CARE Nepal

Child Survival in Kanchanpur District, Nepal

Child Survival XV

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Mid-Term Evaluation

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ACRONYMS

ARI	Acute Respiratory Infection
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
BCC	Behavior Change Communication
CBW	Community Based Workers
CDD	Control of Diarrheal Disease
CHO	Community Health Officer
CHE	Community Health Extensionists
CMA	Community Medical Assistant
CS	Child Survival
CV	Curriculum Vita
DCM	Diarrhea Case Management
DDC	District Development Committee
DHO	District Health Office
DIP	Detailed Implementation Plan
DOSA	Discussion-Oriented Organization Self Assessment Program
DPHO	District Public Health Officer
EHP	Environmental Health Project
EOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
FHE	Family Health Extensionists
FCHV	Female Community Health Volunteers
FM	Local Area Radio Program
FPAN	Family Planning Association of Nepal
HA	Health Assistant
HBMC	Home Based Maternity Card
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System
HMG	His Majesty's Government
HP	Health Post
HPMC	Health Post Management Committee
HQ	Headquarters
HS	Health Supervisor
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Devices
JJ	Jeevan Jal
JSI	John Snow Incorporated
KPC	Knowledge Practice and Coverage
LCHSSP	Logistics in Child Health Support Services Project

LRSP	Long Range Strategic Plan
MCHW	Maternal and Child Health Worker
MG	Mothers Group
MMR	Maternal Mortality Rate
MNC	Maternal and Newborn Care
MOU	Memorandum of Understanding
MO	Medical Officer
MOH	Ministry of Health
NDHS	Nepal Demographic and Health Survey
NGO	Non-Governmental Organization
NNSWA	Nepal National Social Welfare Association
ORC	Outreach Clinic
ORS	Oral Rehydration Solution
PAC	Project Advisory Committee
PCM	Pneumonia Case Management
PHC	Primary Health Center
PLA	Participatory Learning & Action
PM	Project Manager
PNC	Post-Natal Care
PVO	Private Voluntary Organization
QOC	Quality of Care
R/R	Respiratory Rate
SCM	Standard Case Management
SHDK	Safe Home Delivery Kit
SHP	Sub-Health Post
SHPMC	Sub- Health Post Management Committee
STIS	Sexually Transmitted Infections
SWC	Social Welfare Council
TBA	Traditional Birth Attendant
TER	Total Fertility Rate
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization

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A. SUMMARY

1. Program Description and Objectives

CARE Nepal initiated a USAID/BHR/PVC-funded Child Survival Project (CS XV) on October 1, 1999 in 19 Village Development Committees (VDCs) and one Municipality of Kanchanpur District for a period of four years. Kanchanpur District is located in the Far Western Terai, a lowland area on the boarder with India characterized by flatland rice farming and dense population. The target population of the project is 53,306 children under five and approximately 66,630 women of reproductive age.

The interventions of the project include: breastfeeding/nutrition, control of diarrheal disease, pneumonia case management, maternal and newborn care and control of malaria. The project goal is to reduce maternal and child mortality in Kanchanpur by the end of the project through the following objectives:

- Behavioral: Caregivers of children below five years of age, particularly mothers, will be practicing health behaviors and seeking medical care from trained sources when needed.
- Increased access to services and supplies: Families will have increased sustainable access to health education, quality care and essential medicines,
- Institutional: Local and community-based institutions and local NGOs with capacity to support child survival activities on a sustainable basis will be developed or strengthened.
- Quality of Care: MOH personnel, FCHVs, TBAs and other service providers will be practicing appropriate case management of diarrhea, pneumonia, malnutrition and maternal and newborn care.

2. Main Accomplishments of Program

Since the beginning of CARE's Child Survival Project in Kanchanpur, the following accomplishments have been made by the project.

- Due to quality training and field support, FCHVs are quite knowledgeable in the five intervention areas, are capable of treating pneumonia using cotrim and preparing Jeevan Jal for treatment of dehydration as well as if not better than FCHVs in other districts. This is due to the additional supervision provided by CARE and JSI in coordination with the DPHO and health facility staff.
- FCHVs are receiving strong moral and financial support from the VDCs, which has lead to a more significant and respected role in the community and will lead to the sustainability of the program.
- The number of active FCHVs has increased from 171 to 666, which has greatly increased coverage of services.

- Mothers Groups have provided a forum for even uneducated women to discuss their health care issues, which may lead to the resolution of problems associated with their needs.
- Mothers group meeting attendees have very good knowledge of key messages which has lead to increased community demand for health care services such as iron tablets, antenatal and postnatal care.
- DDC is taking an active role in coordination of health and development activities, better than in many other districts.
- DDC has made a written commitment to continue FCHV program beyond the life of the project, which may ensure the sustainability of the FCHVs valuable role in the community.
- Rather than rely on the central government, some VDCs are beginning to take action regarding supply of drugs: community drug program, sale of the "blue cup" for ORS (Jeevan Jal) preparation, and FCHV endowment.
- Capacity building and linkages with local NGO partners is taking place, which will hopefully lead to better sustainability.
- The project field workers, CHE/FHEs, have a strong commitment, knowledge about intervention areas and relationships with VDCs which makes for a smooth transition when the time comes for the project to end.
- TBAs are able to identify at least three danger signs during pregnancy and can refer the pregnant women to an appropriate facility.
- DPHO is encouraged that maternal mortality is now being reported so that there is a baseline from which to work.
- DPHO has noted a decrease in the epidemic of diarrhea and, therefore less demand for Jeevan Jal.
- Total malaria case detection has increased due to project coordination with DPHO and health facility staff.
- JSI and CARE staff are "like a family", facilitating close and effective relations with the DPHO and DDC and improving supervision of the CB-IMCI program.
- The husbands and mother-in-laws who received an orientation on maternal and newborn care/nutrition had more knowledge than those who had not received and orientation.
- Oriented husbands and mother-in-laws indicated a change in practices.
- Sub-health post and health post staff have seen positive changes in health care seeking behavior, i.e., more women are attending ANC/PNC clinics.
- Training of SHP/HP staff in the five intervention areas has enhanced their capabilities in providing health services.

