Monitoring the Transition from IFA to MMS

A look into Nepal's current information systems and how they might support the phase-wise transition from iron–folic acid to multiple micronutrient supplementation

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Eleanor Crook Foundation

HELEN KELLER INTL

JOHNS HOPKINS
BLOOMBERG SCHOOL of PUBLIC HEALTH

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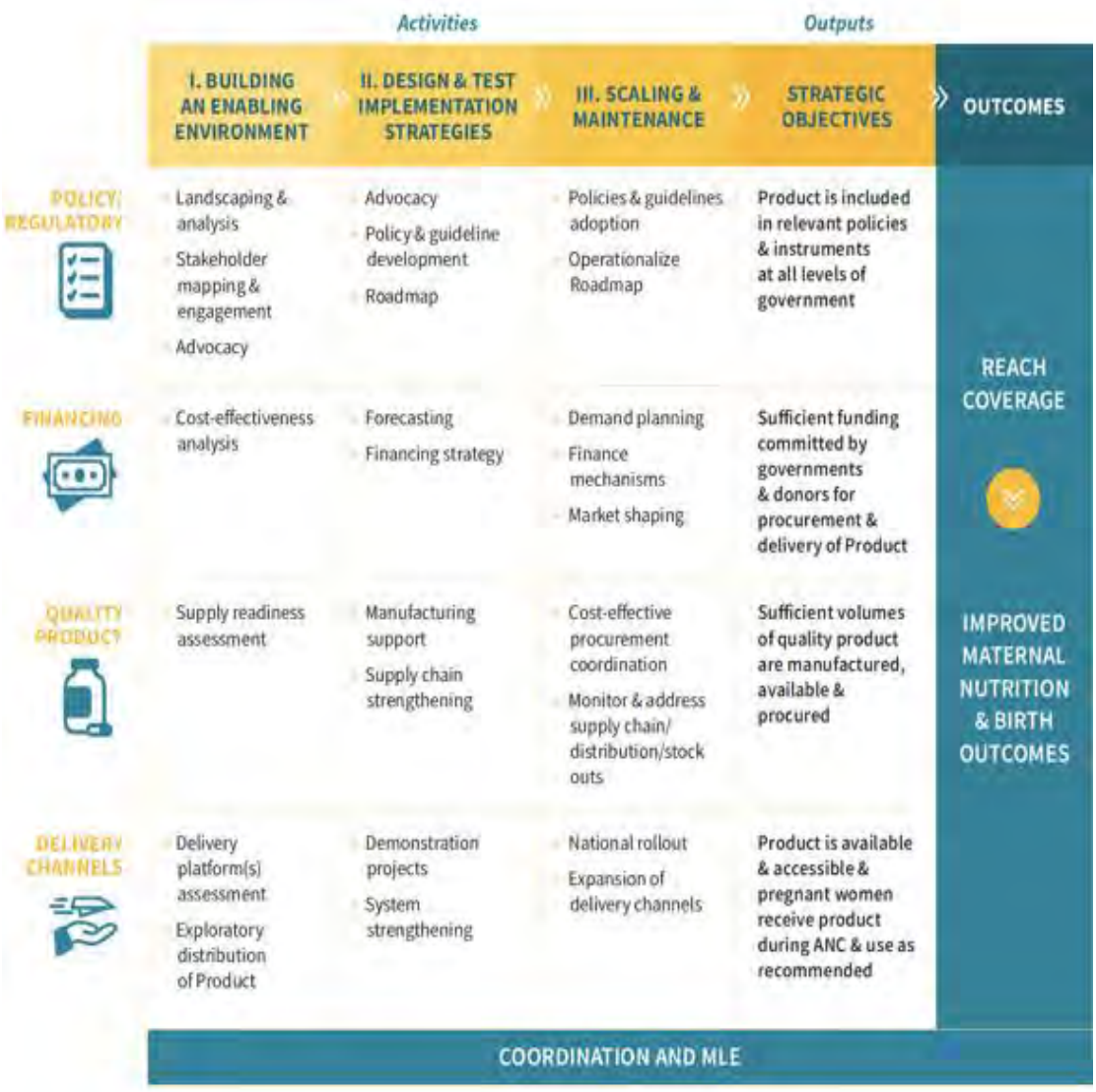
1. Introduction

Maternal undernutrition remains a persistent public health concern in Nepal, contributing to adverse pregnancy outcomes—including anemia, low birth weight, and preterm birth—as well as long-term health, social, and economic impacts on the child [1]. To address micronutrient deficiencies during pregnancy, Nepal has long relied on Iron and Folic Acid Supplementation (IFAS) as part of its antenatal care (ANC) and postnatal care (PNC) package [2]. Over the years, IFAS has been successfully integrated into routine maternal health services. The 2022 Nepal Demographic and Health Survey shows that 96% of women took some form of iron-containing supplements during pregnancy—an impressive rise from 23% in 2001. However, only 65% of women took the supplements for the recommended 180 days, indicating that while nearly all women are reached with IFA, timing of initiation and/or adherence may be lower than desired.

Emerging global and regional evidence suggests that Multiple Micronutrient Supplementation (UNIMAP MMS), which includes a broader range of essential vitamins and minerals, offers additional benefits for maternal and newborn health [3]. In line with these developments, Nepal is currently exploring a phased transition from IFAS to MMS.



In line with this phased transition, Nepal's progress can be mapped onto the global stakeholder framework for MMS scale-up, which outlines three key phases: enabling environment, design

and testing, and scale-up. Nepal has already completed several foundational activities from Phase I, including landscape analysis, stakeholder mapping, cost-effectiveness analysis, and supply readiness assessments. Building on this, critical Phase II milestones are well underway, such as advocacy efforts, policy and guideline development, and the creation of a national forecasting and implementation roadmap, supported by demonstration projects. Simultaneously, Phase III activities have begun, including policy adoption, roadmap operationalization, and ongoing efforts to include MMS in Nepal's essential medicines list.

However, what remains notably underemphasized—even in this otherwise comprehensive scale-up framework—is the role of routine monitoring systems. While coordination and MEL are listed, the framework does not fully capture the operational realities of data systems that must adapt in real time to track and support this transition. As with any major shift in public health programming, robust and responsive monitoring systems are crucial to ensure that the transition is proceeding according to plan and that vulnerable women are being reached with the new intervention. For accountability it is important to maintain continuity and comparability of data with existing IFAS indicators while also collecting new information that can facilitate adaptive planning and continuous improvement across the stages of MMS introduction, scale-up and maintenance.

This report provides a brief analysis of Nepal's current monitoring system for IFAS and reflects on the opportunities and challenges in adapting this system to support the gradual introduction and scale-up of MMS. It draws on insights gathered from consultations with federal, provincial, municipal and health facility-level stakeholders and review of available documentation.

2. Methodology

This report adopts a mixed qualitative synthesis approach, combining a desk review and stakeholder consultations to assess the readiness and adaptability of the country's health sector monitoring infrastructure—including DHIS-2, eLMIS, and periodic surveys such as the Demographic and Health Survey and the Health Facility Survey—in supporting a potential phased transition from IFAS to MMS. The objective was to identify key strengths, limitations, and opportunities of the existing systems and to propose practical options for integration of indicators required to monitor the IFA to MMS transition.

2.1 Desk Review

The desk review focused on national HMIS documentation, other routine information systems, periodic surveys (such as the Demographic and Health Survey and Health Facility Survey), and policy guidelines related to maternal nutrition.

Key sources information sources included:

- ANC to PNC Continuum of Care Guideline (2023)
- The Annual Health Report (2080/81) from the Department of Health Services
- HMIS tool specifications and revision records (e.g., HMIS 3.6, 9.3)
- Maternal and Newborn Health cards and registers
- DHIS-2 platform access documentation and operational flowcharts
- Government reports related to the 2078/79 tool revision process
- Relevant implementation literature and review materials provided by programme stakeholders

Special emphasis was placed on analyzing how IFAS is currently monitored across both paper-based and digital systems, including data flow structures, recording practices, and alignment with supply chain systems such as eLMIS.

2.2 Stakeholder Consultations

To complement the desk review, semi-structured interviews were conducted with 8 key informants across federal, provincial, and local levels of the health system. Participants included:

- Officials from the Family Welfare Division and the Integrated Health Information Management Section (IHIMS) (n=3)
- Provincial health directorates from Madhesh and Sudurpaschim (n=2)
- Health facility in-charges, auxiliary nurse midwives (ANMs), and data focal persons from both demonstration (Madhesh Province) and non-demonstration sites (n=2)
- Development partner (n=1)

These interviews explored institutional experiences with IFAS monitoring, perceptions of system readiness for MMS rollout, and reflections on the integration of vertical programmes into HMIS. Thematic insights from the consultations were analyzed to capture perspectives on data entry and its usage practices, field-level implementation challenges, reporting fatigue, and the utilization of existing data for decision-making.

Verbatim quotes are included in the report to preserve authenticity and illustrate how health workers and officials interpret and experience the current monitoring framework in practice.

2.3 Analytical Framework

The analysis followed a thematic approach, grounded in a structured review of documentary evidence and qualitative reflections from stakeholders. Themes were developed inductively, based on recurring patterns in the audio, and then grouped according to their relevance to the prospective transition from IFAS to MMS.

The review sought to examine not only what is being monitored but how monitoring systems operate in practice—emphasizing the processes and operational realities of data collection, reporting, and use. Particular attention was given to the following dimensions:

- **System design and structure:** How the current IFAS monitoring system is configured, including tools, indicators, and reporting formats.
- **Operational workflows:** Day-to-day recording and reporting practices at health facility, municipal, and provincial levels.
- **Perceived gaps and strengths:** Stakeholder reflections on areas of effectiveness, confusion, and opportunity for improvement.
- **Transition readiness:** The extent to which the current system may support, constrain, or adapt to the introduction of MMS

2.4 Consensus-Building Workshop

To validate findings from the desk review and stakeholder consultations, a national-level consensus-building workshop was convened in Kathmandu on August 1, 2025. The event brought together 32 participants representing federal entities (Family Welfare Division, Management Division, and IHIMS section of the Department of Health Services), provincial health directorates and development partners (UNICEF, GIZ, WHO, Helen Keller International, Eleanor Crook Foundation).

The workshop provided a platform to present preliminary findings, facilitate dialogue across system levels, and jointly identify opportunities and challenges for integrating MMS into Nepal's monitoring architecture. Presentations from government and technical experts highlighted global and national lessons, including the need to adapt HMIS and eLMIS tools, strengthen interoperability, and integrate MMS into periodic surveys. Group discussions were structured to elicit practical recommendations on indicator design, data workflows, and the sequencing of changes during a phased rollout.

Proceedings from the workshop were synthesized to capture collective priorities, clarify areas of agreement, and highlight unresolved questions requiring further technical or policy deliberation. These insights were triangulated with desk review and interview findings to strengthen the validity of the analysis and ensure that recommendations are grounded in both technical evidence and stakeholder consensus.

3. About IFAS and anemia screening interventions in Nepal & status of proposed transition to MMS

IFAS in Nepal is delivered through multiple platforms and targets a range of population groups as part of the national strategy to combat anemia. The primary target group is pregnant women, who are expected to receive 180 iron-folic acid tablets over the course of their pregnancy. Postpartum women are recommended an additional 45-day supply to replenish iron stores.

Pregnant women identified as anemic during ANC screening —through clinical pallor or hemoglobin testing—may receive therapeutic doses of iron; however, this is typically managed separately from routine supplementation. Women with mild to moderate anaemia (Hb 7–11 g/dL) are typically started on an intensified iron regimen—two iron tablets per day for three months. Counselling on fibre- and iron-rich diets is also provided, and follow-up is advised after one month, either during the next ANC visit or earlier if danger signs appear. If haemoglobin levels improve (Hb ≥11 g/dL), the woman is transitioned back to the standard preventive IFAS protocol. Mild cases are usually managed at the primary care level, while severe cases (Hb <7 g/dL, or <8 g/dL with clinical signs) are referred to higher-level hospitals for advanced management, including blood transfusion if necessary.

Beyond pregnancy, IFAS is also provided to non-pregnant adolescent girls aged 10–19 years, with supplementation regimens of either 13 or 26 weeks per year, depending on the program modality. There are also occasional provisions for non-pregnant women of reproductive age, particularly those diagnosed with anemia, although such cases are less systematically monitored.

As Nepal considers a transition from IFAS to MMS, it is important to note that the proposed shift currently applies only to preventative supplementation for pregnant and postpartum women. Other target groups— adolescent girls, and anemic non-pregnant women—are not yet

included in the scope of the MMS transition and should therefore continue to be monitored under the existing IFAS frameworks.

4. Current IFAS Monitoring System

The findings and analysis presented in Section 4 are entirely based on a comprehensive document review and analysis of national health information systems, policy frameworks, and recent facility-level assessments.

4.1 Overview of data sources

The country monitors ANC and IFAS through multiple data sources that serve different but complementary purposes. The HMIS, integrated into the national DHIS-2 platform, provides routine administrative data from health facilities across the country. The electronic Logistics Management Information System (eLMIS) tracks the supply and availability of IFA tablets across the supply chain. Nationally representative household surveys such as the Nepal Demographic and Health Survey (NDHS) and the Nepal Health Facility Survey (NHFS), both funded by USAID and conducted in close coordination with the Ministry of Health and Population, generate periodic estimates on coverage, adherence, service quality, and access. In addition, cross-sectional surveys and research studies—often implemented by external partners or academic institutions—offer valuable insights into compliance, knowledge, and programme effectiveness, based on national protocols and specific study objectives.

