Dear Friends and Family,

Since we started our programs in Nepal, One Heart Worldwide’s programs have reached over 400,000 pregnant women and newborn infants in rural Nepal. 388 Birthing Centers have now been upgraded. 398 Skilled Birth Attendants and thousands of community-based volunteers have been trained on safe motherhood. As a result, we have seen consistent improvements in the number of women delivering in a birthing center with a trained attendant.

I am extremely proud of our team for these tremendous accomplishments! Over the last ten years, we have all had to overcome great obstacles. In every instance our team has chosen to see opportunities instead of difficulties and has remained steadfast to our vision. We are creating a world where no woman delivers alone and where mothers and newborns are surrounded by our Network of Safety. Our team works tirelessly to make this vision into a reality in Nepal.

Over the past few years, Nepal has undergone a decentralization which increased the autonomy of the local government (municipality) in terms of healthcare planning and budgeting. This process has not been easy but our team managed to turn this challenge into a wonderful opportunity. Leveraging our strong community-based partnerships, our team has been key in helping local communities prioritize and commit resources to their maternal and newborn health services. In 2019, we are thrilled to be able to report that all the local government in the OHW program districts co-invested an average of 38% of the funds required to renovate health posts into certified birthing centers. And many of them indicated that they would be interested in increasing their investment in the future, becoming more and more invested into this process. This is groundbreaking!

When I think of all of you, our donors, our partners - our One Heart Family - I think of this Einstein quote: “There are two ways to live: you can live as if nothing is a miracle; or as though everything is a miracle.” Together we are working to create a world where miracles happen. Hand-in-hand, we are driving systemic behavior change for generations to come and allowing all women to have access to a safe clean delivery with a skilled birth attendant in Nepal...and beyond.

Thank you for being a part of this beautiful journey with us.
Arlene Samen, CEO
OUR MISSION - 7
The Network of Safety - 9
Story from the Field - 11
Where We Work - 17

OUR IMPACT - 18
2019 Program Impact - 21
Impact Highlight - 23
Programs Spotlight - 25
Completed District Outcomes - 27

FINANCIALS - 28

OUR YEAR AHEAD - 30
Looking Ahead - 33
Expanding to the Terai - 35

OHW FAMILY - 36
Board of Directors - 38
Our Team Members - 40
Letter from Our Executive Director - 43
Partners + Supporters - 44
7000 newborns¹ & 810 women² die every day from complications related to childbirth

A child born in South Asia, is 9x more likely to die in their first month of life than a child born in a high-income country³.

³ Same reference as (1); South Asia refers to: Sri Lanka, Maldives, Bhutan, Bangladesh, Nepal, India, Afghanistan & Pakistan
Our Mission:
To save the lives of mothers and newborns worldwide

Our vision is to implement a simple, effective, replicable and sustainable model to reduce maternal and neonatal mortality by at least 50% in the most remote, rural areas of the world.
Our model, the **Network of Safety**, identifies **6 key players** of a mother’s “Network” who together have the ability to save her life and the life of her baby: the government, health facilities, Skilled Birth Attendants (SBAs), Female Community Health Volunteers (FCHVs), her community, her family, and of course, the mother herself. The **Network of Safety** responds to a global need to eliminate preventable maternal and neonatal mortality once and for all. In particular, it provides a structure for NGOs to implement aid programs responsibly and effectively. By addressing healthcare service provision from the community level all the way up to the government level and by doing this in a culturally appropriate manner, we strive to create a **continuum of care** that ensures there are no gaps in the systems that could result in low quality healthcare services for women and their newborns.
Lal Kumari Barmi, 29, is relieved after reaching the suspension bridge. She runs over the Pokali Waterfalls and decides to rest for a while. She is sweating all over. Heaving out deep breaths of exhaustion, she takes one end of her kurti’s shawl and wipes her face and forehead.

Lal Kumari has walked for over two hours on a narrow trail that runs up a steep hill, passing through a small quaint village with water-logged terrace-rice fields, crevices, moist subtropical jungle – where cicadas never stop whirring, streams flow, and elevated rocky steps bend around ridges and climb to great heights.