3. Overall Progress Achieving Program Objectives

To date, CARE's Child Survival Project in Kanchanpur has met all of its objectives for years one and two of the DIP. All five intervention trainings and related activities have been completed successfully. Given the responses of the various groups interviewed during the evaluation, knowledge was very high and practices changed which illustrates the effectiveness of the trainings and activities.

Women and caregivers of children are practicing improved health behaviors and seeking medical care from trained sources when needed. Families have increased access to health education, quality care and essential medicines. DDC, VDCs, and local NGOs are being strengthened with capacity to support child survival activities. DPHO and health facility personnel, FCHVs, TBAs and other service providers are practicing appropriate case management of diarrhea, pneumonia, malnutrition and maternal and newborn care.

4. Main Constraints, Problems and Areas in Need of Further Attention

The following areas need further attention in the remaining two years of the project:

- FCHVs are weak in the area of newborn care.
- Although CARE is not responsible for providing incentives, the FCHVs identified the lack of incentives as a major issue.
- Not all mothers, especially from marginal communities, have access to Mothers Groups.
- Process of recruiting FCHVs and implementing activities in the municipality has been slow and inadequate.
- VDC female ward members have not been mobilized sufficiently for community level child survival activities.
- Tension between those NGOs who are involved in the project and those who are not.
- CARE and the DPHO are not jointly analyzing HMIS data effectively
- Medical shop owners are not aware of CS Project activities
- There is confusion regarding the sale of cotrim—FCHVs are selling while health facilities are not.

5. Summary of Capacity-Building Effects of Program **This is how it is written in the guidelines.**

CARE is very good at building the capacity of its personnel. Of the 31 CARE Nepal staff involved in the CS Project in Kanchanpur, 22 have worked in previous CARE projects. They have all received extensive training and some have been provided with learning opportunities in other countries. The CS Project management and field staff meet every three months for two days. During that time they discuss achievements to date in each program area, any problems and solutions associated with current implementation, program planning for future implementation activities and budget update.

As for local partner organizations, the project has both government and non-government partners. The government partners are the Child Health Division of the Ministry of Health at the national level and the District Public Health Office at the district level. The project is working to develop technical, managerial and supervisory capabilities of the entire district health care delivery system.

Although the project supports all levels of staff, the focus is on improving the capabilities of the FCHVs and TBAs.

Health worker performance has been strengthened through improving technical and supervisory capacity by providing technical trainings in all five intervention areas and joint supervision at the field level. Given the discussions with the health facility staff regarding their knowledge, it seems the trainings have worked to strengthen their technical capacity and performance.

The project uses a cascade approach to training. Top DPHO and CARE Health supervisors are trained first and then involved in the training of the next level of health facility and CARE field staff. Depending on the intervention, the FCHVs are usually the final group to be trained jointly by CARE and government health facility staff. The FCHVs then provide training to Mother's groups.

The project has also identified four local NGOs at the VDC and municipality level. The NGOs were selected using a fair and objective process. (the field told me it was 4) At the municipality level, the mayor has been dissatisfied and resentful of the activities carried out by local NGOs. At the VDC level, the relationship with local NGOs is much better. They have received training in all five intervention areas and used this information for teaching mothers groups.

6. Summary of Prospects for Sustainability

The entire CS Project has been designed with sustainability in mind—the thought that the project will end in four years. First, the project is structured such that CARE staff are supporting the DPHO staff rather than replacing them. It is hoped that by providing training to health facility staff at all levels, each level's technical capacity will be built and sustained. In addition to the five intervention areas, emphasis has been given to keeping stocks of necessary supplies at health facilities through proper planning and cost recovery schemes.

However, CARE is also very aware that there is high turnover within the DPHO and that the staff that they train may very well be transferred. Therefore CARE has put a stronger emphasis on building capacity at the community level through FCHVs, TBAs, mothers groups, VDCs, the municipality, DDC and local NGOs. The thought is to empower communities to assume responsibility for their own health, enabling them to prioritize, plan, implement, maintain and evaluate local interventions through improved management skills, technical knowledge, resource generation and mobilization techniques.

Specific activities related to sustainability include: mothers group formation; FCHV associations; reviving Health Post Management Committees; and training at all levels in the five intervention areas. Already some VDCs have shown their commitment to health by using some of their government allocation to set up revolving drug funds and purchase other needed equipment. Some VDCs have

even put money aside as an endowment for FCHVs. Finally, the DDC has in writing made the commitment to continue support of the FCHV program after the CS Project has finished.

7. List of Priority Recommendations Resulting from Evaluation

- Strengthen FCHVs counseling skills for communicating with mothers.
- Improve IEC materials and teach FCHVs to use them more effectively.
- Encourage communities/VDCs to provide incentives for FCHVs.
- Empower MG members to counsel other mothers who are not attending meetings.
- Identify specific strategies to address the needs of marginal groups.
- Continue orientation for husbands and mother in laws and add other topics.
- Orient medical shop owners on the rational use of drugs using the existing MOH curriculum.
- Refresh DDC/DPHO/Municipality/NGOs on the project intervention strategies and partnering issues.
- Collaborate every three months with DPHO on the analysis and use of HMIS data.
- Provide further training to local NGOs conducting street dramas including local dialects and expanding coverage area.
- Further orient female ward members on CS Project interventions.
- Implement the Community Drug Program in all VDCs.
- Provide refresher/additional training in maternal and newborn care to all health workers at all levels including FCHVs.
- Learn from other newborn care projects in the country such as DFID-funded MIRA Project in Makwanpur.

No, I am not going to mention the methodology as it is not necessary and it is listed as an attachment in the table of contents.

B. Assessment of Progress

1. Technical Approach

a. Project Overview

CARE Nepal initiated a USAID/BHR/PVC-funded Child Survival Project (CS XV) on October 1, 1999 in 19 Village Development Committees (VDCs) and one Municipality of Kanchanpur District for a period of four years. The partners include the District Development Committee (DDC), the District Public Health Office (DPHO), VDCs, John Snow Incorporated (JSI), Environmental Health Project (EHP) and local non-government organizations (NGOs).

Kanchanpur District is located in the Far Western Terai, a lowland area on the boarder with India characterized by flatland rice farming and dense population. The population is a diverse mix of ethnic and caste groups. The project focuses on the most disadvantaged groups such as the landless Tharus, bonded laborers (Kamaiya) and those of low caste (Kami, Damai, and Sarki). The target population of the project is 53,306 children under five and approximately 66,630 women of reproductive age.