Table 1: Key data sources for monitoring iron and folic acid supplementation in Nepal: purpose, indicators, disaggregation, and frequency

Source	Purpose	Key Indicators	Disaggregation	Frequency
HMIS / DHIS-2	Routine administrative reporting; national monitoring of maternal and adolescent nutrition	• % pregnant women receiving 180 IFA tablets • % postpartum women receiving 45 tablets • ANC-related variables*	By age, gestational stage, facility type, delivery setting, and reporting unit (palika/district/province)	Routine updates
eLMIS	Supply chain tracking of health commodities including IFA	• Quantity of IFA received, distributed, and in stock	By facility, province/district, and time period	Routine updates
National Surveys (e.g., NDHS)	Population-level estimates of coverage, timing, and adherence to IFAS	• % women taking any IFA during pregnancy • % taking IFA for ≥180 days • Source of IFA • Barriers to adherence	By age, education, wealth quintile, province, ecological zone, urban/rural, and source of supplements	Every five years
Facility Surveys (e.g., NHFS)	Assessment of service readiness, availability, and quality of ANC and IFA provision	• Availability of IFA and related ANC supplies • Observation of IFA counselling • Reported IFA receipt post-service	By facility type (e.g., HP/PHCC/hospital), ownership (public/private), and region	Every five years
Cross-sectional Surveys & Studies	Evaluation, operational research, and monitoring exercises by external partners or academic institutions	• Varies based on study objective—may include IFA coverage, compliance, reasons for non-use, supply gaps, knowledge and beliefs	Typically disaggregated by socio-demographics (age, caste/ethnicity, parity, education) and geographical areas	Decisions depend on the project, donor obligations, and available budgets for evaluations or

Source	Purpose	Key Indicators	Disaggregation	Frequency
				cross-sectional studies. The government may also make special requests to partners, which are usually followed.

Note:

- *For cross-sectional surveys and research studies, indicators and methodology depend on the nature of funding and study objectives. However, question framing typically adheres to national protocols and aligns with government priorities to ensure comparability and utility for programme monitoring.*
- *NDHS and NFHS were funded by USAID and conducted in close coordination with the Ministry of Health and Population.*

** ANC-related variables in the HMIS include indicators that directly influence or track the quality of IFAS delivery, such as: the timing of the first ANC visit (to track early initiation of IFA); the number of ANC visits (8 visits as per national protocol); and the distribution of related commodities like Calcium and Deworming tablets (Albendazole) which are part of the comprehensive maternal nutrition package.*

4.2 Health Management Information System (HMIS)

The HMIS managed by the Integrated Health Management Information System Section at the Management Division under the Department of Health Services plays a central role in monitoring maternal nutrition indicators, including IFAS. The system uses the District Health Information System 2 (DHIS-2) platform and has nationwide coverage. For private health facilities, reporting access to DHIS-2 is provided; however, they do not have viewer access. They are only authorized to report on services aligned with national protocols, limited to indicators that require submission to the national system.

When a pregnant woman visits a health facility for her first ANC check-up, the health worker records her Last Menstrual Period (LMP) and calculates her Expected Date of Delivery (EDD). Based on this, the register guides when key services should be provided—such as IFA tablets, hemoglobin testing, calcium supplements, and deworming. During each ANC contact, health workers are expected to screen for anemia, often by checking for visible signs like pallor and, where possible, using hemoglobin tests.

According to the NHFS 2021, the method and frequency of this screening vary notably by facility type. Screening via clinical signs (physical examination for pallor) was assessed in 20.7% of all observed ANC consultations, a practice that is relatively uniform across public tiers—ranging from 17.2% in Federal/Provincial hospitals to 23.5% in Health Posts (HPs). However, a marked readiness gap exists for laboratory-based hemoglobin (Hb) testing. While Hb testing capacity is nearly universal in Federal/Provincial Hospitals (100%) and Primary Health Care Centers (90.2%), it is available in only 18.2% of Health Posts and less than 6% of Urban Health Centers and Community Health Units. This capacity gap is reflected in clinical

practice: during observed first ANC visits, Hb tests were conducted in 81.9% of consultations at Federal/Provincial hospitals, compared to 46.4% at the Health Post level.

If anemia is detected, the woman is given appropriate treatment as per national guidelines. While the standard preventative protocol for all pregnant women is one IFA tablet daily starting from the 4th month of pregnancy, those diagnosed with anemia are prescribed a therapeutic dose (typically two tablets daily). This treatment is continued until hemoglobin levels normalize, after which the woman reverts to the standard daily preventative dose to complete the required 225-day course (covering pregnancy and 45 days postpartum). All services provided, including the specific dosage of IFA tablets distributed for prevention or treatment, are recorded in the Maternal and Newborn Health Register.

While preventative IFAS indicators are well integrated into the HMIS, data related to the diagnosis and treatment of anaemia remain limited and fragmented.

However, these anemia treatment processes are not consistently recorded in HMIS. While health workers may document pill distribution in the Maternal and Newborn Health Register, there is no dedicated field to distinguish between therapeutic and preventive supplementation. Moreover, follow-up data and recovery tracking are not systematically captured, especially at the reporting level. Even at the recording level, individual patient notes must be reviewed to confirm this information—something that depends entirely on the health worker providing care.

At the end of each month, the facility aggregates individual patient data from manual registers into standardized reporting forms. While recording remains primarily paper-based at the point of service, the majority of health facilities now report these monthly totals directly into the web-based DHIS2 platform. In cases where facilities lack stable internet or technical infrastructure, reports are submitted in hard copy to the Municipal Health Section, where the data is then digitized into the national system. While this process effectively tracks the quantity of iron supplements distributed, it does not capture patient adherence (whether women actually took the tablets) or biological response to the treatment.

4.2.1 Key Indicators Tracked by HMIS

At its current state, IFAS is monitored under the broader Maternal and Newborn Health, and Nutrition programme indicators. The key indicators related to IFAs include:

- **% of women who received 180 tablets of IFA during pregnancy**
- **% of postpartum women who received a 45-day supply of IFA**

The reported indicators are analyzed with associated disaggregation including age and delivery setting among other variables.

4.2.2 HMIS Recording and Reporting Tools

Data on IFAS is routinely captured using a mix of manual and digital recording tools at the health facility level. These data are then reported using standardized reporting tools on a monthly basis to the DHIS-2 platform.

The system operates through a two-tier process: Recording Tools are used at the point of care to track individual patient progress and service delivery in real-time. At the end of each month, these individual entries are aggregated into Reporting Tools, which summarize facility-wide performance for submission to the national Integrated Health Management Information System. While recording tools provide granular data for clinical follow-up, the reporting forms

focus on key national indicators, such as the completion of the full 180-tablet course for pregnant women and the 45-tablet course for postpartum women.

Recording Tools and What They Track

Recording Tool	What It Tracks
HMIS 3.5 Maternal and Newborn Health Card	Iron tablets* provided to pregnant women (number of tablets) Anemia (yes/no) tracked during each ANC visit
HMIS 3.6 Maternal & Newborn Health Register	ANC and PNC details, including IFA and calcium tablet distribution
HMIS 4.1 Outreach Clinic Register	Iron table distribution | new and repeated.
HMIS 4.2 FCHV Service Register	- Pregnant women receiving 180 IFA tablets during pregnancy - Postpartum women receiving 45 IFA tablets

**While official HMIS recording forms (such as 3.5 and 4.1) use the term "Iron," in the context of Nepal's national protocol, this refers to combined Iron and Folic Acid (IFA) tablets (60mg elemental iron + 400µg folic acid).*

Reporting Tools and What They Summarize

Reporting Form	What It Reports
HMIS 9.1 FCHV Report Collection Form	Number of postpartum women receiving 45 IFA tablets who delivered at home
HMIS 9.2 Outreach Clinic Report	Number of pregnant women distributed iron tablets | New and Repeated Number of postpartum women who received 45 IFA tablets
HMIS 9.3 Basic Health Facility Reporting Form	Pregnant women receiving IFA tablets for the first time Pregnant women receiving 180 IFA tablets Postpartum women receiving 45 IFA tablets
HMIS 9.4 Public Hospital Reporting Form	Pregnant women receiving IFA tablets for the first time Pregnant women receiving 180 IFA tablets Postpartum women receiving 45 IFA tablets
HMIS 9.5 Non-Public Hospital Reporting Form	Pregnant women receiving IFA tablets for the first time Pregnant women receiving 180 IFA tablets Postpartum women receiving 45 IFA tablets

4.2.3 HMIS Data Flow and Structure

The monitoring of IFAS in Nepal follows paper-to-digital data flow structure:

- Data Entry at Facility Level: Health workers at the frontlines—primarily from community health units, health posts, primary health care centres, and public and nonpublic hospitals—manually record service-level data using standard HMIS recording tools. There is a provision to record this digitally in the DHIS2 platform too, yet a majority of them rely on maintaining paper-based recording tools, developing tally sheets, and then reporting it to the DHIS2 platform.
- Monthly Reporting Flow: At the end of each Nepali calendar month, health facilities compile summary data from registers into reporting forms (example reporting forms HMIS 9.1 to 9.4). The data of the previous month has to be entered within a week of the corresponding month. If the facility has the necessary digital capacity, the data is entered directly into the DHIS-2. In facilities where user access or trained personnel are lacking, the responsibility of data entry in DHIS-2 shifts to the health section of the respective local level.
- Data Aggregation and Access: Once uploaded, the data becomes part of the national HMIS database and is accessible to authorized users. Authorized users can pull this data to see how their programmes are doing and use those insights for future planning and

implementation. The review is typically conducted by statistics officers, whose key responsibilities include preparing the Department of Health Services' Annual Report and responding to programme-specific data requests as needed.

4.2.4 HMIS Strengths

- The inclusion of IFAS indicators, such as the percentage of pregnant women receiving 180 iron tablets, in HMIS framework ensures standardized data collection.

4.2.5 HMIS Limitations

- The current HMIS is designed to track service outputs—specifically the number of tablets distributed—rather than behavioral outcomes, such as how consistently those tablets are consumed. This is a reflection of both a technical reporting gap and a broader community health system limitation, where the emphasis remains on supply-side delivery. Because the system lacks indicators for tracking adherence, side effects, or reasons for missed doses, it is difficult for health managers to develop targeted strategies for improving patient compliance.
- Operational and structural bottlenecks:
  - Lack of timely supply of recording and reporting tools to all health facilities hinders consistent data entry, disrupts routine reporting, and increases the likelihood of incomplete or inaccurate documentation at the facility level.
  - The division of roles between the national and subnational entities including Ministry of Health and Population/Department of Health Services, Provincial Health Directorate, local level governments in terms of printing, distributing, and verifying tools remains poorly defined. (Based on past experiences, the Government has discouraged decentralized printing at the local level due to quality concerns such as the use of thin paper, blurred or incomplete printing, and inconsistency in format.)
  - Many health workers have not received refresher training or new orientations or clear user guidance, leading to inconsistent data entry practices and compromised data quality.
  - High turnover of health workers familiar with the tools and system creates reporting gaps, as there is often no structured handover or internal grooming mechanism to transfer knowledge to incoming personnel.
- Although IFAS data is captured in HMIS, there is a significant lack of automated linkage between HMIS and other critical systems like the electronic Logistics Management Information System (eLMIS). Currently, data must be manually extracted and cross-referenced by the Family Welfare Division and the Management Division to support planning and forecasting. This manual workaround is a key systemic weakness; without real-time, automated communication between consumption data (HMIS) and supply data (eLMIS), the system struggle to respond to stock-out risks. This is evidenced by the nationwide IFA tablet stock-out in 2024/2025, where communication gaps and missed procurement cycles—despite the existence of multi-year plans—resulted in a total break in the supply chain.
- The process of updating HMIS tools to accommodate new interventions (such as MMS) is complex and requires a lot of engagement. It requires approval from national authorities, budget allocation for reprinting forms, technical revisions to DHIS-2, and retraining (including revision of training manuals) at multiple levels. This procedural rigidity limits the system’s ability to adapt quickly during programme innovation or transition phases.

- Routine Data Quality Assessments (RDQA)[1] have repeatedly exposed systemic weaknesses in the country's HMIS that go beyond any single programme area. These include inconsistencies between source registers and reported data, incomplete or inaccurate record-keeping, varying interpretations of indicators due to insufficient training, and delays in reporting caused by staffing or technical capacity gaps. RDQA findings also highlight that most health facilities do not analyze or use their own data for local decision-making, and that feedback mechanisms for data quality correction are weak or absent.

4.3 Past Experiences in Integrating New Programmes into HMIS

The country's HMIS has evolved over the last 20 years from programme-specific reporting environment into a more unified, centralized system built on the DHIS-2. Across time, various programmes have been integrated into the national HMIS, including the Aama Programme (which provides free delivery services and cash incentives to promote institutional births), Community-Based Newborn Care Programme (CB-NCP) (focused on delivering essential newborn care through trained community workers), Integrated Management of Neonatal and Childhood Illness (IMNCI) (which combines treatment for childhood illnesses like pneumonia and diarrhea), the Expanded Programme on Immunization (EPI) (ensuring routine vaccination coverage), nutrition services (including growth monitoring and micronutrient supplementation such as Baalvita distribution), and national programmes for tuberculosis (TB) and HIV/AIDS, which support prevention, diagnosis, and long-term treatment. This integration has improved data coherence, reduced redundancy, and enhanced the capacity of the health system to generate routine data for planning and accountability.