Leaning on the one-sided rail, somewhere in the middle of the suspension bridge, Lal Kumari overlooks the waterfall that divides the hill at the top and flows between the ridges, making two large drops before meeting a river down in the valley—the sound reverberating with its crashing waves. On clear days, the sun rays reflect a half rainbow at one of the drops—people say that multiple rainbows can be seen on certain days.

It will take about an hour or more for Lal Kumari to reach the Likhu Rural Municipality Ward-9 office. She will have to cross the rock outcropping on the other face of the hill. Being one of the elected women out of two, Lal Kumari is going there to attend a scheduled meeting with five other members. They are going to discuss different issues, among which Lal Kumari will highlight the issue of improving services and access to the health post and birthing center.

"Climbing these hills was like doing daily chores for me before. But it seems like I lost some of my strength after surviving a childbirth complication a few months ago. I also gained weight after that. That might also be the reason, but I surely feel weaker following my near-death childbirth experience. I feel so fortunate to have survived and share my experience now."

Lal Kumari immediately developed back and joint pain after being pregnant with her first child. One night, in her third month of pregnancy, she dreamed of having twin babies. She asked the nurses about it during her next ultrasound session. They said that it was likely but was too early to confirm. In the sixth month of her pregnancy, Lal Kumari Barmi was appalled by white discharge coming from her uterus. She went for a check-up at the hospital in the district headquarters. It was then that the doctors confirmed she was pregnant with twins and prescribed her some medicines, telling her that one child was in a breech position but might return to a normal position by the time of delivery.

On this particular night, in her seventh month of pregnancy, Lal Kumari Barmi started having white mucus-like discharge. Her abdominal pain was not as severe as before but her excretion was not abating any time soon. "The whole mattress was drenched and I was getting extremely nervous about it. I called out for my mother in law to take me to the health post. There was a power outage at that time and it took us more than half an hour to get there," she says.

After reaching the birthing center, one of the nurses took care of her and released her, assuring everything was fine. Though the discharge from her uterus never completely stopped, Lal...
Kumari took a nap for some hours out of weakness. She woke up around five in the morning to use the toilet. As soon as she squatted, she almost lost her senses. Horrified, she discovered that one of the legs of her baby was already out. She was home alone at that moment. Her mother had already left to collect grass for cattle.

She cried for help to her neighbors. Soon the Female Community Health Volunteer arrived with a stretcher and they struggled to carry her to the birthing center—it took them almost an hour, twice the time it takes to get there on normal days.

Assessing the severity of the situation while two nurses conducted her delivery, the Health Volunteer’s colleagues from the ward office arranged for a helicopter, which could not fly due to unknown reasons, according to Lal Kumari.

The nurses successfully delivered the child in breech by dilating her uterus and rotating the position of the baby simultaneously. The other baby came out with less hassle. Though both newborns (both daughters) cried normally, the condition of the baby in the breech position was critical. She was black and blue, and her joints in both knees were swollen. It was past midday by the time nurses finished stitching Lal Kumari’s wounds and returned her to a stable condition.

Given the remoteness and poor conditions of the road during high monsoon, a vehicle could not be hired that day. One of her babies passed away in the night and, grief-stricken, Lal Kumari worried about the fate of her surviving child.

It was not until the following morning that they managed to get a vehicle. The villagers carried her all the way to the other side of the hill in order for the vehicle to safely retrieve her. It took another gruesome nine-hour drive on a mud-slicked road with switchbacks down the valley to reach Kanti Children’s Hospital, a hospital managed by a body of Nepal’s Ministry of Health. Lal Kumari’s child was kept inside the Intensive Care Unit there for 22 days. On top of low birth weight, her surviving daughter also acquired jaundice. However, despite the challenges and nervous, grief-filled days at the hospital, Lal Kumari feels fortunate to have a new life for herself and for her baby.