The interventions of the project include: breastfeeding/nutrition, control of diarrheal disease, pneumonia case management, maternal and newborn care and control of malaria. The project goal is to reduce maternal and child mortality in Kanchanpur by the end of the project through the following objectives:

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Government services in Kanchanpur including health have not kept pace with the rapid population growth of the district due to in-migration. Nationally, one Sub-Health Post (SHP) should cover around the 3-5,000 people. In Kanchanpur, one covers as many as 17,000. For example, Chitwan, another Terai district with nearly the same population, has twice as many VDCs and SHPs. As for Female Community Health Volunteers (FCHVs), there should be one for every 400 people, yet in Kanchanpur the FCHVs were serving an average of 1400 people prior to the CSP.

b. Progress report by intervention area.

Breastfeeding/Nutrition

As is described in the DIP, the project is implementing programs related to child-feeding practices, maternal nutrition, and breastfeeding promotion. Mothers and children are the primary targets of the interventions although husbands and mother in laws are also targeted, as they are the main decision-makers at the household level and directly influence mothers' behaviors. Mother's Groups, FCHVs and TBAs are the counselors for this intervention and encourage optimal feeding practices, including maternal nutrition during pregnancy and lactation, early initiation of breastfeeding, exclusive breastfeeding and introduction of semi-solid foods after six months.

As part of the implementation process, the project conducted a qualitative research study on child-feeding traditions, practices and beliefs. Detailed results of this study can be found in the report *Child-Feeding: Traditions, Practices and Beliefs*. Based on the findings, the appropriate messages consistent with MOH guidelines have been used in the training of FCHVs, TBAs and other community members. It is also important to note that the activity contributed to building qualitative research skills of the Kanchanpur-based CARE staff.

To date all the activities proposed in the DIP for years one and two for this intervention have been completed. They include the following:

- MOH Basic training for FCHVs, which covers all five intervention areas of the project.
- CB-IMCI at all health facility levels including FCHVs, which also covers nutrition of under-fives including the importance of continued feeding during illness.
- Training of husbands and mother in laws in maternal nutrition during pregnancy and lactation.
- Training of FCHVs about micronutrient-rich foods, support of the semi-annual National Vitamin A Program and kitchen gardening for villagers.
- Training at all levels the importance of iron during pregnancy.

FCHVs' knowledge of key messages regarding breastfeeding and nutritious food was quite good although there was some confusion regarding complementary/supplementary feeding at 5 or 6 months. FCHVs also expressed the need to reach more mothers. Mothers' knowledge of essential breastfeeding and nutrition messages was weak and requires strengthening. Husbands and mother in laws who were oriented in maternal nutrition as part of the Maternal and Newborn Care Orientation had improved knowledge and even expressed a change in practices.

What was most exciting is the intense counseling and use of high calorie, high protein "super flour" or as is known locally "sarbottam pitho" for the treatment of protein energy malnutrition in children under the age of five. The mothers of two cases were visited and interviewed. According to the mothers, the children had improved greatly. It was suggested that the CARE staff take pictures to track the progress of these cases as "before and after". Because these children have made such progress, the community has taken notice and the demand for "super flour" has increased. Due to the increased demand, several FCHVs have begun to produce and sell the "super flour".

Control of Diarrheal Disease

All year one and two activities in the DIP related to CDD have been completed. The CARE Kanchanpur staff as well as all health facility levels of the District Public Health Office were trained in CDD as part of the seven-day IMCI package. Of the Health Staff interviewed, all knew the danger signs of dehydration and the correct preparation of Jeevan Jal. These staff provide training and support supervision to FCHVs. Health Facility level and CARE staff used the Community Based-IMCI to train FCHVs. The majority of FCHVs knew the danger signs of dehydration and treatment using Jeevan Jal. They had little difficulty describing how to prepare Jeevan Jal.

As for mothers, only a few were able to name the danger signs of dehydration and describe how to make Jeevan Jal. However, they did mention the FCHVs were well stocked with Jeevan Jal and were able to get it when needed as there are Community Based Distribution Centers or Depots run by FCHVs or Mothers Groups. These depots are distribution outlets for Jeevan Jal and Safe Home Delivery Kits (SHDKs) and acoording to local NGOs very useful to the community. Many mothers also expressed a change in behavior since the beginning of the CS Project and are giving Jeevan Jal to their children when they have diarrhea and continuing feeding during the illness.

Several of the VDCs are contributing to the control of diarrheal disease by purchasing "blue cups" (they are used to measure water accurately for the preparation of Jeevan Jal). The "blue cups" are then given to households with children under the age of five. This demonstrates a great commitment to health issues at the community level.

Pneumonia Case Management

As with CDD, pneumonia case management is part of the IMCI course for health facility staff and CB-IMCI for FCHVs. The activities in the DIP for this intervention have been completed for years one and two. Health facility staff are very knowledgeable in pneumonia case management. One Sub-health Post In-charge told the interviewer he was very happy to have a timer for counting respirations since he did not know what was fast breathing before the training.

FCHVs' knowledge surrounding the identification, treatment and referral of pneumonia is quite good. The FCHVs that provide treatment seemed very committed and kept good records after review of the treatment register. The only weakness seemed to be that mothers' knowledge of the danger signs associated with pneumonia such as fast breathing and chest indrawing were weak and need to be strengthened.

Due to the increased knowledge and the ability to manage pneumonia cases, many FCHVs are highly visible in their communities. This in turn has raised their status and self-confidence. Several have even been elected as Female Ward Members.