4.3.1 How the Transition Typically Happens

The integration of new programmes into HMIS generally follows a two-phase process:

Phase 1: Vertical (Standalone) Reporting During Early Rollout

- New or pilot health programmes begin with their own bespoke recording and reporting tools, that is maintained outside HMIS, to enable detailed tracking, learning, and donor reporting.
- These systems often use paper-based and digital formats designed specifically for the programme, with data collected by programme-specific government and non-government staff.
- During this phase, there is minimal linkage to HMIS. The focus is on programme performance monitoring and adaptation.

Phase 2: Gradual Integration into HMISI

- As the programme matures and scales, selected indicators are prioritized for inclusion in HMIS.
- A formal revision of HMIS indicators and tools is undertaken, involving:

[1] Originally developed and digitized in Nepal by Anweshan as a self-audit tool, the RDQA platform was maintained for over five years with technical support. However, since the transition to full government ownership, the tool's application has shifted from a quality-improvement self-audit toward a top-down monitoring and scrutiny mechanism. Furthermore, while technical infrastructure exists, the withdrawal of direct partner funding has left a significant resource gap; current implementation relies on limited federal allocations and ad-hoc budgets from specific provinces, such as Bagmati.

- Consultations with all programme divisions and M&E experts.

- Pilot testing of revised tools.
- Once validated, the tools are finalized and rolled out nationwide, accompanied by:
  - Development of user manuals, training modules, and training cascades for health staff and FCHVs.
- The programme's standalone reporting tools are replaced by HMIS tools.
- Integration is complete when the programme is fully monitored through standard HMIS channels, with no parallel reporting.

4.3.2 Key Milestones in HMIS Revision

Fiscal Year (BS)	Milestone
2050–2052 (1993/94–1995/96)	HMIS established and implemented under the Department of Health Services
2058 (2001/02)	ICD-10 training introduced via BPKIHS
2064–2068 (2007/08–2011/12)	HSIS National Strategy developed and piloted; monitoring tools updated
2069 (2012/13)	MS Access-based online reporting started; social inclusion report published
2071/72 (2014/15)	DHIS-2 introduced; vertical programme indicators began integration
2076/77 (2019/20)	DHIS-2 scaled to all 753 local levels for online reporting
2078/79 (2021/22)	Major tool revision: 68 paper-based recording tools and 5 digital reporting tools finalized, including new indicators on mental health and health education
2079/80 onward (2022/23 onward)	IHIMS Roadmap (2022–2030) initiated to strengthen digital governance, interoperability, and dashboard-based analytics

Source: Annual Health Report, Department of Health Services, 2080/81 (2024)

The **2078/79 revision (2021/22)** marked the most extensive overhaul in HMIS history, aligning tools with new programmatic requirements while maintaining paper-based recording at facility level and digital reporting via DHIS-2. Major revisions like the one in 2022 typically occur every 5 to 6 years. Smaller updates or changes can be made as needed, depending on the engagement and coordination between the concerned divisions or units and the IHMIS team.

4.3.3 Lessons and Enabling Conditions for HMIS integration

Nepal's integration experience offers several lessons:

- Dedicated transition phases are important; vertical reporting allows learning before standardization.
- Cross-programme consultations ensure that indicators reflect practical monitoring needs.
- Standardized training and supervision are vital to reduce reporting burden and maintain data quality.

4.3.4 Challenges to HMIS Integration

Despite significant achievements, challenges remain:

- Interoperability gaps between HMIS and parallel systems like e-LMIS.
- Incomplete hospital-level reporting, particularly in public tertiary centres, private hospitals and academia.
- Lack of ICT and medical record staff at many provincial and local levels.
- Delays in updating target populations affect denominator accuracy for coverage indicators.
- System rigidity—new indicators like MMS require formal approval, tool redesign, field testing, and nationwide roll-out.

These historical insights are highly relevant to the ongoing transition from IFAS to MMS. A phased approach, beginning with parallel tracking and accompanied by clear plans for eventual HMIS integration, will be essential to ensure data consistency, minimize frontline burden, and support informed decision-making.

4.4 Processes for Integrating MMS into Other Data Platforms: Household Surveys, Facility Surveys, and eLMIS

Periodic household and facility surveys are a vital part of the country's health data landscape. Surveys like the DHS and the NHFS provide nationally representative data that complement routine HMIS reporting and support programme design, policy updates, and priority-setting. Although these surveys are typically carried out by external technical agencies and funded by partners such as USAID, their design is finalised in close coordination with the Ministry of Health and Population.

The FWD, which leads maternal, newborn, and child health programmes—including iron and folic acid supplementation—is closely involved in shaping the content of these surveys. This includes selecting indicators, refining survey tools, and contributing to analysis plans. Through technical meetings and formal consultations, FWD recommends updates to nutrition indicators, followed by joint reviews of draft questionnaires, participation in pretesting, and input into tabulation plans and dummy tables.

Key Indicators Tracked By Periodic Population- and Facility-based Surveys

The Nepal Demographic and Health Survey (NDHS) 2022 tracks IFA supplementation through direct questions posed to respondents. The survey specifically asks:

- "Have you received iron-folic acid supplementation in the last 3 months?" and then displays tablets to aid recall.
- For current or recent pregnancies, women are asked: "During this pregnancy, were you given or did you buy any iron tablets or iron syrup?" followed by a prompt to "SHOW TABLETS".
- A crucial follow-up question determines adherence: "During the whole pregnancy, for how many days did you take the iron tablets or syrup?", with interviewers probing for an approximate number if the initial answer is not numeric.
- Finally, to understand barriers to compliance, the DHS asks: "What is the main reason for not taking the iron/folic acid tablets for 180 days?".

Similarly the Nepal Health Facility Survey (NHFS) monitors the availability and provision of Iron and Folic Acid (IFA) services within health facilities. It directly queries facility staff regarding

the offering of specific antenatal care (ANC) interventions, including "Iron Supplementation," "Folic Acid Supplementation," and "Combined Iron and Folic Acid." Beyond reported services, NHFS employs an observational component, where surveyors visually inspect the facility's inventory to verify the physical presence and validity of "Iron Tablets (individual tablets)," "Folic Acid Tablets (individual tablets)," and "Combined Iron and Folic Acid Tablets" on-site.

For a detailed understanding of the data collection instruments, please refer to the specific questionnaires presented in Annex 1.

4.4.1 About eLMIS

The Electronic Logistics Management Information System (eLMIS) in Nepal is a comprehensive and evolving digital platform designed to strengthen the management of health commodities, including iron folic acid supplements, across all administrative levels from central government warehouses down to local health facilities. The system, overseen by the Integrated Health Information Management System (IHMIS) section of the Management Division under the Department of Health Services, integrates inventory management and consumption reporting into a single platform to enhance countrywide data visibility, accuracy, and ownership.

Historically, Nepal's logistics management for health commodities began with paper-based LMIS reporting in 1997 and gradually evolved through web-based and real-time online inventory systems up to the district level by 2013–2014. However, delays in reporting (often 9–18 months to reach central level), lack of active data use, fragmentation between consumption and inventory systems, and weak forecasting capabilities created inefficiencies in supply chain management. These limitations drove the introduction of eLMIS in 2018, supported by USAID's GHSC-PSM project. Built on the Entution Vesta platform, eLMIS provides real-time, integrated data for planning, forecasting, pipeline monitoring, and stock status monitoring through dashboards.

The system architecture includes two main components: the Transactional System and the Reporting System. The Transactional System manages real-time inventory transactions such as receipts, issuance, batch and expiry tracking, stock adjustments, and physical stock-taking. It operates across online, offline, and mobile modules tailored to the connectivity of sites. The Reporting System aggregates periodic data on commodities received, consumed, and stock balances, with automated requisitioning, order tracking, and shipment notifications strengthening coordination across the supply chain. These functions ensure that commodities such as iron folic acid are traceable from central stores through provincial and district warehouses down to service delivery points (SDPs).

The eLMIS has become an essential tool for evidence-based forecasting and quantification, reducing risks of overstock or stockouts, and managing commodities nearing expiry. Dashboards and analytical reports provide visibility to government entities at all levels for procurement planning and real-time decision-making. The platform was also instrumental in Nepal's COVID-19 response by tracking and managing pandemic-related supplies.

However, the eLMIS currently faces significant functional challenges. A planned major upgrade under the USAID GHSC-PSM project (Entution Vesta) was not successfully completed as intended. Consequently, the eLMIS remains largely non-functional or unreliable for tracking, forecasting, or quantifying nutrition commodities like IFA. Because the data is often inconsistent or fragmented, it cannot yet serve as a dependable tool for evidence-based planning.

Currently, data from eLMIS is undergoing migration to the PAMS V2 platform to enhance sustainability and scalability. This involves data migration, feature upgrades, user training, and new dashboard development. The transition also reflects ongoing challenges around funding, infrastructure, and ensuring continuity of operations. The final operational framework of eLMIS under PAMS V2 is still being shaped, requiring close monitoring and support during the transition phase. While data migration is currently underway and migrated portions are already being utilized, the transition is expected to take at least another year before the system is fully operational across all facilities nationwide.

4.4.2 IFAS and eLMIS

In relation to iron folic acid supplementation, commodities are procured centrally and recorded within the eLMIS, with batch and expiry management based on the First-Expired, First-Out (FEFO) principle to reduce wastage. Transactions on stock received, distributed, consumed, or adjusted are entered at each level of the supply chain, ensuring transparent and actionable data on availability. Provincial logistics centres, district warehouses, and service delivery points contribute data that feed into eLMIS dashboards, which provide colour-coded alerts on stock status (e.g., low stock, out of stock, overstock). These tools help identify gaps early and support timely resupply orders, ensuring uninterrupted delivery of IFA tablets to pregnant women and adolescent girls through the public health system.

5. Reflections from Stakeholder Consultations

Understanding the readiness and perceptions of the health system to transition from IFAS to MMS requires not only a review of technical protocols, indicators, and infrastructure, but also a grounded appreciation of lived realities and institutional practices. To inform this transition in Nepal, a series of key informant interviews were conducted with stakeholders at the federal, provincial, and health facility levels.

This section provides a comprehensive narrative synthesis of those consultations, presenting insights into perceived gaps, systemic constraints, and priorities across administrative tiers. Reflections are structured thematically and reinforced with verbatim quotes to maintain the authenticity and nuance of participant perspectives.

5.1 Federal-Level Reflections: Prioritizing Continuity and Analytical Flexibility

At the federal level, stakeholders articulated a clear preference for ensuring continuity and minimal disruption at the point of service delivery during the MMS rollout. The dominant narrative that emerged was one of protecting the existing workflow of health workers, while relying on analytical-level solutions—such as organizational unit disaggregation in DHIS-2—to distinguish MMS from IFAS during the initial phases of implementation.

"Health workers already have a lot to do. If we suddenly change the register or give them new forms just for MMS, it will confuse them. We should keep the tools the same and make sense of the data at our level."

— KII, FWD

This perspective reflects an institutional memory of past system disruptions and a recognition of practical limitations. Federal actors are acutely aware that overburdening facility staff with new tools or duplicate registers risks compromising both data quality and coverage.

However, federal officials also admitted that conversations around monitoring MMS have been limited so far. While there is growing policy-level momentum for introducing MMS, the operational planning, including indicator design, form modification, and data flow alignment, remains in its infancy.

"To be honest, we haven't really discussed what data to collect for MMS. Right now, it's just at the idea stage. The actual monitoring framework hasn't been decided."

— KII, FWD

This disconnect between strategic interest and technical planning may stem from the perception that MMS is a commodity-level adjustment, not a service delivery overhaul. Yet stakeholders acknowledged that the monitoring system must eventually capture distinctions in supplement type, adherence, and behavioral uptake—dimensions that current IFAS reporting does not accommodate.

Federal-level discussions revealed that while there is broad consensus on the need for a smooth transition from IFAS to MMS, routine monitoring remains a neglected component of programme design and review.

"We barely discuss about recording, reporting and the data quality. Even during such review meetings, these are done at the end—at a time when all the participants feel like leaving home or are in a rush to leave the venue."

— KII, FWD

This also means that there is a prevailing tendency to regard data systems as administrative afterthoughts rather than as integral elements of programme performance and accountability. Discussions on service delivery, commodity procurement, or training typically receive sustained attention, whereas recording and reporting are frequently relegated to the final moments of meetings—precisely when energy and focus have waned. This pattern reveals a broader cultural and institutional gap: routine data systems such as HMIS are often viewed as isolated technical tools, rather than embedded components of programme design and strategic decision-making. Consequently, their potential to inform, adapt, and strengthen implementation remains underutilized, despite being essential to the achievement of programme objectives.

The lack of structured dialogue on data quality, verification processes, or indicator adaptation also signals that data governance is yet to be considered a core component of transition planning. Without shifting this mindset, there is a risk that the MMS transition will replicate the same weaknesses observed in IFAS monitoring—namely, a focus on commodity distribution without robust systems to track adherence, dropout, or actual coverage.

Another important point raised was the lack of actionable data from the existing IFAS reporting system. Federal-level actors consistently noted that the current HMIS data for IFAS reflects distribution only—not consumption or adherence. While this limitation is well known, expanding the indicator set is seen as difficult due to system rigidity and resource constraints.

"We can't add indicators just like that. It has to go through IHMIS review, field testing, budget allocation, printing of new tools—it's not a small change."

— KII, IHMIS

In the meantime, federal actors suggested that interim solutions—such as disaggregated analysis based on implementation geography—could serve as a stopgap. This approach would

allow DHIS-2 analysts to distinguish between MMS and IFAS data without requiring immediate changes to national recording or reporting forms.