“I feel extremely lucky for me and my child. If it was not for the nurses, my villagers, the driver who drove me to Kathmandu and the doctors at the children’s hospital, I do not know what might have happened to us,” says Lal Kumari, as she struggles to hold back tears.

“If it was not for the Skilled Birth Attendant at the health post, who took care of me during the critical time, I would not have been alive to share my experience. Not only was our birthing center completely renovated, One Heart also provided all the equipment and training to our nurse. Now, people like me are very confident about the quality services it is providing. Being one of the elected members of the Pokali Rural Municipality, I am advocating for maternal and neonatal health. Now that we have a good birthing center and skilled people here, we need better roads and ambulances at the health post so that we can act immediately. My own experience gives me motivation to work for women and children, and I feel fortunate for being able to do so,” says Lal Kumari.
One Heart Worldwide relies heavily on data for all programmatic decisions. Our primary program data is collected quarterly by the Central and District-level OHW teams and incorporates both quantitative and qualitative methods. Our secondary data is accessed annually from the Nepali government’s Health Management Information System (HMIS). In addition, we contract external third-party research agencies to conduct baseline and endline surveys in order to independently assess program impact in our program districts.

We completely digitized our M&E system, replacing our former paper-based data collection system with tablets using the KOBO platform for data collection. The tablets also collect GPS coordinates of events recorded which will enable us to make GIS maps for our program monitoring. The data is then uploaded into a new centralized Salesforce CRM database. We expect this new exciting development to improve our overall data quality and report generation but most importantly, to be able to provide us with real time data for program decision-making.

As our data informs our work, it is essential that our metrics be effective. We have long included measurements of appropriate antenatal care (ANC) as one of our key program indicators, however, this has proven much more challenging since this indicator was recently re-defined, using a different structure to the metric (4 visits at specific times during pregnancy instead of 4 visits anytime during pregnancy). ANC rates are dropping all over Nepal, not solely in the OHW districts. The realities of life in rural communities make it difficult for pregnant women to attend ANC within the very rigid timeline of the new metric, and as a result the rates drop. Another part of the issue stems from a lack of centralized recording system. Some women attend ANC in more than one health facility which will be separately recorded in each facility. This problem is increasing as the number of health facilities is increasing. In response, we decided to remove ANC as one of our key program indicators and identify new metrics reflecting quality of care.

OHW is also committed to support the efforts of the Government of Nepal to transition from their paper-based data management system to an electronic health (eHealth) system that will allow healthcare providers to easily track facility and patient level data in rural health facilities and transmit information regularly. This system has two separate components: DHIS-2, an electronic platform for the current aggregated service delivery data collected in each health facility and HMIS 3.6.1, an individual patient record system with individual level service utilization data which will tremendously improve the accuracy of the data collection process at the facility level and allow for patient follow-ups. We are supporting MoHP to scale up the DHIS-2 in Sindhupalchok, Sankhuwasabha, and Terhathum and pilot-testing HMIS 3.6.1 in Sankhuwasabha. This pilot program has been nominated as a country-led implementation research initiative for Universal Health Coverage (CIRU) in Nepal. This implementation research program will be co-funded by the World Health Organization (WHO) and Nepal Health Research Council (NHRC).
By the end of 2019, the OHW programs had reached a cumulative total of 205,704 pregnancies in support of Nepal’s national plan to provide quality MNH services to rural pregnant women and their newborns.

In line with our new program cost-sharing goals, OHW began to advocate for the local governments to co-fund some of the training activities implemented through the Network of Safety:

*3 SBA training from the Maternity Hospital in Thapathali were funded by the federal government of Nepal and 2 SBA from Tehrathum were partially covered by their local municipalities. OHW provided technical support for all 5 trainees.

