills to continue to deliver and develop impactful health programs and will further expand our work in this sector to improve health outcomes for other vulnerable communities in the region over time.

Our strategy and health program model

Health is fundamental to personal growth, and a long and quality life. Improved levels of public health services, knowledge and wellbeing have the power to transform a community, enhance economic development and build a more equitable society. Given our experience and passion for health, and the extent of health needs in the Himalayan region, health development will remain a core part of AHF's work into the future, with a particular focus on women and children. During this time, we plan to continue working with our existing partners, strengthen our research base, periodically evaluate our programs, sharpen program design and assess impact. We do this with a view to both consolidate our results, and position ourselves to scale and expand into new communities. In light of COVID-19, the modalities of our program delivery will be monitored and adapted to cater for the field realities.

AHF Health Program Model Overview

Program Goal: AHF Strategic Goal 2: Ensure healthy lives and promote children's wellbeing

Pillars	Supporting Health Centres and Decision-Makers	Supporting Health Workers	Supporting Children and Women
Program components	Health Centre Governance & Facilities	Healthcare workers Support	Community Health Outreach programs
Specific objectives	• Develop governance capacity of government health management structures such as HFOMCs* • Develop health facilities and strengthen capacity of local health services.	• Support recruitment, training and retention of health workforce.	• Improve access to essential health care services and information, including sexual and reproductive healthcare services, in selected districts of Nepal. • Improve maternal and child health • Promote mental health and wellbeing.

Cross-cutting approaches

1/ Safeguarding vulnerable groups and promoting inclusion and gender equality
Specific Objectives:

- Promote equitable access to education and health care for girls, children with disabilities and children in vulnerable situations.
- Take action to end discrimination and violence against women and girls.
- Strengthen women's leadership and participation in governance and decision making.
- Include and safeguard children, women, people with disabilities and other vulnerable groups in projects, partner organisations and AHF.

2/ Strengthen capacity of partners to implement best practice and sustainable development programs, and to respond to crises.

Specific Objectives:

- Strengthen partners' governance and management.
- Develop key partnerships with stakeholders in Australia and in the countries we work to support AHF operations, projects and partners.
- Support partners to ensure the sustainability of their operations.
- Strengthen partner capacity to respond to crises, including COVID.

Foundations of success

Strong partnerships with local partners and ongoing capacity strengthening. Relationships based on trust and mutual respect. Long term commitment. Adaptive programming. Safeguarding, inclusion and equality. Continuous improvement and learning.

* Health Facility Operation and Management Committee (HFOMC)

Image: Mark Morrissey

Our health strategy engages different stakeholder groups and health services by drawing on a suite of 'program components' aligned with each of the three pillars: Supporting Health Centres and Decision-Makers, Supporting Health Care Workers, and Supporting Children and Women.

Looking forward – AHF Health Programs 2021+
In 2021-2025, AHF will implement the following program components:

Supporting Health Centres and Decision-Makers:
We aim for AHF supported birthing centres and local ward health posts to have: strong governance systems and management; adequate, well equipped and safe facilities; and improved child and mother-friendly services, particularly regarding sexual and reproductive health. To support this, we will:

- work to assess and build the capacity of Health Facility Operation and Management Committees (HFOMCs) to meet governmental Minimum Service Standards and guidelines and to effectively manage, monitor and supervise the health facility;
- increase HFOMC and community knowledge and capacity in safeguarding and gender equality, disability and social inclusion (GEDSI) through orientation and implementation of improved procedures, and participation and empowerment of vulnerable and disadvantaged groups;
- build local HFOMC and community advocacy skills to effect greater health funding and resourcing through more lobbying at Rural Municipality level, including for provision of all sanctioned staff, for monitoring regularity of staff attendance at health posts, and for timely provision of adequate essential equipment and medicines;
- improve health facilities ensuring they when required and ensure health posts are well equipped, supplied, staffed and managed, particularly regarding sexual and reproductive health
- where required, improve access to some basic health services, including for family planning, safe motherhood and child health, by strengthening health outreach clinics so basic health services are more accessible and regular.