What federal officials meant by this is that, ideally, if sufficient resources were available, the rollout of MMS would happen at the scale of an entire province rather than in scattered districts or selected facilities. The vision is that no public health facility within the chosen province would be excluded, and from a set date, all pregnant women who previously received IFAS would be switched to MMS supplementation.

Technically, under this approach, the current HMIS recording and reporting fields labelled "Iron" would be repurposed to reflect MMS in the areas where it is rolled out. While the paper-based recording forms used at health facilities may continue to include more detailed distinctions (e.g. product name, formulation), the monthly summary reports submitted to DHIS-2 would not distinguish IFAS from MMS at the form level. Instead, DHIS-2 analysts at the federal level would rely on geographical tagging: they would know that in a given province or district, MMS is being implemented, and they would interpret the "Iron" data from that area as MMS data for the purpose of analysis and reporting.

"If we know which local levels are using MMS, we can extract their data separately from DHIS-2. There is no need to change the form during the pilot."

— KII, IHMIS

For example, if MMS were rolled out across all districts of Madhesh Province, then all supplementation data from Madhesh submitted under the existing IFAS indicator would be analytically treated as MMS. In other provinces where IFAS continues, the same field would continue to represent iron-folic acid supplementation. This geographic disaggregation would allow central-level stakeholders to estimate MMS coverage and trends without modifying the reporting forms, offering a practical compromise during the early phases of transition.

However, this approach comes with caveats: it depends heavily on accurate tagging of implementation areas, assumes full compliance at the facility level, and risks confusion or data misclassification if programme areas overlap or if rollouts are not executed province wide. Still, as an interim measure, it represents a resource-efficient and operationally feasible strategy to monitor MMS uptake while preparing for more permanent HMIS integration in the future.

5.2 Provincial-Level Reflections: Systematically Excluded but Operationally Capable

Provincial stakeholders presented a different narrative—one marked by limited involvement in system design, despite having strong operational experience in implementing similar pilots. Their role was characterized as largely downstream, with responsibilities centered on cascading federal instructions rather than contributing to initial planning.

"By the time we are invited to Kathmandu, everything is already decided. We are trained, given presentations, and asked to replicate that in our province. But our experiences are rarely asked for in advance."

— KII, Madhesh Province

This passive positioning is at odds with the rich history of pilot implementation held by provinces. Multiple respondents pointed to their leadership in piloting innovations such as Rural USG, Sayana Press, CB-IMNCI, and IMAM scale-up programmes, yet expressed

frustration that these experiences were not systematically documented or used to inform future rollouts.

"We handled many of the pilot programmes before it went national. We coordinated the stock, the training, and the reporting. But when new things like MMS come, we are treated like it's our first time doing a pilot."

— KII, Madhesh Province

Such underutilization of provincial expertise not only diminishes institutional memory but also weakens implementation planning. Respondents noted that federal designs often fail to account for local operational realities, which could otherwise be captured through early consultation with provinces.

Another theme that emerged was the gap in feedback loops. While provinces receive DHIS-2 data access and are responsible for data quality assurance within their territories, they feel they lack mechanisms to provide upward feedback on what works or does not work in the field.

"Sometimes the registers are revised, but we are not informed. We see the new format only when the forms arrive. It would help if there was a system where our feedback is collected during revision."

— KII, Sudurpaschim Province

Despite these challenges, provincial stakeholders expressed readiness to coordinate pilot monitoring if given the mandate, highlighting their experience in supporting logistics, data verification, and supervision.

"If the federal level is planning MMS, they should let us co-design the pilot monitoring system. We have the local understanding of who records what, and what supervision is needed."

— KII, Sudurpaschim Province

5.3 Health Facility-Level Reflections: Confusion in Timing, Unclear Reporting, and Missed Opportunities for Follow-Up, and Reporting Fatigue

At the health facility level, the system is not yet designed to support MMS, as national rollout is still pending. However, small adjustments—such as clearer instructions, better-aligned recording tools, and routine feedback—can help prepare facilities for future integration. These improvements would not only reduce current confusion and inconsistency but also strengthen follow-up and build staff readiness for the eventual transition.

One key area where this lack of preparedness within the current system becomes visible is in the maternal health register itself. The maternal health register begins with the calculation of the Last Menstrual Period (LMP) and Estimated Date of Delivery (EDD). Based on these calculations, the register includes a structured timeline for service delivery. Facilities are required to document the first ANC visit, followed by visits at 12 weeks, 16 weeks, 20–24 weeks, and subsequent gestational periods. In principle, this structure enables health workers to deliver care in alignment with clinical guidelines and to track service provision chronologically.

In practice, however, there is considerable inconsistency in adherence to this structure. Across multiple visited sites where standard IFAS is administered health workers were found to have

recorded iron supplementation as early as 12 weeks, despite guidelines recommending initiation only after the first trimester. This deviation appears to stem from both habitual practice and a lack of clarity in job aids or refresher training. The consequence is not only a misalignment between service delivery and clinical guidelines but also ambiguity in the interpretation of recorded data, particularly when data are cross-referenced at district or federal levels and presented only in disaggregated form.

Equally problematic is the absence of a mechanism to track distribution versus consumption. While registers may document that 30 or 60 tablets were provided, there is no field to indicate whether the woman consumed them, discontinued midway, or experienced side effects. As a result, compliance remains entirely absent from routine reporting, generating a misleading perception of coverage and programmatic success.

"We write that 30 tablets were given, but we never know if she took them or not. Some mothers say it causes vomiting, but there's no place to write that."

— ANM, Health Post, Sudurpaschim Province

In some demonstration sites where MMS has been introduced, the register lacks a dedicated field for MMS. Instead, health workers have adopted a local workaround by manually annotating 'MMS' at the top of the iron supplementation field. While this adaptation allows for rudimentary differentiation during facility-level reviews, both IFAS and MMS are aggregated under the same "iron" indicator once data are summarized and uploaded into DHIS-2, resulting in significant data dilution.

"We've started giving MMS, but the report goes as 'Iron tablets'. We just write 'MMS' by hand in the margin."

— KII, BHSC, MMS demonstration site, Madhesh Province

Beyond the technical limitations, facilities reported cases of supplement discontinuation due to misinformation, even within demonstration areas. For instance, one pregnant woman discontinued MMS after receiving conflicting advice from her gynecologist, reflecting a broader gap in consistent messaging and counselling across cadres.

"One mother stopped taking MMS because a gynecologist told her it wasn't safe. So now she's refusing to restart."

— KII, BHSC, MMS demonstration site, Madhesh Province

Such incidents highlight a critical issue: in settings where follow-up is weak or irregular, misinformation can lead to discontinuity of care, and there is no system in place to monitor or intervene when such dropout occurs. In sites where pregnant women shift providers or migrate mid-pregnancy, there is often no mechanism to verify prior supplementation history, which can result in either duplication or under-coverage.

What emerges from these reflections is not resistance to change, but a call for clearer, more structured, and contextually appropriate guidance. Health workers, already encumbered by extensive reporting obligations are unlikely to engage meaningfully with new supplementation protocols unless instructions are explicit and forms are adequately revised.

"If MMS comes, just tell us where to write and how to report. Don't make it complicated—we're already reporting for all the required indicators of HMIS. The nutrition section in HMIS is not only our priority. All indicators are of equal priority."

— KII, Health Post, Madhesh Province

Finally, a recurring concern was the absence of feedback or supervision once data are submitted. Facility staff rarely receive communication regarding the use, accuracy, or comparative value of their reports. In the absence of feedback loops and meaningful accountability, reporting often becomes a perfunctory task with limited perceived value.

"We send the reports, but nobody ever says if it's right or wrong. There's no follow-up."

— KII, Health Post, Sudurpaschim Province

6. MMS Monitoring Options for Nepal

6.1 Options for Nepal for Transition and Integration of MMS Monitoring into HMIS

As Nepal contemplates a phase-wise transition from IFAS to MMS, careful planning is required to ensure that the recording and reporting (R&R) system supports implementation without disrupting routine service delivery or creating additional reporting burden. The system must also enable clear differentiation between IFAS and MMS, maintain data integrity, and generate actionable insights to guide programme decisions throughout the transition and scale-up. Drawing on lessons from prior integrations of vertical programme (for example of Sayana Press, CB-IMNCI, IMAM) into HMIS system and stakeholder consultations, the following three options are proposed for structuring the R&R system during the transition period.

These options offer a spectrum of trade-offs between ease of implementation, data visibility, and long-term integration potential.

Option 1: Continue Using Existing HMIS Tools with Analytical Disaggregation

Approach:

During the early phases of MMS rollout, health facilities can continue to use the existing HMIS tools—particularly the "Iron" column in the recording and reporting tools to record and report MMS supplementation. There will be no change to registers or reporting forms during this phase.

A prerequisite for this approach is that MMS coverage must be both universal and exclusive within the selected geography, whether at the provincial, district, or municipal level.

How Data Is Differentiated:

MMS data is disaggregated at the national or subnational levels through DHIS-2 by flagging the geographic/organizational units (health facilities) that have transitioned to MMS. Thus, IFAS and MMS can be distinguished analytically even though they use the same reporting field.

Strengths:

- Zero burden on health workers or local governments during rollout.
- Allows for quick start of phase-wise implementation.
- Uses existing DHIS-2 infrastructure.
- Low-cost and fast to operationalize.

Limitations:

- Cannot directly distinguish IFAS vs MMS at the recording form level.
- High risk of data dilution or misclassification over time.
- Inflexible for adding new indicators such as adherence or side effects.
- Must have universal coverage within the selected transition areas.

Best Fit:

This option is ideal for initial phases where the aim is to maintain simplicity and focus on operational feasibility, especially when only a few districts or municipalities are transitioning.

Option 2: Introduce Additional Field in DHIS-2 to Track MMS Separately

Approach:

This option introduces internal parallel tracking within HMIS by revising both the recording and reporting formats to include a distinct row or column for MMS-related indicators. It allows health workers to record and report MMS separately from IFAS within the same system, enabling clear differentiation during the transition.

Practically, health facilities in transition areas will use the newly added MMS field, while non-transition areas will continue using the existing IFAS field. If a non-transition site reports under the MMS field, this would constitute an error or misreporting. Conversely, if a transition site continues to report MMS under the IFAS field, that too would be considered incorrect.

How It Works:

- Health facilities in MMS rollout areas are provided with updated registers that include an MMS-specific entry.
- Monthly reporting through HMIS 9.3 would include clearly labelled fields to distinguish between IFAS and MMS.
- DHIS-2 would receive and visualize both datasets independently, allowing accurate tracking of supplementation types.
- This establishes a controlled parallel tracking system for IFAS and MMS during the transition period, while keeping all data within the existing HMIS infrastructure.
- In later phases, additional indicators—such as "number of women completing 180 MMS tablets"—could be introduced for enhanced monitoring.

Strengths:

- Allows clear separation of IFAS and MMS in data collection and reporting.
- Prepares the system for nationwide MMS rollout while maintaining consistency in HMIS.
- Enhances decision-making through more granular data from early adopters.

Limitations:

- Requires form revision, printing, and distribution, along with targeted training/orientation for frontline staff.

- Involves coordination with the Integrated Health Information Management Section (IHIMS) for system and tool updates.
- In practice, it introduces parallel tracking of two supplementation regimes, which may increase complexity at the facility level and require stronger data governance during transition.
- Slight increase in reporting burden, though manageable with clear instructions.

Best Fit:

Most appropriate during the intermediate phase of transition—when MMS is being implemented in a significant number of municipalities or provinces—and robust data is needed to inform national scale-up planning and investment decisions.

Option 3: Temporary Vertical R&R System for MMS During Early Phases

Approach:
Create a parallel R&R system for MMS during early transition phases. Health workers in MMS-implementing areas would continue to report IFAS (but this reporting means MMS administered) using the standard HMIS forms but use a separate register and monthly summary sheet for MMS. This system would be discontinued once full integration is feasible.

How It Works:

- MMS-specific tools capture distribution, adherence, and supply indicators.
- Data may be digitized using Excel or a simple app at the local level.
- Aggregated data is reviewed alongside HMIS but kept distinct for clarity.

Strengths:

- Maximum flexibility to track additional MMS indicators during early learning.
- No risk of contaminating HMIS data during transition.
- Supports implementation research or phased evaluation.

Limitations:

- Double workload for health workers in transition areas.
- Risk of parallel system becoming entrenched or poorly aligned with HMIS.
- Delays integration and increases supervision burden.

Best Fit:

Appropriate for select early transition districts where MMS is introduced alongside IFAS, or where monitoring demands are high (e.g., donor-supported research sites).