**147 CME trainees were funded by the local government with technical support from OHW.

***9 ultrasounds were purchased by local governments and 2 were supplied by the Karuna Foundation.
We were having a tough time managing Walankha Birthing Center because the facility was in dire need of renovation. Though we had allocated a budget for the facility management, the full upgrade that was needed was too much for our annual budget because of other priorities like road repair and drinking water. We were very delighted to know that One Heart Worldwide was willing to help us upgrade the birthing center. We were happy to contribute 35% for the renovation from the budget of our Walankha Rural Municipality. On behalf of the whole community, I want to extend our gratitude to One Heart for providing support at one of the most remote municipalities in the district. We are already seeing improvement in the MNCH services, which will improve even more in the days to come.

Netra Bahadur Khatri
Chairperson, Walankha, Ward Aamchok R.M-4, Bhojpur

A critical component to our programs is local buy-in. This is why direct partnership with local government and communities is an intentional cornerstone to our Network of Safety model as we seek to connect and engage local stakeholders to impact long-lasting change.

Following the recent decentralization of the Nepali government, OHW has initiated a new cost-sharing partnership with our local government partners. One of the primary opportunities of Nepal’s new federal system is that it places much more funding authority at the municipal level, where local needs are most visible. This shift is crucial for OHW, as our entire work is based on impacting long-lasting change in direct partnership with the communities where we work.

Over the past four years, our local government partners have increased their portion of birthing center renovation cost-sharing from 2% in 2016 to 38% in 2019. Between 2018 and 2019 alone, cost-sharing increased by 75% as OHW started to provide technical support to the municipalities, improving their ability to plan and budget their Maternal and Newborn Health services.

In 2019, 100% of our municipalities partners financially co-invested in BC renovation with contributions ranging between 35% and 50%.

This increased participation has the potential to be a game-changer in terms of our scale-up strategy. Until recently, most of the cost-sharing components were centered solely around the BC upgrades. But in 2019, we began to see the beginning of a shift in other areas as well. Over the past year, OHW has been working with the local government to increase their awareness of MNH. All of our municipality partners have started prioritizing MNH by setting aside budgets specifically ear-marked for this purpose. We are beginning to see the local government considering cost-sharing components of our program including training and medical equipment provision.

Local buy-in of a program, particularly to this extent, is a nearly unheard-of achievement and a strong indicator that our program is not only desired by the communities we serve but worth investing in by the communities we serve. We hope to continue building trust in the coming years and eventually increase the government’s cost-share contribution to 50% across all municipalities where we work. Ultimately, this is not only about resource maximization, but a celebration of a successful complementary partnership focused on fostering long-term sustainability and impact.
The long-term goals of our program are to impact both maternal and newborn mortality, however, a long-term sustained impact on mortality can take several years to achieve. Mortality rarely decreases linearly as it is a relatively rare event. As a result, we often see mortality data repetitively increase and decrease during the first six years of our program implementation. A more accurate marker of progress in the intermediate term (during our 6 years of program implementation) is to look at rates of maternal and newborn healthcare (MNH) utilization instead.

Therefore, our intermediate (3-6 years) program impact goal is a 30% or more increase in MNH services utilization as measured by the number of deliveries attended by a skilled birth attendant (SBA) and the number of institutional deliveries. We have achieved this goal in all of our districts who completed Phase 2 (3+ years of OHW programs).

**Programs Spotlight by the Numbers**

SBA Attended Deliveries*

Institutional Deliveries*

*2016 baseline numbers for both SBA Attended Deliveries and Institutional Deliveries recorded by the Demographic Heath Survey 2016. The SBA attended deliveries and institutional deliveries rates presented below include the pregnant women from each district that are attending care outside the district.

*OHW programs have been implemented.*

SBA Attended Deliveries, Baseline to Actual:
seven districts, six of which are still in the implementation phase, have already seen an increase in SBA attended deliveries. Dhading and Sindhupalchok (in yellow) were both affected by the 2015 earthquake, and therefore spent more time in the implementation phase, have also shown marked increase since OHW programs have been implemented.