Supporting Health Workers:

- Health Centres in rural Nepal find it difficult to recruit, retain and provide professional development for healthcare workers. Many Skilled Birth Attendants and nurses in remote areas have received limited training. To support Health Workers, AHF will:
- provide periodic training to local health staff and female community health volunteers (eg. FCHVs), particularly on sexual and reproductive health;
- resource short-term staffing solutions (roles such as Auxiliary Nurse Midwife or Assistant Health Worker) with consideration of transitioning resourcing of these personnel to the Rural Municipality.

To address mental health challenges, AHF will:

- strengthen mental health, wellbeing and suicide prevention training for school counsellors and educators, and for the counsellors working with out partner RENEW;
- where required, support staffing solutions to provide improved services to children and women.

Supporting Children and Women:

To support children and women, AHF will continue to work with mothers' groups as they are a key means of engagement with local communities and provide a forum for awareness raising sessions such as on reproductive health and hygiene and sanitation. AHF will aim to increase the participation in mothers' group meetings, assessing and addressing barriers to participation such as time constraints, low engagement, male and in-law recognition. In addition, AHF will:

- support targeted health camp initiatives to deliver vital health services in a community (such as uterine prolapse camps), and strengthen outreach health services;
- deliver trainings and awareness-raising sessions in schools, mothers' groups and local communities such as on reproductive health, maternal health care knowledge, mental health and wellbeing, and hygiene practices;
- integrate hygiene, wellbeing and safety project outcomes in AHF education projects, targeting issues such as mental health, suicide, menstruation and reproductive health;
- provide counselling and support to children, particularly for those impacted by violence and abuse.

Safeguarding and Mainstreaming Gender and Disability Inclusion:
Importantly, gender and disability inclusion, and child safeguarding approaches and principles will continue to be mainstreamed across all health program modalities and activities. One aspect of this mainstreaming approach is support to partners around the collection and review of disaggregated data, to better understand the health outcomes across different segments of the community.

Growth and Expansion:
On the basis of our learnings in Solukhumbu, AHF will grow its health program in Nepal (eg West Nepal). AHF will ensure health outcomes are considered in other programs, and integrated where possible, such as wellbeing activities and outcomes in our education work in Bhutan.

Australian Ambassador to Nepal, Felicity Volk, with Waku community at the inauguration of Waku Health Post. International Women's Day 2022.
Image: Ramona Codd-Miller

Risks

- **COVID-19** poses a continued risk for the implementation of the AHF health program strategy. AHF has worked with our partners and supporters to amend our existing health activities when required and to support COVID-19 prevention and response. The ongoing impact of COVID-19 will be monitored regularly, and project activities pivoted accordingly to, as much as possible, meet strategic objectives. With partner and community input, AHF seeks to support COVID-19 responses as required, but also to maintain/re-establish regular programs as soon as possible, with COVID-19 safety measures in place. When adapting programming is not possible, alternative programming will be discussed in close liaison with partners and to support stakeholders, including governmental efforts.

- **Accessing reliable and timely health data** is important for informing programming and assessing impact, however, this can often be a challenge in the remote and lower income country contexts where AHF focuses. To better understand our operating context and our results, AHF has placed an explicit focus on strengthening data collection and reporting.

- **Child safeguarding and PSEAH** risks are assessed for all programs undertaken by AHF and relevant mitigation strategies identified and implemented.

- **Funding Sustainability:** The AHF funding cycle relies on fundraising during the year for projects implemented in the same year, thereby posing a risk to projects' continuity. AHF is working at more predictable, reliable and diverse sources of multi-year funding commitments, as well as progressing to a budgeting cycle of committing to fund a project only once a base portion of the funding is raised.

- **Outcome Sustainability:** Approaches to promoting the sustainability of programming, and importantly the sustainability of outcomes after programs have concluded, include; a) starting with the end in mind; b) co-funding projects with local actors and other global donors, including seeking commitment from local government and other NGOs; c) building local skills and knowledge which are retained in community and provide a foundation for future activities.