Summary Comparison of Transition Options

Criteria	Option 1: Status Quo (Geography-Based Analysis Only)	Option 2: Internal Parallel Tracking (Revised HMIS Tools)	Option 3: Separate Parallel System (Standalone Tools)
Health Worker Burden	Very Low – No change in forms or workflow	Low to Moderate – Minor adjustments in tools and reporting procedures	High – Requires managing two tools and dual reporting
Data Accuracy for MMS vs IFAS	Indirect – Inferred based on geography where MMS is implemented	Direct – Separate column/row enables precise differentiation	Direct – Fully distinct tools ensure clean tracking
Ease of Implementation	Very Easy – No new forms or approvals needed	Moderate – Needs form revision, training, and coordination	Complex – Requires creating, distributing, and maintaining an entirely new system
Cost and Resources Required	Minimal – Utilizes existing formats and workflows	Moderate – Requires printing of revised forms, training sessions, and technical alignment	High – Involves separate tools, extra training, and dual data management
System Integration Alignment	High – Works within current HMIS and DHIS-2	High – Integrated into revised HMIS structure and DHIS-2	Low – Sits outside HMIS; risks duplication and weak alignment
Ability to Add New Indicators (e.g. adherence)	Very Limited – Requires national-level HMIS overhaul to include new indicators	Moderate – Allows addition of selected MMS-specific fields (e.g. 180 tablet completion) in revised formats	High – Customization possible without constraint from existing HMIS framework
Risk of Data Dilution or Misclassification	High – Same reporting field used for both MMS and IFAS	Low – Clearly separated fields reduce chances of confusion	None – Full separation ensures data clarity
Suitability for Phase-Wise Rollout	Short-Term – Useful for interim analysis and learning	Mid-Term – Appropriate as MMS expands to more districts/provinces	Long-Term (Optional) – Could be used for early pilots but not ideal for national scale-up

6.2 Considerations for MMS Transition and eLMIS

As Nepal moves from IFA to multiple micronutrient supplements (MMS), eLMIS must also adapt. Transitioning cannot be limited to replacing IFA with MMS in the system. New variables must be added to distinguish preventive and curative supplementation, manage more complex formulations, and monitor batch and expiry details for MMS. Stock reports, requisition forms, and pipeline monitoring templates must be updated to capture MMS separately while maintaining continuity with historical IFA data for trend analysis and accountability.

Moreover, the ongoing migration to PAMS V2 provides a strategic opportunity to integrate MMS indicators into the system architecture. Designing user-friendly dashboards, training staff at all supply chain levels, and ensuring interoperability with HMIS will be crucial. Without these adjustments, there is a risk of incomplete monitoring or data fragmentation during the transition. Embedding MMS within eLMIS from the outset will therefore be critical for ensuring robust commodity management, timely resupply, and smooth national scale-up.

Table 2: Mapping of IFA variables in eLMIS to MMS transition requirements

Current IFA Variable in eLMIS	Description / Use	MMS Transition Requirement	Rationale
Commodity name (Iron Folic Acid)	Records stock of IFA supplements as a single commodity.	Introduce "Multiple Micronutrient Supplement (UNIMMAP)" as a separate commodity line.	Allows distinct tracking of MMS vs IFA; avoids confusion and ensures continuity of historical IFA data.
Batch number and expiry date	Captures batch details with FEFO (First-Expired, First-Out) applied.	Maintain for MMS; ensure expiry alerts reflect shorter/varied shelf-life if applicable.	MMS may have different stability profiles; expiry tracking is crucial for minimizing wastage.
Stock received	Records incoming IFA stock at each facility.	Add MMS as new commodity line; differentiate between preventive vs curative procurement batches if required.	Ensures supply continuity and avoids misallocation between programme uses.
Stock issued/distributed	Tracks quantities issued to lower levels.	Add MMS distribution tracking; include reporting on transition phase (IFA vs MMS overlap).	Supports visibility of both commodities during phased transition.
Stock on hand (balance)	Current IFA balance at each reporting unit.	Maintain MMS balances separately while retaining IFA balances for comparability.	Ensures accurate pipeline monitoring during dual-use period.
Consumption (tablets dispensed)	Number of IFA tablets given to beneficiaries.	Add MMS consumption tracking; disaggregate by target group (pregnant women, adolescents, etc.).	Enables monitoring of MMS uptake and comparability with historical IFA consumption.
Stock status alerts (e.g., stockout, near expiry, overstock)	Automated dashboard indicators for IFA.	Apply same alerts for MMS, but customise thresholds if dosage or packaging differs.	Prevents stockouts during transition and optimises resupply cycles.
Requisition forms & order tracking	Requests for resupply generated automatically in eLMIS.	Update templates to include MMS; maintain IFA requisitions during overlap phase.	Facilitates smooth transition without disrupting supply chains.

7. Key Gaps and Considerations for Transition for R&R

While Nepal mulls over a phase-wise transition from IFAS to MMS, the success of this transition depends heavily on the strength of its monitoring and reporting mechanisms. Drawing from stakeholder interviews, prior programme transitions, and the realities of data management across health system levels, this section outlines the critical gaps and system-level considerations that must be addressed to ensure the transition is effective, accountable, and scalable.

7.1 Lack of Tailored Indicators and Form Updates

The current HMIS was designed around IFAS and does not contain dedicated indicators or data fields for MMS. This presents a significant bottleneck for real-time tracking, interpretation, and decision-making during the transition.

Without changes to these tools, MMS will either be recorded inaccurately under IFAS, or go unreported, making it difficult to track uptake, coverage, and supply needs. Moreover, there are no existing fields to track MMS-specific dimensions, such as:

- Number of women receiving the full 180-tablet MMS course
- Dropout rates or non-adherence
- Adverse effects or side effect monitoring
- Availability and stock-outs of MMS

This absence of tailored indicators could lead to an evidence vacuum, where programme managers lack the information needed to adapt rollout strategies or respond to early challenges.

7.2 Risks of Data Error and Analysis Challenges

One of the most significant risks during the transition period is data misclassification—that is, MMS being reported as IFAS in the national system. This can occur at multiple points:

- When health workers are instructed to use the existing "Iron" field for MMS.
- When supervisors and local officials aggregate and report data without clarifying the supplement type.
- When the national system receives data that does not distinguish between IFA and MMS but uses it to inform procurement or programme performance.

Such misclassification carries operational consequences:

- **Procurement errors:** If MMS is being distributed but reported as IFAS, central authorities may continue to purchase the wrong product.
- **Misleading coverage data:** MMS coverage could appear artificially high or low, depending on how the data is interpreted.
- **Confused health workers:** Unclear guidance may result in variation across facilities—some may label MMS correctly in margins or notes, while others may follow previous IFAS routines.

7.3 Ensuring Meaningful Participation of Subnational Stakeholders

Provinces have played a pivotal role in the piloting and scale-up of major public health interventions in Nepal—including Sayana Press, CB-IMNCI, Rural USG, and IMAM scale-up. However, their involvement in the planning stages of the MMS transition has been minimal to date.

Provinces consistently reported that:

- They are often brought in only after federal-level decisions are made.
- They are expected to cascade training and information without having been part of initial design conversations.
- Their prior implementation experience is underutilized.

Failing to involve provincial actors early not only limits the system's adaptability but may lead to **operational designs that are out of sync with local realities**—such as data collection burdens, staffing capacity, and supervision logistics.

7.4 Need for Early Planning and Clear Data Guidance

At present, there is a notable absence of structured guidance on how MMS should be recorded and reported during the phase-wise transition. Federal-level stakeholders confirmed that monitoring guidance is still under discussion and that coordination with the IHMIS section has not yet begun.

This delay risks:

- Confusion at the facility level.
- Inconsistent practices between districts or provinces.
- Missed opportunities to align rollout with existing reporting cycles.

Several health workers reported receiving MMS commodities without any formal instruction on how to record or report them. Others shared that outdated registers were still in use in MMS implementation sites, making it impossible to report MMS-specific data at all.

This lack of clarity erodes data quality and increases the burden on health workers who are left to interpret national intent on their own.

7.5 Considerations for eLMIS and Supply Chain Data

While HMIS captures service delivery data, the eLMIS is the backbone of supply chain reporting and must also be adjusted for MMS transition. At present, eLMIS dashboards and reporting fields are structured around iron and folic acid supplements, with variables on batch number, expiry, stock received, stock issued, and stock balance. Transitioning to MMS requires more than simply substituting "IFA" with "MMS"; new data fields are needed to track MMS-specific commodities, including differentiated stock categories (preventive vs curative use), expiry profiles for a more complex formulation, and consumption disaggregated by target groups. Without these changes, there is a risk of stockouts, procurement mismatches, or data gaps in pipeline monitoring. As eLMIS undergoes migration to the PAMS V2 platform, embedding MMS variables into dashboards, requisition templates, and stock status alerts from the outset will be critical for ensuring data integrity and comparability with historic IFAS records.

7.6 Role of Periodic Surveys and Special Studies

Routine reporting systems like HMIS and eLMIS cannot capture all dimensions of MMS uptake, adherence, and programme performance. For example, side effects, adherence to the full 180-tablet course, or community perceptions are often missed in routine records. These gaps underscore the importance of periodic household surveys, facility assessments, and other routine studies. Surveys such as the Demographic and Health Survey (DHS) and Nepal Health Facility Survey can provide population-level and facility-level insights on coverage, adherence, and equity dimensions that routine systems overlook. In addition, smaller-scale operational research and independent monitoring exercises can help validate routine data and identify implementation bottlenecks during the transition. Ensuring that MMS-related modules and questions are integrated into these periodic surveys will be essential for building a comprehensive evidence base that complements HMIS and eLMIS data, and for supporting adaptive programme management.

Conclusion

While discussions on transitioning from IFAS to MMS in Nepal are underway, there has been limited attention to how the monitoring system will need to adapt—despite its central role in ensuring that maternal nutrition services are effectively delivered, tracked, and integrated into the health system. The Health Management Information System in Nepal has evolved significantly over the years, but its current structure is not equipped to differentiate between types of supplementation or to capture key indicators such as adherence, discontinuation, or stockouts. As a result, the system remains primarily focused on tracking distribution rather than outcomes, limiting its capacity to support a responsive and accountable rollout of MMS.

Insights from consultations with stakeholders at federal, provincial, and facility levels reveal a consistent theme: although there is broad support for MMS, the monitoring system is not being prioritized early enough in the planning process. Federal officials cite resource limitations and procedural delays in updating tools. Provincial actors, despite their experience in managing previous pilot programmes, are often excluded from early design discussions. Health workers at the facility level report outdated forms, unclear instructions, and minimal feedback. These findings underscore the need for more structured guidance, streamlined tools, and stronger data governance.

As Nepal prepares for the phased rollout of MMS, there are multiple monitoring options to consider, each with its own strengths and limitations. Option 1 proposes using existing HMIS tools while distinguishing IFAS and MMS through geographic disaggregation during analysis. Option 2 recommends minor revisions to HMIS forms to enable internal parallel tracking within the existing system. Option 3 involves a temporary standalone reporting system to track MMS separately during early phases. The choice among these should be guided by considerations of sustainability, integration with national systems, ease of implementation, and the ability to generate meaningful data without overburdening health workers. A clear and coordinated transition strategy, backed by early planning and institutional ownership, will be essential to ensure that the monitoring system effectively supports the MMS scale-up and strengthens routine data use in Nepal's health sector.

Recommendations

A successful transition from IFAS to MMS requires more than commodity procurement. It demands a carefully planned and well-integrated monitoring system that can guide programme performance, inform decisions, and ensure accountability across all levels. Based on system review and stakeholder reflections, the following recommendations are proposed:

- Prioritize monitoring system design from the outset, as it directly influences implementation quality, data use, and accountability.
- Foster strong coordination among programme and data stakeholders, including IHIMS, Family Welfare Division, and Logistics Management Division, to ensure coherent planning and rollout.
- Involve provincial and local governments in the development of tools and indicators to ensure practicality and alignment with ground-level realities.
- Select a monitoring approach based on sustainability, feasibility, and long-term system integration, with Option 2 offering the most balanced pathway.
- Ensure timely revision, distribution, and training on updated tools so that frontline workers can accurately and consistently report data.

Reference

[1] Ministry of Health and Population [Nepal], New ERA, and ICF. Nepal Demographic and Health Survey 2022. Kathmandu, Nepal: Ministry of Health and Population [Nepal].; 2023.

[2] Ministry of Health and Population [Nepal], New ERA, and ICF. Nepal Healthy Facility Survey 2021. Kathmandu, Nepal: Ministry of Health and Population [Nepal].; 2022.

[3] MoHP. ANC to PNC Continuum of Care Guideline. Ministry of Health and Population; 2023.

[4] WHO Antenatal Care Recommendations for a Positive Pregnancy Experience. Nutritional Interventions Update: Multiple Micronutrient Supplements During Pregnancy. 1st ed. Geneva: World Health Organization; 2020.

Nepal Health Facility Survey:

1. Inventory Questionnaire

Under Section 14: Antenatal Care

Provision of Iron Supplementation to pregnant women.