Institutional Deliveries, Baseline to Actual:
seven districts, six of which are still in the implementation phase, have already seen an increase in Institutional Deliveries. Dhading, which is now in the completion phase, is well past the Nepal National average after increasing Institutional Deliveries 52% since OHW programs began in 2014.
Once we complete our programs in a district, our long-term (+6 years) program impact goals are to:

1. Maintain a 30% or more increase in MNH services utilization as measured by the number of SBA attended deliveries and the number of institutional deliveries

2. Decrease by at least 50% both maternal mortality (measured as Maternal Mortality Ratio - MMR) and newborn mortality (measured as Neonatal Mortality Rate - NMR)

To measure our long-term program impact in our completed districts, OHW contracts an external (third-party) research agency to conduct an endline cross-sectional survey among women who gave birth within the last 12 months. The survey assesses both the utilization of MNH services and mortality and compares the results to the districts’ baseline data (prior to the start of the OHW programs). The results of the external survey conducted in Baglung and Dolpa in 2019 revealed that we achieved our goals in both districts, both in terms of MNH service utilization and in terms of mortality.

Maternal Mortality Ratio (MMR) per 100,000 live births: In Dolpa, MMR decreased by 88% - dropping to 192 in 2019, from 1,663 in 2011; while in Baglung, MMR decreased by 90% - dropping to 39, from 374 in 2011. Both 2019 totals are below the Nepali National Average MMR recorded in 2016 by the Nepal Demographic and Health Survey (NDHS) at 239.

Neonatal Mortality Rate (NMR) per 1,000 live births: In Dolpa, NMR decreased by 81% - dropping to 21 in 2019, from 108 in 2011. In Baglung, NMR dropped by 92% - dropping to 39, from 374 in 2011. Both 2019 totals are below the Nepali National Average NMR recorded in 2016 by the Nepal Demographic and Health Survey (NDHS) at 21.
87¢ of every dollar was invested in OHW programs in 2019

**INCOME***

- Foundational (83%)
- Individual Donors (3%)
- Events (2%)
- In-Kind Donations (12%)

**EXPENSES***

- Program Services (87%)
- Fundraising (2%)
- Administrative (11%)

* internally prepared
Our Year Ahead:

Looking Forward:
Clinton Health Access Initiative

Expanding to the Terai
The Clinton Health Access Initiative (CHAI) will be embarking on a project starting in January 2020 to codify the concept of ‘Networks of Care’ (NOC). The goal of the project is to present to a global audience an evidenced-backed definition and framework that can be utilized in low- and middle-income countries to operationalize a commitment to continuous improvement of efficiency, quality, and patient outcomes shared across levels of care.

Evidence from a scoping literature review, stakeholder interviews, and descriptive case studies of operational effective NOCs in diverse geographies, will be synthesized in a collection of papers in a special issue of the peer-reviewed journal Heath Systems & Reform in Q3 of 2020. One Heart Worldwide’s Network of Safety makes an excellent descriptive case study of an effective NOC.

**Four domains of an effective NOC**

1. Agreement and enabling environment
2. Operational standards
3. Quality, efficiency, and responsibility
4. Adaptation and learning

In preliminary reports, CHAI found that, “the flexibility and comprehensive view of the network of safety model underlies the positive impact OHW had in the earthquakes disaster response. While moving quickly to serve those displaced in the moment, OHW documented and advocated successfully for changes in normative disaster response so that the needs of expectant women would not be forgotten in future disaster relief efforts.

The five-year span of the OHW model seems to promote active learning and adaptation, and is a clear contributor to the scalability of the OHW network of safety. CHAI looks forward to sharing these findings in a descriptive case of the OHW model, an effective and sustainable NOC.”
In 2019, in collaboration with our government partners at the federal and provincial levels, we conducted an in depth assessment of Nepal’s districts’ current health outcomes to determine our upcoming target districts for the next five years. At the request of the Social Welfare Council and the Ministry of Population and Health, we included districts from the Terai region in this process.

We first reviewed existing government data, looking at our impact indicators and a wide array of determinants of MNH access including the local population’s patterns of movement to neighboring districts for health care services, socioeconomic status of the district, availability of nearby referral sites, and the Human Development Index (HDI) to short-list of districts in need. Field assessments were then conducted in the short-listed districts to collect primary data on similar MNH service delivery and outcome indicators in order to determine the highest-need districts.