- **Limited human resourcing -** Strategy implementation relies on a small number of partners and key individuals. AHF is working with partners on all parts of project management and sustainability to assist with business (project) continuity should a key stakeholder become unavailable.

- **Fraud, corruption, terrorism and other risks** relating to compliance with AHF policies and specific to each project will also be assessed and relevant mitigation strategies also identified and implemented.

Monitoring, Evaluation and Learning

The delivery and outcomes of AHF programs are closely monitored, and programs are periodically evaluated. While each AHF project has its own detailed monitoring and evaluation framework, the **AHF Strategy (2020-2025)** provides the overarching framework outlining specific goals and outcomes for our work in health, together with relevant indicators and means of verification. Results against those will be used as learning for new phases of the health program and shared with AHF stakeholders through annual reports and other communication. See our detailed health indicator matrix in Annex 1.

Continuous learning and evaluation informs the evolution of all our programs. A summary of the 2020/2021 three-year/end of phase evaluation of the Nurses for Nepal Program and a AHF literature review of health interventions in South Asia can be accessed on our website here.

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Annex 1 – Health Sector Program MEL Indicator Framework

GOAL 2: Ensure healthy lives and promote children's well-being.		
REF	**Outcomes**	**Indicators**
2-1	Improve access to essential health care services and information, including sexual and reproductive health-care services, in selected districts of Nepal.	# of people accessing health services (and % increase) # of women accessing family planning services (and % increase) # of people with improved access to WASH facilities # of people receiving health and hygiene information
2-2	Improve maternal and child health.	# of pregnant women who had 4 ANC checkups as per protocol; # of pregnant women who received TD2 and TD2+; # of institutional deliveries; # of women supported with post-natal care; # of children immunized with all vaccine by 15 months;
2-3	Develop health facilities and strengthen capacity of local health services.	# health facilities developed # of health committees trained and able to effectively manage health centres at project end
2-4	Support recruitment, training and retention of health workforce.	# of health staff recruited, trained and retained
2-5	Promote mental health and wellbeing.	# of children reporting improved wellbeing in Bhutan # of staff trained in psycho-social health

GOAL 5: Intensify our work to safeguard vulnerable groups and promote inclusion and gender equality		
REF	**Outcomes**	**Indicators**
5-1	Promote equitable access to education and health care for girls, children with disabilities and children in vulnerable situations.	# of girls # of children with disability # of children from indigenous groups accessing education and healthcare in AHF projects % retention and enrolment rates of girls, children with disability # of girls and children with disability receiving scholarship support
5-2	Take action to end discrimination and violence against women and girls.	# of people trained in gender and social inclusion # of people trained in child safeguarding and PSEAH # of people trained in providing effective counselling for children survivors of abuse and violence Gender and disability inclusive strategies implemented in all projects # of partners with policies and procedures on gender, PSEAH, child safeguarding
5-3	Strengthen women's leadership and participation in governance and decision-making.	% women in leadership positions in governance committees (eg. health committees, school management committees...) # women and girls participating in decision-making process for design, monitoring, implementation and evaluation of projects
5-4	Include and safeguard children, women, people with disabilities and other vulnerable groups in projects, partner organisations and AHF.	# children, women, people with disabilities and other vulnerable groups included in projects # of incidents against children, women, people with disabilities and other vulnerable groups

GOAL 6: Deepen partnerships and strengthen capacity of our development partners to implement best practice and sustainable development programs, and to respond to crises		
REF	**Outcomes**	**Indicators**
6-1	Strengthen partners' governance and management	Capacity strengthening plan developed and implemented with all partners; High partner satisfaction through survey and feedback
6-3	Support partners to ensure the sustainability of their operations	AHF partners have successfully reached sustainability for part of their operations and reduced reliance on AHF # grants applied for jointly; $ partners obtain from other sources to reduce AHF support/ increase their reach
6-4	Strengthen partner capacity to respond to crises, including COVID	#, type and size of responses provided in crises, including COVID