SECTION 14: ANTENATAL CARE

1400	**CHECK Q102.05** ANC SERVICES AVAILABLE IN FACILITY ☐	ANC SERVICES NOT AVAILABLE IN FACILITY ☐ NEXT SECTION OR SERVICE SITE ←		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE ANTENATAL CARE SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT ANTENATAL CARE SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.			
1401	How many days in a month are antenatal care services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS/MONTH ☐☐		
1401A	How many days in a month are ANC-specific PHC outreach clinic conducted from this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS/MONTH ☐☐		
1402*	Do ANC providers provide any of the following services to pregnant women as part of routine ANC?		YES	NO
01	IRON SUPPLEMENTATION		1	2
02	FOLIC ACID SUPPLEMENTATION		1	2
04	TETANUS DIPTHERIA VACCINATION		1	2
05*	ALBENDAZOLE		1	2
06*	MISOPROSTOL/ MATRI SURAKCHHYA CHAKKI		1	2
07**	COMBINED IRON AND FOLIC ACID		1	2
08**	CALCIUM		1	2
09**	CHX (Navimalam)		1	2
1403*	**CHECK Q1402.04** Td VACCINATION ☐		Td VACCINATION ☐	

Under Section 14: ANC, Equipment & Supplies for Routine ANC

Availability of iron tablets, Folic acid Tablets and combined iron folic acid tablets

1422*	Please tell me if any of the following medicines / items are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY	DK / NO, OR NEVER AVAILABLE
01	IRON TABLETS (INDIVIDUAL TABLETS)	1	2	3	4	5
02	FOLIC ACID TABLETS (INDIVIDUAL TABLETS)	1	2	3	4	5
03	COMBINED IRON AND FOLIC ACID TABLETS	1	2	3	4	5
05	TETANUS DIPTHERIA TOXOID VACCINE	1	2	3	4	5
06*	LONG LASTING INSECTICIDE TREATED NETS (LLINs)	1	2	3	4	5
07*	ALBENDAZOLE	1	2	3	4	5
08**	CHX (Navimalam)	1	2	3	4	5
09**	MISOPROSTOL/MATRI SURAKCHHYA CHAKKI	1	2	3	4	5
10**	CALCIUM	1	2	3	4	5

Under Observation of Antenatal-Care Consultation:

IRON PROPHYLAXIS

111*	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT OR COUNSELLING:	
01	Prescribed or gave iron pills or folic acid (IFA) or both	A
02	Explained the purpose of iron or folic acid	B
03	Explained how to take iron or folic-acid pills	C
04	Explained side effects of iron pills	D
05**	Prescribed or gave calcium tablets	E
06	None of the above	Y

2. ANC Client Exit Interview:

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
108*	During this visit (or previous visits) did a provider give you iron pills, folic acid or iron with folic acid? SHOW THE CLIENT AN IRON PILL, A FOLIC-ACID PILL, OR A COMBINED PILL.	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→109
108A	During this visit (or previous visits) did a provider give you a prescription for iron pills, folic acid or iron with folic acid?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→111A
109	During this visit (or previous visits) has a provider explained to you how to take the iron pills?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
110*	During this visit (or previous visits) did a provider discuss with you the side effects of the iron pill?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
111	Please tell me any side effects of the iron pill that you know of. PROBE: ANY OTHER?	NAUSEA . . . . . A BLACK STOOLS . . . . . B CONSTIPATION . . . . . C OTHER_____ X DON'T KNOW . . . . . Z	

3. Exit Interview Questionnaire for Postpartum Women:

Under Quality of Care:

411	At the time of discharge did the health staff check/advise the following on both mother and baby?		**Yes**	**No**	**Don't know**
		Mother			
		1. Check BP	1	2	8
		2. Check pulse	1	2	8
		3. Check temperature	1	2	8
		4. Check leg for tenderness/swelling	1	2	8
		5. Inspect perineum for tear, bleeding, swelling	1	2	8
		6. Examine breast for retracted nipple, cracked nipple, engorgement	1	2	8
		7. Ask she has passed urine without difficulties	1	2	8
		8. Uterine consistency	1	2	8
		9. Bleeding	1	2	8
		10. Cord care advise	1	2	8
		11. Breastfeeding advise	1	2	8
		12. Family Planning advise	1	2	8
		13. Post Natal Care (PNC) check up advise	1	2	8
		14, Carried out wound site examination (e.g. after C section/episiotomy)	1	2	8
		15. Advised on danger signs during postpartum period	1	2	8
		16. Wound care advise	1	2	8
		17. Iron for 45 days advise	1	2	8
		Baby			
		18. Check baby temperature			

Nepal Demographic Health Survey 2011

Under the Women's Questionnaire

Section 4: Pregnancy and Postnatal Care

421	During this pregnancy, were you given or did you buy any iron/folic acid tablets? SHOW TABLETS.	YES . . . . . 1 NO . . . . . 2 (SKIP TO 423) DON'T KNOW 8
422	During the whole pregnancy, for how many days did you take the tablets? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS ☐☐☐ DON'T KNOW . . . 998
422A	CHECK 422:	LESS THAN 180 DAYS ☐ OTHER ☐ (SKIP TO 423)
422B	What is the main reason for not taking the iron/folic acid tablets for atleast 180 days?	DID NOT LIKE IT . . . 1 DID NOT RECEIVE COMPLETE DOSE . 2 NOT AVAILABLE . . . 3 DID NOT KNOW . . . 4 OTHER _____ 6 (SPECIFY)

440A	After delivery were you given or did you buy any iron/folic acid tablets? SHOW TABLETS.	YES . . . . . 1 NO . . . . . 2 (SKIP TO 441) DON'T KNOW 8
440B	After delivery, for how many days did you take the tablets? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS . ☐☐ DON'T KNOW . . . 98

Nepal Demographic Health Survey 2016

Under The Women's Questionnaire:

Section 4: Pregnancy and Postnatal Care

420	During this pregnancy, were you given or did you buy any iron tablets? SHOW TABLETS.	YES ..... 1 NO ..... 2 → (SKIP TO 422) DON'T KNOW 8
421	During the whole pregnancy, for how many days did you take the tablets? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS ..... [ ][ ][ ] DON'T KNOW 998

Nepal Demographic Health Survey 2022

Under the Women's Questionnaire:

Section 2: Reproduction

235B	Have you received iron-folic acid supplementation in the last 3 months? SHOW TABLETS.	YES ..... 1 NO ..... 2 DON'T KNOW 8	

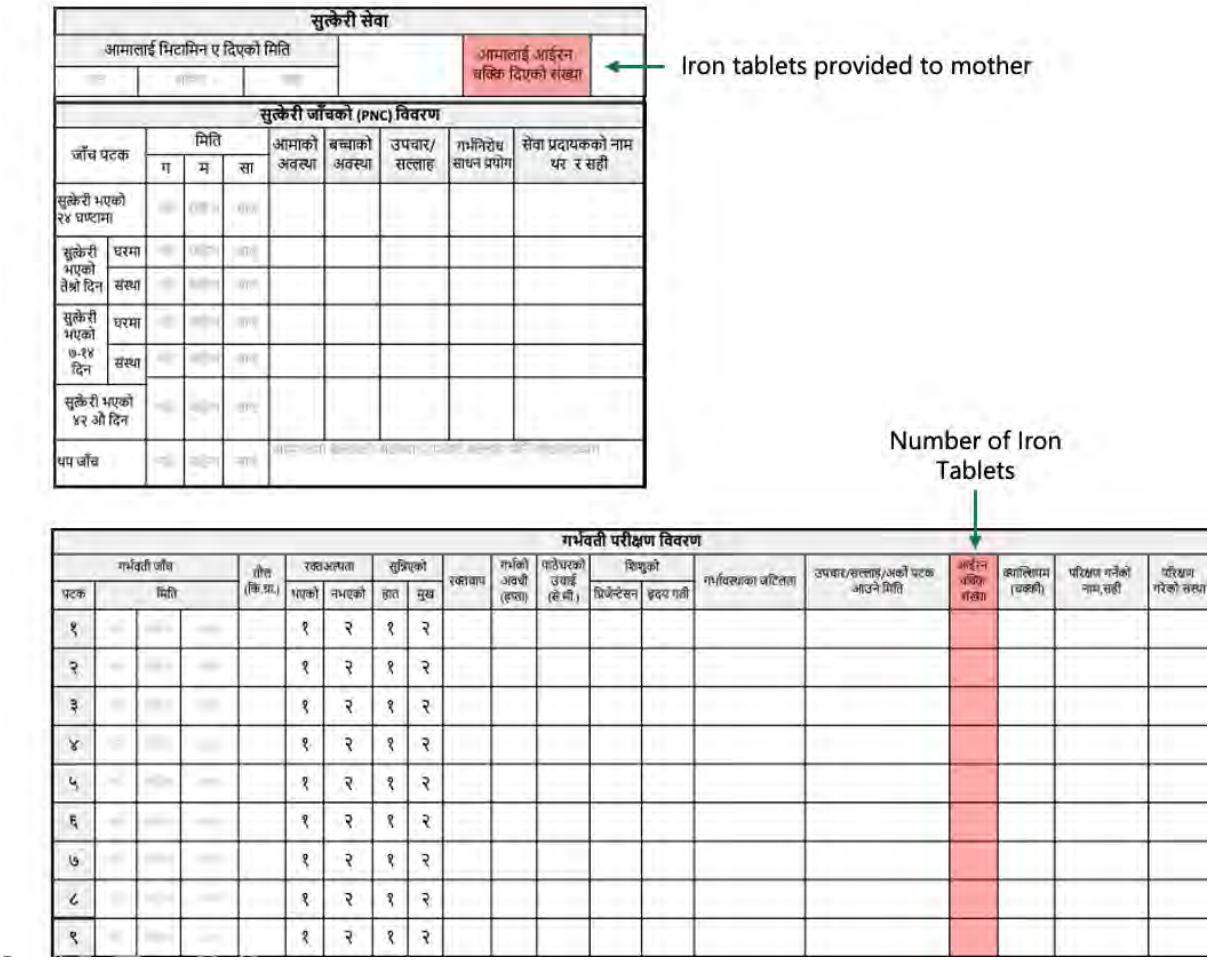
Section 4: Pregnancy and Post Natal care

426	During this pregnancy, were you given or did you buy any iron tablets or iron syrup? SHOW TABLETS.	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 429

427	Where did you get the iron tablets or syrup? Anywhere else? PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC, PRIVATE, OR NGO SECTOR, RECORD 'X' AND WRITE THE NAME OF THE PLACE(S).	**PUBLIC SECTOR** GOVERNMENT HOSPITAL ..... A PHC/PRIMARY HOSPITAL ..... B HEALTH POST ..... C BASIC HEALTH CARE CENTER ..... D URBAN HEALTH CENTER ..... E COMMUNITY HEALTH UNIT ..... F FCHV ..... G OTHER PUBLIC FACILITIES _____ H (SPECIFY) **PRIVATE MEDICAL SECTOR** PRIVATE HOSPITAL ..... I PRIVATE CLINIC ..... J PHARMACY ..... K OTHER PRIVATE MEDICAL FACILITIES _____ L (SPECIFY) **NGO MEDICAL SECTOR** FPAN ..... M MARIE STOPES ..... N OTHER NGO MEDICAL FACILITIES _____ O (SPECIFY) **OTHER SOURCE** SHOP ..... P MARKET ..... Q OTHER _____ X (SPECIFY)
428	During the whole pregnancy, for how many days did you take the iron tablets or syrup? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS ..... ☐☐☐ DON'T KNOW 998
428A	CHECK 428: LESS THAN 180 DAYS ☐ OTHER ☐ → 429	
428B	What is the main reason for not taking the iron/folic acid tablets for 180 days?	DID NOT LIKE TASTE ..... 1 DID NOT RECEIVE COMPLETE DOSE ..... 2 NOT AVAILABLE ..... 3 NOT AWARE ..... 4 FORGOT TO TAKE ..... 5 DUE TO LOCKDOWN ..... 7 OTHER _____ 6 (SPECIFY)

Recording Tools

HMIS 3.5 Maternal and Newborn Health Card



सुत्केरी सेवा

आमालाई भिटामिन ए दिएको मिति			आमालाई आईरन चक्कि दिएको संख्या

Iron tablets provided to mother

सुत्केरी जाँचको (PNC) विवरण

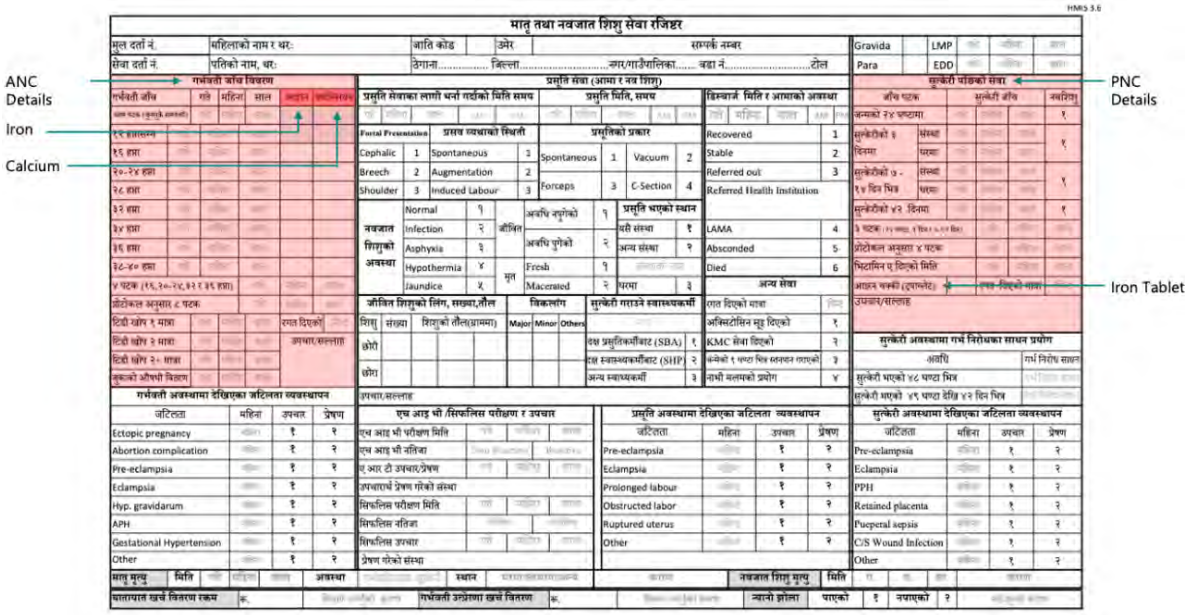
जाँच पटक		मिति			आमाको अवस्था	बच्चाको अवस्था	उपचार/ सल्लाह	गर्भनिरोध साधन प्रयोग	सेवा प्रदायकको नाम थर र सही
		ग	म	सा					
सुत्केरी भएको २४ घण्टामा									
सुत्केरी भएको तेश्रो दिन	घरमा								
	संस्था								
सुत्केरी भएको ७-१४ दिन	घरमा								
	संस्था								
सुत्केरी भएको ४२ औ दिन									
थप जाँच									