Our results showed that many districts in the Terai region still fall behind in terms of development indices and access to health services. The status of women in particular is very poor. Among the seven provinces of Nepal, both Province 2 (part of the Terai) and Province 6, have the poorest health outcomes including low numbers of institutional deliveries and high maternal and neonatal mortality. While the Terai has been the recipient of many international development programs, none of them provided a comprehensive type of intervention such as the Network of Safety, with support at all levels of the health system.

Starting in 2020, we will pilot our model in our first district that includes the Terai region (Sarlahi; population 888,986; 21,406 annual pregnancies). Because the specific cultural and geo-political context of the Terai is very different from the Hill and Mountain districts, we have enlisted the support of a team of cultural anthropologists at Dartmouth College to conduct an ethnographic study. We anticipate the insights from their work to guide our adaptation of the Network of Safety as we expand our model to this new geographic area.

In addition to Sarlahi, we are also expanding into Province 4 (Gandaki) including Parbat District (7 palikas; population 148,392; 4,054 annual pregnancies) and Myagdi District (6 palikas; population 111,082; 2,975 annual pregnancies).
OUR TEAM MEMBERS

SAN FRANCISCO OFFICE, USA
CEO, ARLENE SAMEN
CFO, JAMES VANREUSEL
CONTROLLER, PATSY DOUILLIE
OPERATIONS MANAGER, HILLARY S. SMITH
GRANTS MANAGER, MICHAELA HAYES
COMMUNICATIONS COORDINATOR, KATIE DYAS

KATHMANDU OFFICE, NEPAL
EXECUTIVE DIRECTOR, SURYA BHATTA
DIRECTOR OF MERL, LILAH DAR DHAKAL
PROGRAM DIRECTOR, GEETA SHARMA
BABITA BINDU
BELI BALAMI
BHAGAWATI SHRESTHA
BHADAYA MAHARJAN
DHANA NARAYAN SHRESTHA
DIPENDRA JUNG THAPA
KRISHNA DANGI
JAYANDRA BISHWAKARMA
JAYESH SHRESTHA
KRISHNA SAPKOTA
MAYA NEPAL
PRATIKSHA RAI
PREM SINGH KAMI
RAJESH KUMAR SHRESTHA
SAJANA MAHARJAN
SHREEJANA SUNUWAR
SUCHITRA SAPKOTA
SUMIT LAUDARI

EASTERN REGIONAL OFFICE, DHARAN, NEPAL
SANTOSH NEUPANE
MAHENDRA CHAUDHARY
NITYANAND THAKUR
PRAKASH PANT
RABINDRA KUMAR DANWAR
SABITA KC
SANGEETA LAMA