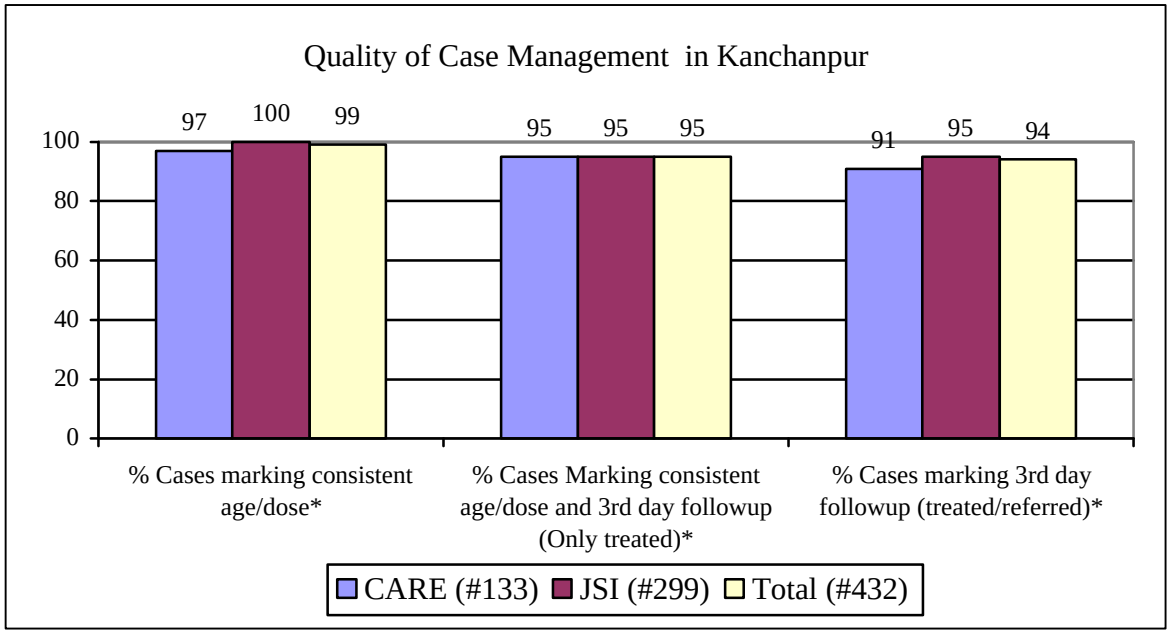
Another issue was with the sale of cotrim for the treatment of pneumonia. It seems the FCHVs are selling the cotrim as part of a cost recovery scheme while the health facilities are not. Also, only a few of VDCs have set up bank accounts or revolving funds for the FCHVs to put their money once collected and it was reported that one FCHV had lost her money. It is anticipated that both of these issues will be alleviated once the government Community Drug Program is implemented throughout the district at the VDC level. CARE will be assisting the DPHO in the implementation of this program.

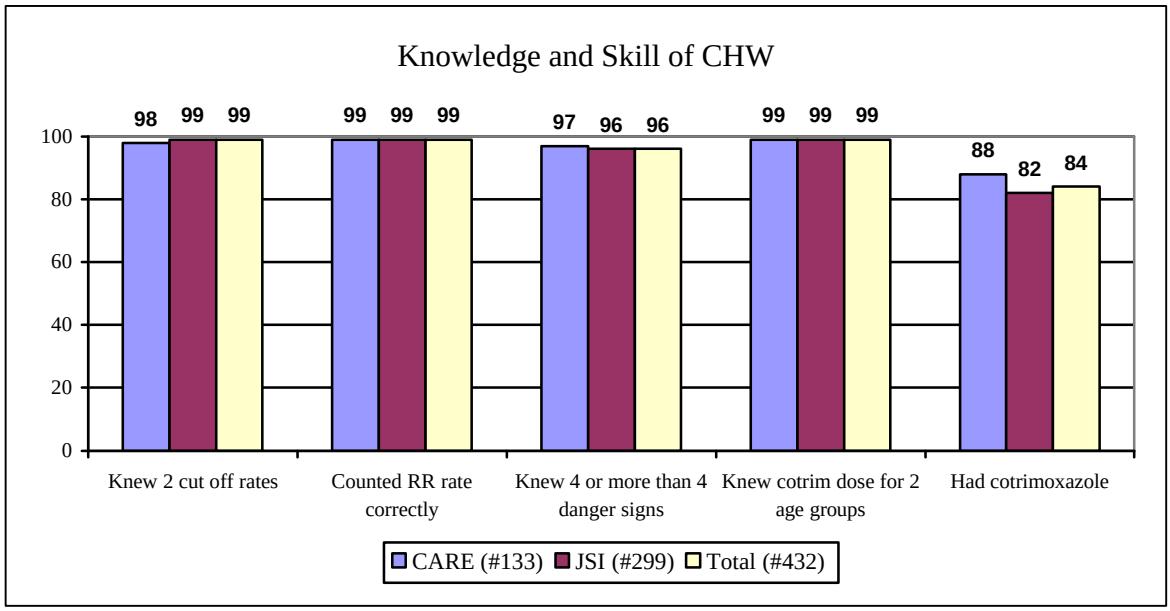
It was also found that the local medical shops had not been oriented on the CS Project interventions and require training on the rational use of drugs. Dr. Sun Lal Thapa of the CDD/ARI Section, Child Health Division of the Ministry of Health suggested that the orientation developed by WHO be used to train medical shopkeepers. On the other hand, several of the shopkeepers did state that they were dispensing fewer drugs for the treatment of pneumonia, which is a sign of fewer cases.

A real success of both the CDD and PCM programs is the close working relationship between the DPHO, JSI and CARE. JSI's mandate is to build the capacity of government health facility staff in child survival interventions in all districts throughout the country and has staff situated in five regional offices to do this. Thanks to the partnership with CARE in Kanchanpur, JSI has benefited from this division of labor without duplication of effort. JSI staff has been able to provide CARE with strong technical and supervisory skills while JSI has learned more effective ways to communicate with the community and how to increase participation in trainings using interactive games. Most importantly, both CARE and JSI work hand in hand with the DPHO to strengthen their technical and supervisory skills by making joint field visits, attending FCHV meetings to correct errors and analyze data with the HMIS person.

The following two graphs were provided by JSI and contain information collected from supervision visits conducted by both CARE and JSI. The first graph illustrates the high quality of pneumonia case management by FCHVs in

Kanchanpur. This information is obtained by reviewing the FCHVs treatment record book. The second graph demonstrates the knowledge and skill of the FCHVs and is collected through interviews and direct observation.





* 10 most recent cases

Maternal and Newborn Care

The CS Project addresses antenatal, delivery, postpartum and newborn care and focuses on improving community norms related to maternal and neonatal health

and health seeking practices. The main strategy is to mobilize pregnant women by mothers groups to practice healthy behaviors and optimal care seeking. In addition the CS Project staff are supporting the DPHO in promoting and sustaining the ANC/PNC services at the health facilities through capacity building of health facility staff, FCHVs and TBAs. As was mentioned in a previous section, husbands and mother in laws are also targeted as they are the main decision-makers at the household level and directly influence mothers' behaviors. To date all year one and two activities of the DIP have been completed in relation to this intervention. Some examples of these activities include: MOH Basic FCHV training; TBA Basic training; training and orientations for VDC members, women leaders, husbands and mother-in-laws on the importance of antenatal and post natal care; establishment of Safe Home Delivery Kit centers.