Number of Iron Tablets

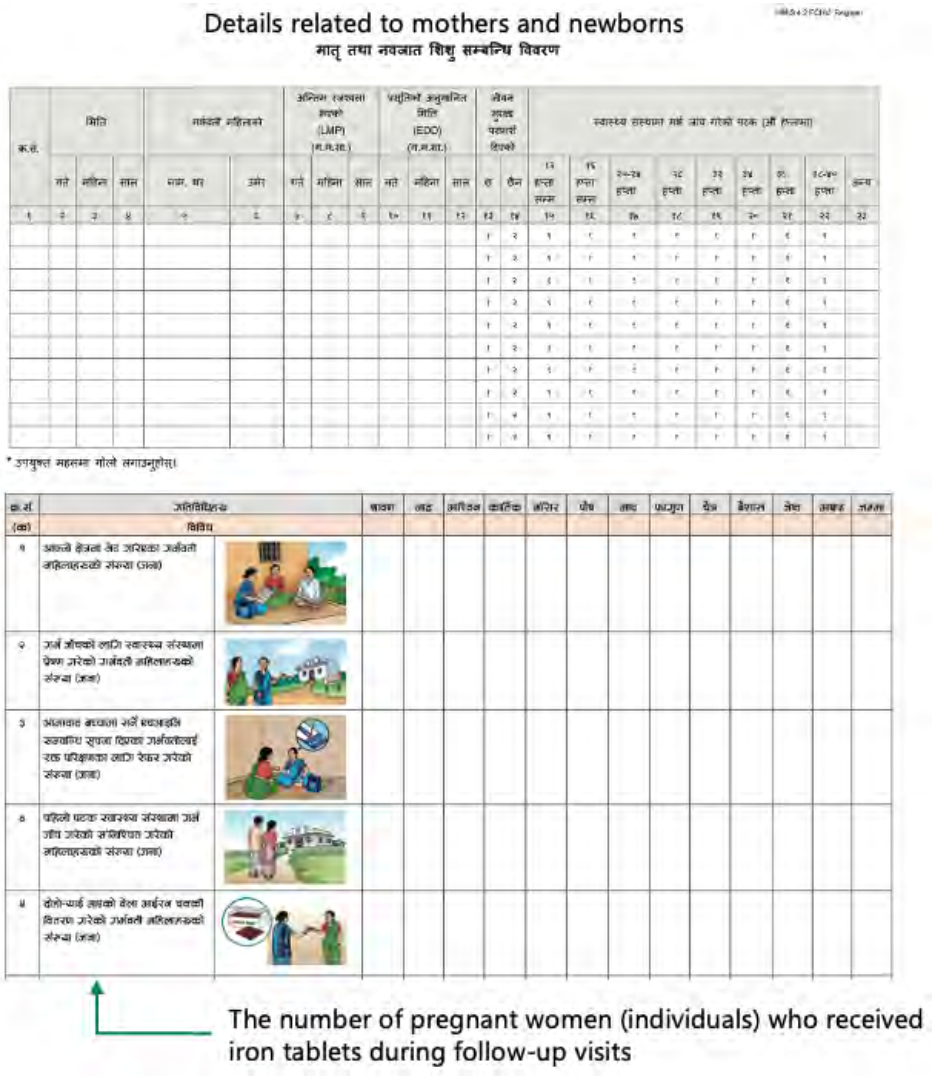
गर्भवती परीक्षण विवरण

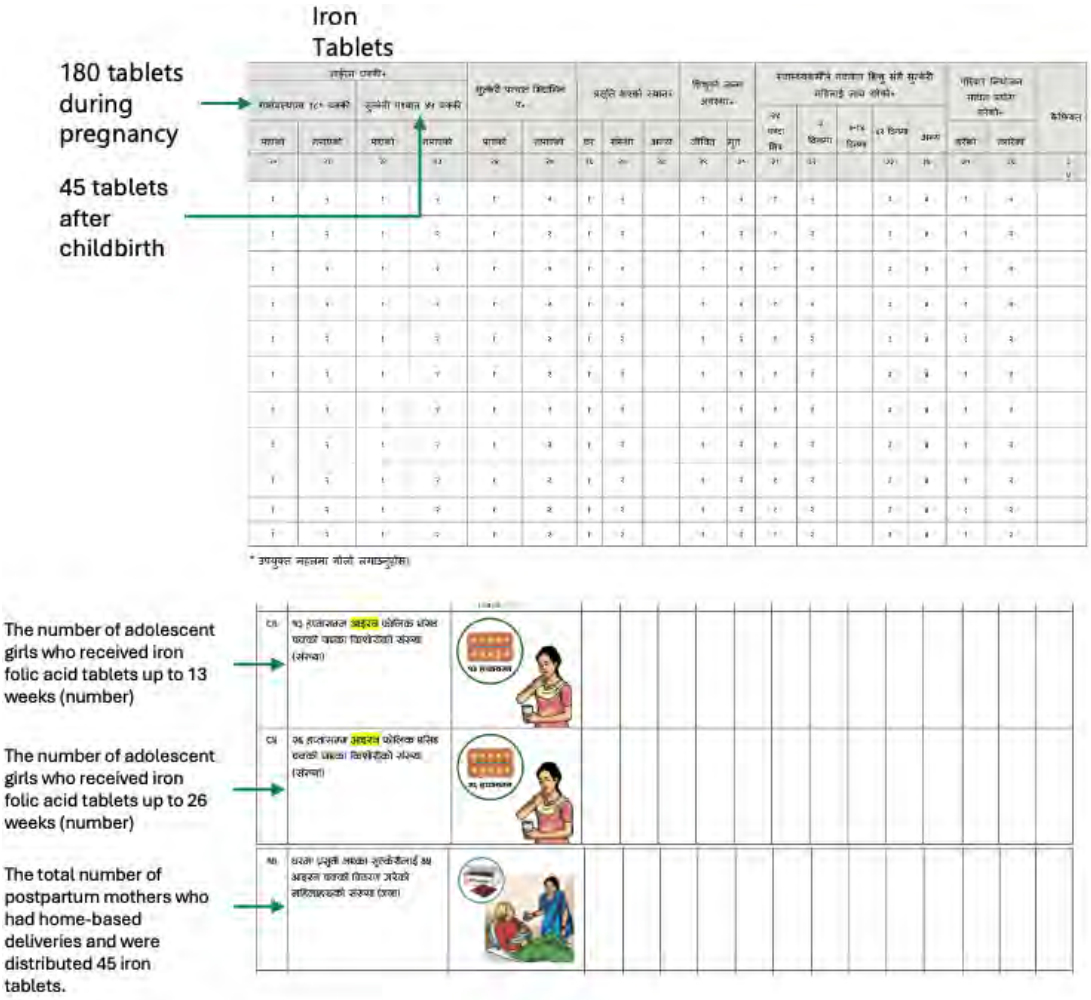
गर्भवती जाँच				तौल (कि.ग्रा.)	रक्तअल्पता		सुन्निएको		रक्तचाप	गर्भकी अवधी (हप्ता)	पाठेघरको उचाई (से.मी.)	शिशुको		गर्भविस्थाका जटिलता	उपचार/सल्लाह/अर्को पटक आउने मिति	आईरन चक्कि संख्या	क्यालशियम (चक्की)	परिक्षण गर्नेको नाम,सही	परिक्षण गरेको संस्था
पटक	मिति				भएको	नभएको	हात	मुख				प्रिजेन्टेसन	हृदय गती						
१					१	२	१	२											
२					१	२	१	२											
३					१	२	१	२											
४					१	२	१	२											
५					१	२	१	२											
६					१	२	१	२											
७					१	२	१	२											
८					१	२	१	२											
९					१	२	१	२											

HMIS 3.6 Maternal & Newborn Health Register

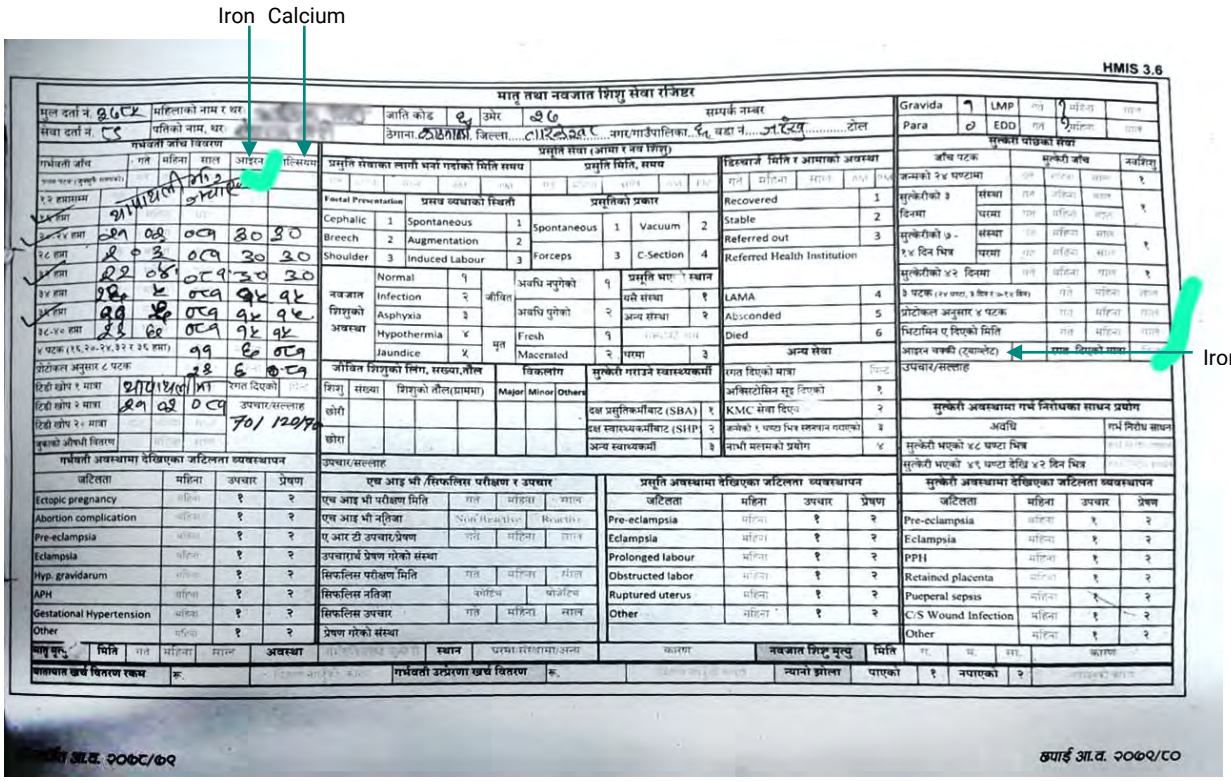


HMIS 4.2 FCHV Service Register





Real example of reporting and how information is filled in



Reporting tool

HMIS 9.1 FCHV Report Collection Form

HMIS 9.1: Monthly FCHV Reporting Form

नेपाल सरकार
स्वास्थ्य तथा जनसंख्या मन्त्रालय
स्वास्थ्य सेवा विभाग
स्वास्थ्य व्यवस्थापन सूचना प्रणाली
महिला स्वास्थ्य स्वयं सेविका कार्यक्रमको मासिक प्रतिवेदन

संस्थाको	नामः			प्रतिवेदन पेश गरेको	मितिः	...../.../२० ..
	ठेगाना जिल्लाः				आ.ब.	२० .../२० ....
	गा.पा./न.पा:		वडा नं.		महिनाः	

महिला स्वास्थ्य स्वयंसेवीकाको जम्मा संख्याः		प्रगति विवरण पेश गरेका महिला स्वास्थ्य स्वयंसेवीकाको संख्याः	

(ग)	आमा र नवजात शिशु स्वास्थ्य		
१३	शिशु तथा बाल्यकालिन पोषण व्यवहार सम्बन्धी सल्लाह दिएको आमाहरुको संख्या	जना	
१४	सुत्केरी जाँचको लागि प्रेषण गरेको महिलाहरुको संख्या	जना	
१५	घरमा प्रसुती भएका सुत्केरीलाई ४५ आइरन चक्की वितरण गरेको महिलाहरुको संख्या	जना	
१६	भिटामिन ए दिएको सुत्केरी महिलाहरुको संख्या	जना	

The number of women who distributed 45 iron tablets to postpartum mothers at home.

HMIS 9.2 Outreach Clinic Report

HMIS 9.2: PHC-ORC Level

नेपाल सरकार
स्वास्थ्य तथा जनसंख्या मन्त्रालय
स्वास्थ्य सेवा विभाग
स्वास्थ्य व्यवस्थापन सूचना प्रणाली
समुदायस्तर स्वास्थ्य कार्यक्रमको मासिक प्रतिवेदनः खोप तथा गाँउघर क्लिनिक कार्यक्रम

संस्थाको	नामः			प्रतिवेदन पेश गरेको	मितिः	...../.../२० ..
	ठेगाना जिल्लाः				आ.ब.	२० .../ २०....
	नगर/गाउँपालिका		वडा नं.		महिनाः	

क्र.सं.	गाउँघर क्लिनिक कार्यक्रमः गतिविधिहरू		ईकाइ	गाउँघर क्लिनिक संचालन स्थान						जम्मा
७०	गर्भवती जाँच गराएका महिलाको संख्या		जना							
७१	जुकाको औषधी वितरण गरिएका गर्भवती संख्या		जना							
७२	आइरन चक्की वितरण गरिएका गर्भवती महिला संख्या	नयाँ	जना							
७३		दोहोऱ्याइ आएका	जना							
(ङ)	सुत्केरी सेवा									
७४	सुत्केरी जाँच गराएका महिलाको संख्या		जना							
७५	४५ आइरन चक्की पाएका सुत्केरी महिलाको संख्या		जना							
७६	भिटामिन ए पाएका सुत्केरी महिलाको संख्या		जना							

New

Repeat

The number of pregnant women who received iron tablets.