TAPLEJUNG OFFICE, NEPAL
GANESH BASNET
BHUPENDRA SONI
KHEM HATH DAHAL
POOJA BHANINDARI

ILAM OFFICE, NEPAL
GANESH BAHADUR KHATI
AKANKSHA LANTIEL
NABARAJ PANT

KHOTANG OFFICE, NEPAL
SURYA UPRETI
PRIYANKA SUBEDI
RAJIKHOSR CHAUDHARY
BHUBAN RAJ

DHADING OFFICE, NEPAL
MALATI SHRESTHA

BHOPUR OFFICE, NEPAL
BHARAT BAHADUR HAMAL

TERRATHUM OFFICE, NEPAL
KALPANA SHRESTHA
ISHA BHATTARAI
NABARAJ PANT

OKHALDHUNGA OFFICE, NEPAL
SUDISH ADHIKARI
ASMITA HAMAL
DAN BAHADUR KARKI
MANOJ KUMAR CHAUDHARY

SANKHUWASABHA OFFICE, NEPAL
DEEKSHA SHRESTHA
BIRAM KOIRALA
AVINASH KUMAR UPADHYAYA

ILAM OFFICE, NEPAL
GANESH BAHADUR KHATI
AKANKSHA LANTIEL
NABARAJ PANT

SOLUKHUMBU OFFICE, NEPAL
ABHISEK BK
RITA KARKI
SAFHAL TAMANG GOLE

RAMECHHPA OFFICE, NEPAL
AMIR RUAL
AMRIT KHAOKA
NISHA GIRI
PRAJYA TIMSINA

NUWAKOT OFFICE, NEPAL
SANJOI SILWAL
SAMJHANA PANDIT
SAJANA PANDIT

UDAYAPUR OFFICE, NEPAL
RAJESH KUMAR LOHANI
KALPANA SHRESTHA
RANJEET KUMAR CHAUDHARY

DOLAKHA OFFICE, NEPAL
NILES KUMAR PRAVANA
SADHANA THAPA

KAVRE OFFICE, NEPAL
RABIN JOSHI
ISHA BHATTARAI
DEPENDRA RAI

SINDHUHALCHOK OFFICE, NEPAL
NAGENDRA JUNG RAIH
Namaste friends,

Thank you for supporting One Heart Worldwide’s work in Nepal for over the last decade!

When we first started our pilot work in five villages of Baglung in 2010, several moms and babies didn’t have the maternal and neonatal health care that they deserved. They suffered during childbirth, had complications, and most didn’t make it to health facilities when professional care was needed. This is where One Heart came in. Our team worked together with the government, village leaders, and outreach providers to provide the much needed MNCH service to local women.

We faced a tremendous challenge to get here where we are now. But you have been with us to support the work and gave us the confidence so we can solve the most pressing healthcare problems in the most remote communities of Nepal. We worked across divides of language, culture, and gender to bring maternal and newborn health services in these regions where childbirth was considered a natural birth process that didn’t require special care or support. I remember my 2012 journey to upper Dolpa, where it took several days to cross 5,000 meters above high passes from one village to another, imagining what could go wrong in this region if you are pregnant and have a complication. The simple answer was ‘pray for a favor from god!’ I recall the two week trip from Dunai to Phoksundo to Shey Gompa, Saldang to Dho Tarap, thinking about the most ambitious thing you can do to bring the maternal and newborn health service in this region so people don’t have to pray to god. After a decade of my professional association with One Heart Worldwide, we have come a long way, navigating unforeseen problems and have shaped the maternal and neonatal healthcare structure where we have worked in Nepal. This has included managing exponential program growth and change in the organization itself (in terms of its scope, annual budget, and mandate in Nepal) and managing the organizational culture shifts that go along with such transitions. Our team has worked tirelessly through 2015 mega earthquakes and rebuilt the maternal and newborn health infrastructure in Dhading and Sindhupalchok. Throughout this institutional growth, we have improved our model tremendously in even the most challenging environment and situations. All the experience we have gained has made it possible to scale the program in 19 districts as of end of 2019 and served around 205,000 pregnancies in the last ten years.

Our scope has largely increased in recent years under the new health care structure as Nepal went through an overhaul of its federal system. To navigate new challenges, we aim to partner with municipal, provincial, and federal governments in order to build their capacity and make a lasting impact once we transition from our program districts. We will continue to thrive and innovate to tackle the complex challenges in the maternal and newborn health space of Nepal and keep our momentum going.

On behalf of the team Nepal, I express my deepest gratitude to all who believed in us and have the confidence in us. This important work and positive change wouldn’t be possible without everyone’s support.