The knowledge at the health facility level regarding maternal and newborn care was quite good. The health facilities have sufficient supplies of IFA tablets and the staff knew the protocol for IFA tablet distribution. They also had sufficient vitamin A for post partum dosing. (No, I don't think this is all happening. Yes, the ONE SHP In-charge interviewed has the supplies and he and the staff know the protocols but that does not mean that the stuff is getting to the community, everyone seems to forget that this was NOT a comprehensive QUANTITATIVE MTE. What can one expect in only 3 days of field-work visiting only a few sites?) They claimed to have an increase in ANC/PNC clients since the start of the CS Project. One Sub-Health Post in-charge also mentioned that several of the trained TBAs in his area are attending more deliveries and have sold many of the Safe Home Delivery Kits which are also available through the Community Based Distribution Centers mentioned earlier. As for the Safe Home Delivery Kits, it seems that many medical shops have also noticed an increased demand. The MCHWs who provide the ANC/PNC in the community expressed frustration that there is not always a place to examine the women. Efforts are being made to get the community/VDC to provide a room for the clinics in some VDCs.

FCHVs knowledge of key messages as with all the interventions is quite good but did express that information regarding childbirth is the TBAs' responsibility. CARE did not originally give extensive training in maternal newborn care because it was always seen as TBA territory. Since the project, FCHVs have been consulted on a variety of issues related to maternal newborn care, so in their opinion, it would be helpful for them to have additional training. They also felt they were not reaching all pregnant/lactating mothers, i.e., marginal groups. They requested TBA training and more information regarding newborn perinatal care. (It was their opinion)

As for trained-TBAs, they were able to identify at least three danger signs during pregnancy, suggest post partum vitamin A to mothers and knew how to properly cut the cord. They also had sufficient supplies of SHDKs and said they had sold many. However, it is important to note that not all the trained-TBAs are the TBAs of choice at the village level and that this is common to many parts of Nepal and

not unique to Kanchanpur. Before the CS Project, the DPHO selected women from the villages for training, some of whom were never TBAs while the "popular" local TBAs were missed for training.

The most exciting of the activities is the orientation provided to husbands and mother in laws. It seems to have great potential for behavior change. The husbands and mother in laws who participated in the Maternal and Newborn Care Orientation were enthusiastic about the information they received, demonstrated improved knowledge and even expressed a change in practices. One husband felt he should be given TBA training so he can learn even more and share with other men in the community while other husbands said they are taking care of their children and taking their wives to health facilities.

Control of Malaria

According to the DIP, the CARE CS Project has a three-pronged intervention strategy:

1. Behavior modification for changes in the community. FCHVs and MGs will be used as change agents. Targeted behaviors will include care-seeking for children with fever, promotion of bed-nets, especially for children less than 2 years old and pregnant mothers, and environmental sanitation factors.
2. Improve treatment/quality of care through training and support through all levels of health facility staff and Mothers Groups on malaria prevention and appropriate case management.
3. Feasibility study for impregnated bed-nets in 3 VDCs based on EHP baseline and community interests.

CARE CS Project staff are working closely with the DPHO and EHP for the control of malaria. To date, the project has provided technical assistance in human resources for screening the malaria slides during malaria season in three health facilities that have been equipped. Due to the improved surveillance more cases are being detected and treated. FCHVs were provided a one-day orientation on malaria. Based on this most could name the messages regarding signs, symptoms and preventive measures. Currently, the MOH National Health Training Center, DPHO, EHP and CARE are conducting a cascade of training for all levels of health facility and community level workers in Kanchanpur. It is anticipated that this training will be finished in September 2001. (Madan, what is planned for the next two years?)

c. New tools or approaches

Some new tools or approaches, which have been adopted since the beginning of the project, are as follows:

- Formation of 19 FCHV Associations (one per VDC) to improve supervision and provide mentoring opportunities

- Development of FCHV directory and “pen pal” program
- Social Mapping in six VDCs by FCHVs in each cluster of her ward
- Intensive nutrition counseling along with distribution of “super flour”
- Community Data Board

The purpose of the FCHV associations is to provide a forum for self-monitoring, supervision, and peer learning and support. The development of the FCHV directory and “pen pal” program takes this a step further by providing more opportunities for FCHVs to interact by writing to each other. When asked about the associations and “pen pal” program, FCHVs felt that these forums would help compensate for professional constraints, lack of incentives and allowances. A positive byproduct of the FCHV Association formation is it provides the FCHVs with a more powerful voice in getting their needs met by local community leaders and health facility staff.

(The pen pal program is FCHVs writing to each other to get to know each other and I don’t believe there is any greater function then that. If the field has more to add, then so be it.)

Social mapping is being used by the FCHVs to better understand and know the community in their respective areas. The process has been elaborate and time consuming while the actual benefit is not known, i.e., what action if any the FCHV is taking to use them as a planning or intervention tool. The CS Project staff plan to look further at its usefulness at the community level.

(I don’t know who does the training. I assume it is the CHE/FHEs. I did not receive any information from the MTE team about FCHVs perceptions of the usefulness of social mapping nor did I conduct the interviews regarding social mapping with FCHVs.)

The intensive nutrition counseling (Ask the Kanchanpur office for a copy of the curriculum for what it includes if it is absolutely necessary to include this level of detail.) along with distribution of “super flour” has already been discussed in the section on Breastfeeding/Nutrition.

The Community Data Board contains demographic information and is used to record birth, death, illnesses and data related to indicators for the five key interventions in the FCHVs work area. The boards are located in front of the FCHVs house for the community to examine although the FCHVs house may not be located in an accessible or popular area for male and local leaders to examine. Mainly they are used during MG meetings where mothers and FCHVs discuss the information on the board. The data boards are consistent with HMIS data collected by the DPHO. They require money and time to build and maintain and may not be worth the cost. As with the social mapping, its usefulness needs to be explored. For example, how is the information being used, is it being used

for making decisions and taking appropriate action at the community level. If not, then interest in the two approaches will be lost.