Annex 2 - Sustainable Development Goal 3 – Healthy Lives

SDG 3: Health - Our Global Targets to Ensure healthy lives and promote well-being for all at all ages

- **Target 3.1**- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
  - 3.1.1 - Maternal mortality ratio
  - 3.1.2 - Proportion of births attended by skilled health personnel

- **Target 3.2** - By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
  - 3.2.1 - Under-five mortality rate
  - 3.2.2 - Neonatal mortality rate

- **Target 3.3** - By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

- **Target 3.3.1** Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
  - 3.3.2 Tuberculosis incidence per 1,000 population
  - 3.3.3 -Malaria incidence per 1,000 population
  - 3.3.4 Hepatitis B incidence per 100,000 population
  - 3.3.5 -Number of people requiring interventions against neglected tropical diseases

- **Target 3.4** - By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
  - 3.4.1 - Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
  - 3.4.2 - Suicide mortality rate

- **Target 3.5** - Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
  - o 3.5.1 - Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
  - o 3.5.2 - Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

- **Target 3.6** - By 2020, halve the number of global deaths and injuries from road traffic accidents
  - o 3.6.1 - Death rate due to road traffic injuries

- **Target 3.7** - By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
  - o 3.7.1 - Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
  - o 3.7.2 - Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group

- **Target 3.8** - Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
  - o 3.8.1 - Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
  - o 3.8.2 - Proportion of population with large household expenditures on health as a share of total household expenditure or income

- **Target 3.9** - By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
  - o 3.9.1 - Mortality rate attributed to household and ambient air pollution
  - o 3.9.2 - Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
  - o 3.9.3 - Mortality rate attributed to unintentional poisoning

- **Target 3.a** - Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
  - o 3.a.1 - Age-standardized prevalence of current tobacco use among persons aged 15 years and older

- **Target 3.b** - Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
  - o 3.b.1 - Proportion of the population with access to affordable medicines and vaccines on a sustainable basis
  - o 3.b.2 - Total net official development assistance to medical research and basic health sectors

- **Target 3.c** - Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
  - o 3.c.1 - Health worker density and distribution

- **Target 3.d** - Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks
  - o 3.d.1 - International Health Regulations (IHR) capacity and health emergency preparedness

  (https://sdgs.un.org/goals/goal3)

Annex 3 - Sustainable Development Goal 2 – Ending Hunger

SDG 2: End Hunger (End hunger, achieve food security and improved nutrition and promote sustainable agriculture)

Target

2.1 - By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round

Indicators

2.1.1 - Prevalence of undernourishment

2.1.2 - Prevalence of moderate or severe food insecurity in the population, based on the Food Insecurity Experience Scale (FIES)

Target

2.2 - By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

Indicators

2.2.1 - Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age

2.2.2 - Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)

Target

2.3 - By 2030, double the agricultural productivity and incomes of small-scale food producers, in particular women, indigenous peoples, family farmers, pastoralists and fishers, including through secure and equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment

Indicators

2.3.1 - Volume of production per labour unit by classes of farming/pastoral/forestry enterprise size

2.3.2 - Average income of small-scale food producers, by sex and indigenous status

Target

2.4 - By 2030, ensure sustainable food production systems and implement resilient agricultural practices that increase productivity and production, that help maintain ecosystems, that strengthen capacity for adaptation to climate change, extreme weather, drought, flooding and other disasters and that progressively improve land and soil quality

Indicators

2.4.1 - Proportion of agricultural area under productive and sustainable agriculture

Target

2.5 - By 2020, maintain the genetic diversity of seeds, cultivated plants and farmed and domesticated animals and their related wild species, including through soundly managed and diversified seed and plant banks at the national, regional and international levels, and promote access to and fair and equitable sharing of benefits arising from the utilization of genetic resources and associated traditional knowledge, as internationally agreed

Indicators

2.5.1 - Number of plant and animal genetic resources for food and agriculture secured in either medium or long-term conservation facilities

2.5.2 - Proportion of local breeds classified as being at risk, not-at-risk or at unknown level of risk of extinction