The number of postpartum women who received 45 iron tablets

HMIS 9.3 Basic Health Facility Reporting Form

HMIS 9.3

नेपाल सरकार
स्वास्थ्य तथा जनसंख्या मन्त्रालय
स्वास्थ्य सेवा विभाग
स्वास्थ्य व्यवस्थापन सूचना प्रणाली
_____ गाउँ/ नगरपालिका, स्वास्थ्य शाखा
स्वास्थ्य संस्थाको नाम: _____
स्वास्थ्य संस्थाप्रकार: _____

मासिक प्रगती प्रतिवेदन

स्वास्थ्य संस्था कोड:	
स्वास्थ्य संस्थाको प्रकार:	
पालिका	वडा
प्रेषित मिति:	/ / २० ...
प्राप्त मिति:	/ / २० ...

आर्थिक वर्ष: २० .../...
चलानी नं. _____

श्री स्वास्थ्य शाखा,
_____ गाउँ/ नगरपालिका, स्वास्थ्य शाखा

विषय: जन स्वास्थ्य कृयाकलापहरुको मासिक प्रगती प्रतिवेदन पेश गरेको

प्रतिवेदनको अवधि: ..... महिना, २० ... साल

Pregnant women who received iron/deworming medication

Postpartum women who received iron/vitamin A

३. पोषण कार्यक्रम

यस महिनामा वृद्धि अनुगमनका लागि दर्ता भएका बच्चा	वृद्धि अनुगमन गरिएका बालबालिकाहरुको पोषण स्थिति						वृद्धि अनुगमनका लागि दर्ता गरिएका २३ महिना पुरा नभेका जम्मा बालबालिकाको संख्या	वृद्धि अनुगमनका लागि दर्ता गरिएका २३ महिना पुरा भएका बालबालिकाले तीन पिएको जम्मा पटक	आइरन/जुकाको औषधी पाएका गर्भवती महिला			क्यालसियम चक्की पाएका महिला	आइरन/भिटामिन ए पाएका सुत्केरी महिला		भिटामिन ए/जुकाको औषधी पाएका ५ वर्ष मन्दा कम उमेरका बालबालिका (अप्रे-मार्फिल)			जुकाको औषधी पाएका छात्रा/छात्रहरु (अप्रे-मार्फिल)	
	०-११ महिना			१२-२३ महिना					पहिलो पटक आइरन चक्की	१८० आइरन चक्की	जुकाको औषधी		४५ आइरन चक्की	भिटामिन ए	भिटामिन ए			छात्रा	छात्र
	सामान्य	जोखिम	अति जोखिम	सामान्य	जोखिम	अति जोखिम									६-११ म.	१२-५९ म.	जुकाको औषधी		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
पहिलो पटक भेट																			
दोहोऱ्याइ आएको																			

Revised: FY 2078/79 2 Printed: FY 2078/79

Iron tablets for the first time

45 Iron Tablets

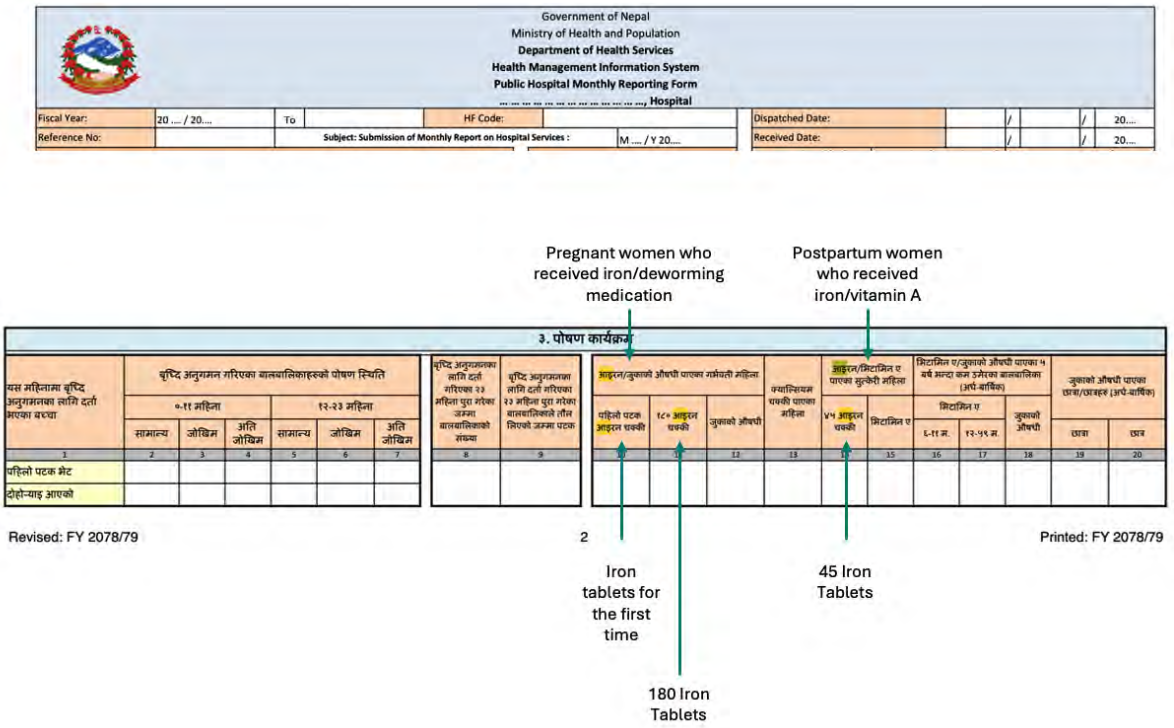
180 Iron Tablets

Distribution of iron tablets

१० क. गाउँघर क्लिनिक र समुदाय स्तर स्वास्थ्य कार्यक्रम

1				2	3		4
प्राथमिक उपचार गरेका					आइरन चक्की वितरण	नयाँ गर्भवती	
तौल अनुगमन गरेका	०-११ महिना	सामान्य				दोहोर्याइ आएका	
		जोखिम				सुत्केरी महिला	
		अति जोखिम			भिटामिन ए पाएका सुत्केरी महिला		
	१२-२३ महिना	सामान्य			प. नि. साधन वितरण	कन्डम	गोटा
		जोखिम				पिल्स	जना
		अति जोखिम					साईकल
गर्भ जाँच गरेका महिला						डिपो	डोज
सुत्केरी जाँच गरेका महिला						सायना प्रेस	डोज
जुकाको औषधी पाएका गर्भवति						आकस्मिक चक्की	डोज
जन्मेको ६ महिनासम्म स्तनपान मात्र गराएको					उपचारमा नियमित नभएका बिरामीको खोज गरेको संख्या (क्षयरोग)		
६ महिनापछि स्तनपानका साथै ठोस, अर्धठोस र नरम खाना सुरु गरेका					रक्त नमुना संकलन गरेको स्लाइड संख्या		
					आमा समुहको बैठकमा भाग लिएको		

HMIS 9.4 Public Hospital Reporting Form



Government of Nepal
Ministry of Health and Population
Department of Health Services
Health Management Information System
Public Hospital Monthly Reporting Form
..... Hospital

Fiscal Year:	20 .... / 20....	To	HF Code:	Dispatched Date:	/ / 20....
Reference No:		Subject: Submission of Monthly Report on Hospital Services :	M .... / Y 20....	Received Date:	/ / 20....

Pregnant women who received iron/deworming medication

Postpartum women who received iron/vitamin A

३. पोषण कार्यक्रम

यस महिनामा वृद्धि अनुगमनका लागि दर्ता भएका बच्चा	वृद्धि अनुगमन गरिएका बालबालिकाहरुको पोषण स्थिति						वृद्धि अनुगमनका लागि दर्ता गरिएका २३ महिना पुरा नगरेका जम्मा बालबालिकाको संख्या	वृद्धि अनुगमनका लागि दर्ता गरिएका २३ महिना पुरा गरेका बालबालिकाले तौल लिएको जम्मा पटक	आइरन/जुकाको औषधी पाएका गर्भवती महिला			क्यालसियम चक्की पाएका महिला	आइरन/भिटामिन ए पाएका सुत्केरी महिला		भिटामिन ए/जुकाको औषधी पाएका ५ वर्ष भन्दा कम उमेरका बालबालिका (अर्ध-वार्षिक)			जुकाको औषधी पाएका छात्रा/छात्रहरु (अर्ध-वार्षिक)	
	०-११ महिना			१२-२३ महिना											भिटामिन ए		जुकाको औषधी		
	सामान्य	जोखिम	अति जोखिम	सामान्य	जोखिम	अति जोखिम			पहिलो पटक आइरन चक्की	१८० आइरन चक्की	जुकाको औषधी		४५ आइरन चक्की	भिटामिन ए	६-११ म.	१२-५९ म.		छात्रा	छात्र
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
पहिलो पटक भेट																			
दोहोऱ्याइ आएको																			

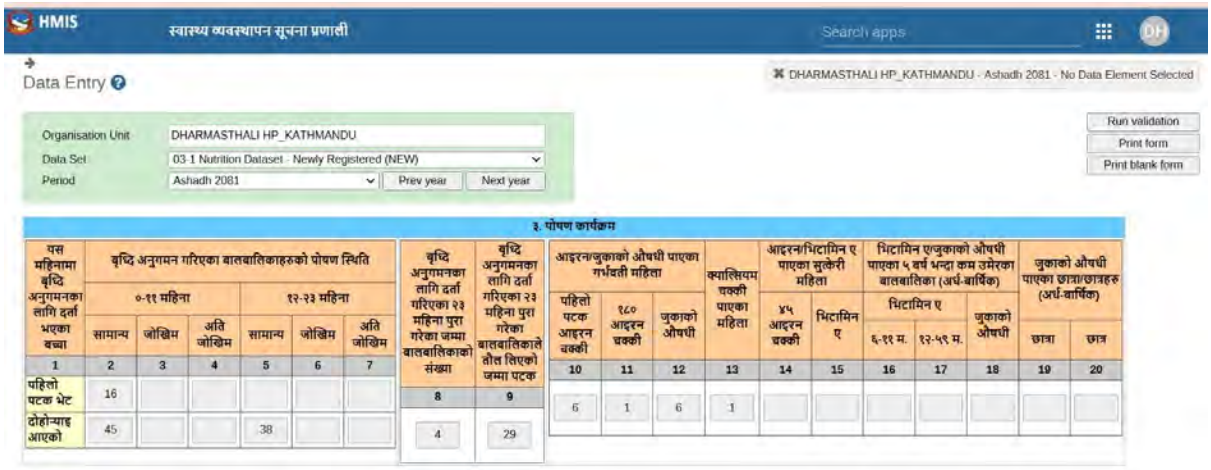
Revised: FY 2078/79 2 Printed: FY 2078/79

Iron tablets for the first time

180 Iron Tablets

45 Iron Tablets

Real example of reporting



HMIS स्वास्थ्य व्यवस्थापन सूचना प्रणाली

Search apps

Data Entry

DHARMASTHALI HP_KATHMANDU - Ashadh 2081 - No Data Element Selected

Organisation Unit: DHARMASTHALI HP_KATHMANDU
Data Set: 03.1 Nutrition Dataset - Newly Registered (NEW)
Period: Ashadh 2081 Prev year Next year

Run validation
Print form
Print blank form

३. पोषण कार्यक्रम

यस महिनामा वृद्धि अनुगमनका लागि दर्ता भएका बच्चा	वृद्धि अनुगमन गरिएका बालबालिकाहरुको पोषण स्थिति						वृद्धि अनुगमनका लागि दर्ता गरिएका २३ महिना पुरा नगरेका जम्मा बालबालिकाको संख्या	वृद्धि अनुगमनका लागि दर्ता गरिएका २३ महिना पुरा गरेका बालबालिकाले तौल लिएको जम्मा पटक	आइरन/जुकाको औषधी पाएका गर्भवती महिला			क्यालसियम चक्की पाएका महिला	आइरन/भिटामिन ए पाएका सुत्केरी महिला		भिटामिन ए/जुकाको औषधी पाएका ५ वर्ष भन्दा कम उमेरका बालबालिका (अर्ध-वार्षिक)			जुकाको औषधी पाएका छात्रा/छात्रहरु (अर्ध-वार्षिक)	
	०-११ महिना			१२-२३ महिना											भिटामिन ए				
	सामान्य	जोखिम	अति जोखिम	सामान्य	जोखिम	अति जोखिम			पहिलो पटक आइरन चक्की	१८० आइरन चक्की	जुकाको औषधी		४५ आइरन चक्की	भिटामिन ए	६-११ म.	१२-५९ म.	जुकाको औषधी	छात्रा	छात्र
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
पहिलो पटक भेट	16																		
दोहोऱ्याइ आएको	45			38			4	29	6	1	6	1							