2. Cross-cutting approaches

a. Community Mobilization

The essential community mobilization activities of the project to date are as follows:

- Orientations in the entire district to key stakeholders at all levels to increase involvement in project design and support
- Formation of 666 (I got this number from Indra's handout) Mother's Groups to expand knowledge and practice
- Health Post Management Committee
- Street Dramas

At the beginning of the CS Project, governmental and non-governmental organizations and community members were oriented to the goals and objectives of the projects, the five essential interventions and the strategies for carrying those out. As part of this orientation these essential stakeholders provided input for project design to increase ownership and sustainability of project activities once the CS Project ends in Kanchanpur. Given that people change and sometimes forget what was discussed, it was suggested that CARE CS Project staff reorient the key stakeholders about the project and focus more on the sustainability aspects of the project.

The formation of mothers groups has been very successful as a community mobilization tool. One group is formed by each FCHV in her area. MG meetings are held regularly and the knowledge of the attendees is quite good. They provide leadership for those who are uneducated. The MG attendees are being empowered but more effort is needed to take them from passive education recipients to active change agents in the community. There is a need for a mother-to-mother approach to increase coverage and improve knowledge. This includes role playing good communication skills, requesting each mother to reach out to 5 or 10 mothers, tracking these outreach efforts through and possibly providing incentives to those mothers that meet and effectively council mothers in the five intervention areas. (Ask the guy from Freedom from Hunger what he means by MTM since the group latched on to his terminology. That's where the idea came from.)

The Health Post Management Committees are at the VDC level and are responsible for the management of one health facility, i.e., HP or SHP. They are slowly becoming more active as a result of the project and will become even more active once the Community Drug Program has been implemented. They need to coordinate more with the DPHO, DDC, and LNGOs to identify needs and

concerns. This body also has the power to pressure S/HP staff in the area of performance.

Street dramas seem to be very successful in motivating the community. There is quite a bit of active participation and the dramas contain the correct messages. However, the actors could use more skill development to be more effective in training and some of the dramas need to be conducted in the local languages. It has been suggested that CARE will request some training for troupes by someone who was used to improve this method in other districts.

b. Communication for Behavior Change

The essential communication for behavior change approaches are:

- Individual Coaching/Counseling in the five intervention areas
- Trainings for key household decision makers such as husbands and mother-in-laws
- Design of pamphlets in local languages for low-literate populations
- Developed information cassettes containing songs about the five intervention areas

Individual coaching/counseling is part of each of the five interventions. Although this mid-term evaluation was qualitative and did not provide a representative sample of the entire district, it is safe to say that individual counseling requires strengthening to make it more effective. It has been mentioned that JHU/PCS will be providing training in this specific area, as it is their area of expertise. As part of the debriefing process it was also suggested that mother-to-mother counseling be explored.

The trainings for essential household decision makers such as husbands, mother in laws has been very successful, and there is even demand for more training. As was mentioned earlier in this report, even changes in practices have been noticed.

CARE had designed pamphlets in local languages for low-literate populations and although the FCHVs are happy to have the pamphlets they don't know how to use them effectively. It might help to field test the pamphlets with various mothers groups or actually have them help with the design so that they might be more effective.

The CS Project has also developed some cassettes with local singers who are actually health facility staff and FCHVs as the singers. These cassettes are in high demand although their effectiveness on behavior change has not been measured.

c. Capacity Building Approach

Strengthening the PVO Organization

Of the 31 CARE Nepal staff involved in the CS Project in Kanchanpur, 22 have worked in previous CARE projects. The majority of the staff received training in the following technical areas: IMCI/CDD/ARI; breastfeeding and nutrition; nutrition qualitative research; safe-motherhood and newborn care; gender; participatory learning appraisal; long-range strategic planning; malaria/Japanese Encephalitis; partnership management; teambuilding; traditional birth attendant; performance management; immunization; logframe planning; monitoring and evaluation; proposal writing; baseline quantitative research; health facility management training; and family planning.

In addition, some of the staff had the opportunity to attend the Annual CARE Child Survival Workshop in India for 2001 and Peru for 2000. From the CARE India project visits, they brought back the idea of distributing "bangles" to each woman who gets an antenatal check-up and how to better partner with NGOs. In Peru, they learned the benefits of and how to implement social mapping, household numbering and organization of CHV associations. The project manager, DDC chairman, and DPHO also visited CARE's CS project in Kenya. There they learned about their insecticide treated bed-net program, how to improve the community data board, strengthen CB-IMCI and effectively implement community drug schemes.

The CS Project management and field staff meet every three months for two days. During that time they discuss achievements to date in each program area, any problems and solutions associated with current implementation, program planning for future implementation activities and budget update. Sometimes staff-development training in the areas of teambuilding and management is conducted. In addition, the project management team, which includes the Project Manager, Community Health Officer, Social Mobilization Officer, Health Supervisors and other office staff, meets every week to plan the weekly schedule, discuss current problems and solutions, and management.

Strengthening Local Partner Organizations

The CS Project has both government and non-government partners. The government partners are the Child Health Division of the Ministry of Health at the national level and the District Public Health Office at the district level.

The project is working to develop technical, managerial and supervisory capabilities of the entire district health care delivery system. Although the project supports all levels of staff, the focus is on improving the capabilities of the FCHVs and TBAs. As was mentioned earlier in the report, FCHV associations have been formed at the VDC level. The formation of these associations provide

a community-based structure to support sustainability beyond the life of the project. This was also discussed in the section on new approaches.

The project has also identified four local NGOs at the VDC and municipality level. The NGOs were selected using a fair and objective process. At the municipality level, the Deputy Mayor has been dissatisfied and resentful of the activities carried out by local NGOs, as he would like to see NGOs selected with his political interests in mind. He also feels the process to recruit FCHVs for the municipality has been slow. In addition, there seems to be tension between those NGOs who were selected and those who were not. Some of the NGOs at the ward level are virtually nonexistent except by name only in government records. They also wanted to be included in CARE activities but were not selected during the screening process which has lead to tension.

At the VDC level, the relationship with local NGOs is much better. They have received training in all five intervention areas and used this information for teaching mothers groups. They are also responsible for the street dramas mentioned in an earlier section of this report. They are very positive about the training that they have received from CARE and about working with CARE. They desire more training.