Target

2.a - Increase investment, including through enhanced international cooperation, in rural infrastructure, agricultural research and extension services, technology development and plant and livestock gene banks in order to enhance agricultural productive capacity in developing countries, in particular least developed countries

Indicators

2.a.1 - The agriculture orientation index for government expenditures

2.a.2 - Total official flows (official development assistance plus other official flows) to the agriculture sector

Target

2.b - Correct and prevent trade restrictions and distortions in world agricultural markets, including through the parallel elimination of all forms of agricultural export subsidies and all export measures with equivalent effect, in accordance with the mandate of the Doha Development Round

Indicators

2.b.1 - Producer Support Estimate

2.b.2 - Agricultural export subsidies

Target

2.c - Adopt measures to ensure the proper functioning of food commodity markets and their derivatives and facilitate timely access to market information, including on food reserves, in order to help limit extreme food price volatility

Indicators

2.c.1 - Indicator of food price anomalies

Annex 4 - The History of AHF's Health Programming

2005	**Zanskar Primary Health Survey** Community health survey to inform design of Zanskar Primary Health Project, in Ladakh, India
2006-2017	**Zanskar Primary Health Project** Over multiple phases, this project was committed to improving the level of primary health care in Zanskar, a remote region of the Indian Himalaya. In partnerships with Servants of Society and subcontractors, Ladakh Institute of Prevention, specific project objectives included mother and child health care; training the traditional health practitioners (Amchis) and Auxiliary Nurse Midwives to use modern medical care practices and providing medical health services through targeted and intensive medical camps.
2009-2013	**Nepal Cancer Awareness & Prevention Project** From 2009-2013, AHF supported the Nepal Network for Cancer Treatment and Research (NNCTR) and the Nepal Australia Cervical Cancer Foundation (NACCF) to host cervical and breast cancer screening and prevention programs; provide the HPV vaccine to girls; and educate women on vaccines, early detection and cervical and breast cancer.
2013-2017	**Sotang Maternal and Newborn Care Project** From 2013 to 2017, AHF supported the Himalayan Health and Environmental Services (HHES) with the Sotang Maternal and Newborn Care Project. This project was funded through Lincoln Hall (AHF founding Director) Memorial Funds, and it provided maternal healthcare and services for pregnant women, mothers and newborn babies in the lower Solukhumbu region. In 2015 we also worked with HHES to conduct Post Earthquake Medical Camps in Sotang and Kinja.
2017-2021	**Nurses for Nepal Program** In 2017 the 'Nurses for Nepal' program was established in partnership with local organisation, Action for Nepal (AFN). The program aimed to address issues relating to female reproductive health, limited health centre resourcing, high incidences of childhood pneumonia and diarrhoea, and oral health. This program has since evolved, and the new project phase is now known as the 'Solukhumbu Women's Health Project' (2021-2025) - with a stronger focus on sexual and reproductive health. Periodically, AHF has also delivered short-term emergency health responses, and has undertaken a number of needs assessments, evaluations, and research / literature reviews related to its health strategy and programs.

2020-2021

COVID19 Emergency Response Projects

Delivery of the COVID19 Emergency Response Projects (2020 and 2021): AHF worked with Action for Nepal to source and distribute vital Personal Protective Equipment (PPE) and medical equipment and supplies to the remote hospital and five health posts in Mahakulung Rural Municipality in Solukhumbu. Key achievements include:

- 30 health staff trained in COVID prevention and treatment
- 168 health staff benefitting from improved protection
- More than 54,000 people indirectly benefited from the equipment provided to diagnose, treat and manage COVID.

2021-2025

Solukhumbu Women's Health Project

This new project follows the Nurses for Nepal program, incorporating learning from the evaluation of that program. It focuses more specifically on sexual and reproductive health as these areas have been particularly impacted by COVID-19, and key outcome indicators remain to be strengthened (particularly those aligned with SDG Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes). This focus demonstrates clear alignment with the GoN priorities included in the Nepal Safe Motherhood, Family Planning and Female Community Health Volunteer (FCHV) programs.

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