Dhanyabad!
Surya Bhatta, Executive Director
THANK YOU TO OUR SUPPORTERS

FOUNDATIONS / CORPORATE
AESTUS FOUNDATION
ALBERT PARVIN FOUNDATION
AMERICAN EXPRESS EMPLOYEE GIVING PROGRAM
ANONYMOUS FOUNDATIONS
ASHTON FAMILY FOUNDATION
CHARITABLE FOUNDATION
CUBIT FAMILY FOUNDATION
DAK FOUNDATION
DAVID KELBY JOHNSON MEMORIAL FOUNDATION
DIRECT RELIEF
DOTERRA
ELMO FOUNDATION
EVOVE FOUNDATION
THE FORGOTTEN INTERNATIONAL
GLOBALGIVING
HERSHEY FAMILY FOUNDATION
HILEN FOUNDATION
THE INTERNATIONAL FOUNDATION
JAG MOLINA FAMILY FOUNDATION
JASMINE SOCIAL INVESTMENTS
JESTER FOUNDATION
LAERDAL FOUNDATION
NETWORK FOR GOOD
MULAGO FOUNDATION
PECO FOUNDATION
PING & AMY CHAO FAMILY FOUNDATION
PLANET WHEELER
RAS
SCHOONER FOUNDATION
THE SHAPIRO FAMILY FOUNDATION
SORENSON LEGACY FOUNDATION
THANKYOU
TRANSPARENT FISH FUND
TYLER L. RIGG MEMORIAL FOUNDATION
UMOJA SOCKS
VITOL FOUNDATION
WELCH FAMILY FOUNDATION

INDIVIDUAL DONORS
ALEXANDREA ADAMS
FOHZIA AHMED
TARIK ALKASAB
SALEH ALROMAHI
DARCY AMIEL
SHELLEY ANDERSON
JILL ANGELO
ANONYMOUS HOUSEHOLDS
SUSAN & ROGER ARSHY
PATRICIA AVERBACH
SARAH AVERBACH
FAITH BACHMAN
EMILY BALLARD
AYELET BARON
JOHN BATES
EMMA BAUMANN
PETER & ALISON BAUMANN
JENNIFER BAXTER
MARTI BEICAL
JAMES & VICKI BERGER
FABIOLA BERG
NANCY & KENT BEYDA
BETH & JEFF SIEGAL
DANIELLE BROOKS
BRANDI BOSWORTH
MARA BROWN & BRAD MARDEN
JENNY BROWN SCOTTEN
JAIME BRYSON
KYM BUTTSCARIDT
DEANNA & DANN BYCK
MINDY CALDWELL
ANDY CARMONI
SUZANNE CARRINGTON
AUBREY CHANEY
JENNIFER CLAESSENS
RENEE CLARK
AMY COLO
JOY COOPER
DOUGLAS & LYNN COUTTS
TERESA CROCKETT
MICHAEL D'ALESSANDRO
DARTMOUTH MICOS GROUP
DARTMOUTH STUDENT PROJECT - USG EVALUATION
MISSY & KYLE DAWSON
MARK & MERI DECARIA
SUSAN DILLON
HU DING
KLASSANG DIWATSANG
MICHAEL & KAREN DRAPER
PHYLLIS DUBROW
DANIEL DYAS
CHAZ EBER
SAMUEL EISENSTEIN
DEEDEE FEDORCHAK
JERRY FIDDLER & MELISSA ALDEN
BONNIE & DOUG FLINT
SILVIA FOELLER
JEFFREY FRANK
WALT FULLER & LISA KARAM
FRANCESCA GABALES
STEVEN & LAURA GERMAIN
CARLY GETZ
MARK GLASSER
JOHN GLENN
KRISTIN GLENN
MELISSA GLOBERMAN
STEVEN & JUDY GLUCKSTERN
ALAN & CHERYL GREENE
CLIFF GRONSETH
 CRAIG HARDING
MELISSA HARRISON
JACKSON HART
AMANDA HASKFIELD
MICHAELA HAYES
JEFF HAYS
TAMRA HALL
ROBERT HESS
SUSAN HESS LOGEais
ANANYA HIXON
MARK HOGAN
PEG HOOVER
CJ HRONEK
KIM & DAVE HUISH
ALLISON HUNT
TRIP & JULIE HUNTER
SYED IBRAHIM
MAREIKE JACKWORTH
LINA JACOBS
DIWAYNE JENKINS

PARTNERS

Government of Nepal
Thank you to all of the photographers who tirelessly capture our work with dignity and respect in Nepal. Photos featured in this report by Krishna Dangi, Francesco Brembati, Simon Needham, and Sarah Thompson.