Health Facilities Strengthening

The sustainable way to strengthen health facilities is through Health Post Management Committees, which were mentioned earlier. These committees have the potential to hold the health facilities accountable for their performance and maintain a sufficient drug supply.

The project also uses some eight different forms, which in addition to measuring project performance indicators also contains an IMCI Health Facility checklist for the monitoring and improvement purposes.

Strengthening Health Worker Performance

Health worker performance has been strengthened through improving technical and supervisory capacity by providing technical trainings in all five intervention areas and joint supervision at the field level. Given the discussions with the health facility staff regarding their knowledge, it seems the trainings have worked to strengthen their technical capacity and performance.

In the area of supervision, the DPHO mentioned they did not have a budget for supervision for this fiscal year. However, the MCHWs and VHWs in coordination with CARE field staff, CHE/FHEs, do supervise FCHVs through the monthly meetings and both JSI and CARE take the DPHO CDD/ARI focal person or other staff to the field for joint supervision of the CB-IMCI program.

Training

The project uses a cascade approach to training. Top DPHO and CARE Health supervisors are trained first and then involved in the training of the next level of health facility and CARE field staff. Depending on the intervention, the FCHVs are usually the final group to be trained jointly by CARE and government health facility staff. The FCHVs then provide training to Mother's groups.

In addition to the formal technical training, several orientations for community members and local leaders are also carried out.

To date, all of the trainings for years one and two in the DIP have been completed. Given the responses of the various groups interviewed during the evaluation, generally knowledge was very high and practices changed which illustrates the effectiveness of the training.

d. Sustainability Strategy

The entire CS Project has been designed with sustainability in mind—the thought that the project will end in four years. First, the project is structured such that CARE staff are supporting the DPHO staff rather than replacing them. It is hoped that by providing training to health facility staff at all levels, each level's technical capacity will be built and sustained. In addition to the five intervention areas, emphasis has been given to keeping stocks of necessary supplies at health facilities through proper planning and cost recovery schemes.

However, CARE is also very aware that there is high turnover within the DPHO and that the staff that they train may very well be transferred. Therefore CARE has put a stronger emphasis on building capacity at the community level through FCHVs, TBAs, mothers groups, VDCs, municipality and DDC. The thought is to empower communities to assume responsibility for their own health, enabling them to prioritize, plan, implement, maintain and evaluate local interventions through improved management skills, technical knowledge, resource generation and mobilization techniques.

Many of the specific activities related to sustainability have already been mentioned in other areas of this report. They include: mothers group formation; FCHV associations; Health Post Management Committees; working with local NGOs; and training in the five intervention areas.

With the emphasis on decentralization in Nepal, now is a good time to work with the DDC and VDCs, as they have budget for health activities. In some VDCs they have already shown their commitment to health by using the money to set up revolving drug funds and purchase other needed equipment. Some VDCs have even put money aside as an endowment for FCHVs. Finally, the DDC

Chairman has made the commitment in writing to continue support of the FCHV program after the CS Project has finished.

C. PROGRAM MANAGEMENT

1. Planning

The main players in the initial planning process were CARE and local headquarters staff with input from essential stakeholders through orientations and interviews. As has been mentioned throughout this report, CARE has completed all of the activities in years one and two of the DIP work plan. All of the parties have copies of the program's objectives and the monitoring plan. At the community level, they are well aware of the objectives of the project. The project monitoring data is collected and analyzed by field staff every three months and discussed at the quarterly meetings at which time project implementation may be adjusted based on the data analysis.

2. Staff Training

As was already detailed in Strengthening the PVO Organization section, there are many opportunities for staff development. In addition, CARE Nepal offers a scholarship program for further professional training for a small number of selected staff every year.

3. Supervision of Program Staff

During interviews with project FHE/CHEs, it was noted that they did not feel they were receiving valuable supervision often enough by their direct supervisors although they were pleased with the support they received from upper management. Although they meet with their supervisors during two-day quarterly meetings and during various training events, some stated that on average they met with their supervisors in the field less than 10 days a year. Several of the FHE/CHEs felt that they were more qualified in terms of field experience than their supervisors and were frustrated that they were unable to be promoted to supervisory positions just because they did not have the appropriate degree. It is the opinion of upper management in Kathmandu that this issue is really a "gender issue" as nearly all of the supervisors are women and must supervise male staff.

4. Human Resources and Staff Management

The morale of the CS Project staff seems very high and the group seems quite cohesive. It was mentioned that there was high turnover rate at the supervisor level while most other employees have been with CARE for more than five years. Essential personnel policies and procedures are in place and there are job descriptions for all positions at CARE headquarters and the field level. Prior to

the end of the project certain staff may be shifted to other CARE projects in Nepal while some employees may self-select to leave CARE to join another organization. The shifting of staff from project to project is quite common. Another problem with retaining staff is that many live very far from their families.

5. Financial Management

The financial officer for CSP Kanchanpur has worked for CARE Nepal for more than nine years. CSP Kanchanpur office uses the SCALA software package for financial reporting. The financial officer received a 15-day training in 1999 and will receive a refresher in October 2001. The Project Manager will also be receiving training in the use and benefits of SCALA.

According to the financial officer, the software system is easy and simple to use and workload and costs have been reduced since its implementation. More specifically, it possible to breakdown the expenses by intervention, activity, site/VDC, and partner organization, i.e., USAID vs. CARE Matching funds. SCALA is used for both expense reports and budgeting.

In addition, the financial officer can easily import the SCALA information into Excel, which is a more user-friendly format for the Project Manager, and other staff that need to review the records. The CSP Kanchanpur office financial reports are sent monthly to CARE's head office in Kathmandu.

The consultant reviewed several of the financial reports and found them very user-friendly. From review of financial reports and the internal audit from CARE/Atlanta it was determined that 46% of the total funds have been expended which is on target with no foreseeable problems.

In addition to project financial management, the financial officer has also trained the 11 NGOs in this area. He seems to take his role quite seriously and even expects others to do the same. The following quote from his office and training materials sums it up: "Finance is the lifeblood of any organization system. Without finance neither organization can be started nor successfully run."

6. Logistics

The CSP Kanchanpur office has a person assigned to logistics. Logistics management within the project is quite good with the exception of bad road conditions in certain seasons which delays transportation of materials and equipment. The only other major constraint is the current political situation. Due to Maoist activity, often times logistic support is disrupted.

7. Information Management

The CS Project information management system is quite elaborate. There are 8 forms used for data collection and analysis. Most of the forms are from the government or if not, contain government HMIS related information. The information is compiled by VDC. The form descriptions are as follows:

1. Indicator Based Reporting Format: CHE/FHE fills this form out in the field on a monthly basis and turns it in every three months. Information comes from FCHVs. The form tracks progress of the project indicators. It is incorporated into the Project Information Management System and sent to Kathmandu for the six-month report.
2. CB-IMCI Monitoring Forms: these are filled out in the field by all levels of field staff and compiled every three months.
3. TBA Monitoring Forms: collected every three months report every six months from CHE/FHE.
4. Maternal and Newborn Care Form: collected every six months from the FHE/CHE staff.
5. Child Health Form: used to collect information at FCHVs monthly meeting by CHE/FHE.
6. Health Facility CB-IMCI Form: collected during supervision visits analyzed every three months.
7. Nutrition Form: collected during FCHV monthly meeting and analyzed every month
8. Ward Register: reviewed during FCHV monthly meeting, reported every three months.

In addition to these forms others will be developed for the malaria intervention as the activities unfold. Overall, the level of data seems adequate and the staff possess the necessary skills to collect and analyze it. When asked if the amount of data collected was difficult or cumbersome field staff said, “No”.

All of the information collected is entered into the computer by the Community Health Officer and a report is prepared and shared with the DPHO. During our visits with the DPHO, the HMIS person mentioned that he would like to analyze the data together on a quarterly basis rather than CS Project staff conducting their own analysis and providing him with a report.

8. Technical and Administrative Support

The project received about three months of technical support from headquarters in developing the DIP, finalizing the first annual report and two monitoring/supervision visits. The project also received external consultants’ support in conducting the KPC Baseline Survey, Child Feeding Practices Qualitative Study, and organizing different training events. CARE also received training support and facilitator from Local Development Regional Training Academy to organize a “teambuilding” and gender training for the staff. The

Child Health Division of the MOH and JSI organized and supported IMCI training. EHP helped conduct the malaria baseline survey and planning of activities.

D. CONCLUSIONS AND RECOMMENDATIONS

Overall the CS Project in Kanchanpur is going very well and is on target according to the DIP work plan and meeting its objectives. As with all projects, even those that are doing well, there are some areas, which need improvement. The following is a list of what is going well, what is not going well and recommendations for change.

What is going well

Since the beginning of CARE's Child Survival Project in Kanchanpur, the following positive changes have been noticed by the key stakeholders of the project.

- Due to quality training and field support, FCHVs are quite knowledgeable in the five intervention areas.
- FCHVs are capable of treating pneumonia using cotrim and preparing Jeevan Jal for treatment of dehydration as well if not better than FCHVs in other districts. This is due to the additional supervision provided by CARE and JSI in coordination with the DPHO and health facility staff.
- FCHVs are receiving strong moral and financial support from the VDC, which has lead to a more significant and respected role in the community and will lead to the sustainability of the program.
- The number of active FCHVs has increased from 171 to 666, which has greatly increased coverage of services.
- Mothers Groups provide a forum for even uneducated women to discuss their health care issues and possibly leads to the resolution of problems associated with their needs.
- Mothers group meeting attendees have very good knowledge of key messages which has lead to increased community demand for health care services such as iron tablets, antenatal and postnatal care.
- DDC is taking an active role in coordination of health and development activities, better than in many other districts. (This is Lyndon's opinion)
- DDC has made a written commitment to continue the FCHV program beyond the life of the project, which may ensure the sustainability of FCHVs valuable role in the community.
- Rather than rely on the central government, some VDCs are beginning to take action regarding supply of drugs: community drug program, sale of the "blue cup" for Jeevan Jal preparation, and FCHV endowment.
- Capacity building and linkages with local NGO partners is taking place, which will hopefully lead to better sustainability.

- CHE/FHEs have strong commitment, knowledge about intervention areas and relationships with VDCs, which makes for a smooth transition when the time comes for the project to end.
- TBAs are able to identify at least three danger signs during pregnancy and can refer the pregnant women to an appropriate facility.
- DPHO is encouraged that maternal mortality is now being reported so that there is a baseline from which to work.
- DPHO has noted a decrease in the epidemic of diarrhea and a subsequent less demand for Jeevan Jal.
- Total malaria case detection has increased due to project coordination with DPHO and health facility staff.
- JSI and CARE staff are like a family, facilitating close and effective relations with the DPHO and DDC.
- The husbands and mother in laws who received an orientation on maternal and newborn care/nutrition had more knowledge than those who had not received and orientation.
- Oriented husbands and mother in laws indicated a change in practices.
- Sub-health post and health post staff have seen positive changes in health care seeking behavior, i.e., more women are attending ANC/PNC clinics.
- Training of SHP/HP staff in the five intervention areas has enhanced their capabilities in providing health services.

What is not working well

As per the interviews with key stakeholders and observations, the following was found.

- FCHVs are weak in the area of newborn care.
- Although CARE is not responsible for providing incentives, the FCHVs identified the lack of incentives as a major issue.
- Not all mothers, especially from marginal communities, have access to Mothers Groups. This may be due to lack of knowledge about MGs, migration in some areas of the district, lack of acceptance in the group or uncomfortable attending meetings. Each mother from the existing groups is supposed to reach at least five mothers and this is not happening due to lack of interest or time in sharing what they have learned.
- Process of recruiting FCHVs and implementing activities in the municipality has been slow and inadequate. Recruiting was initiated through the NGOs in collaboration with the DPHO, municipality and CARE and due to time constraints, the process was delayed.
- VDC female ward members have not been mobilized sufficiently for community level child survival activities because they have not been taking part in the MG monthly meetings in all VDCs or FCHVs monthly meetings.
- Tension between those NGOs who are involved in the project and those who are not because CARE is unable to provide assistance to all of the NGOs in the district.

- CARE and the DPHO are not jointly analyzing HMIS data effectively
- Medical shop owners are not aware of CS Project activities
- There is confusion regarding the sale of cotrim—FCHVs are selling while health facilities are not.

Recommendations

While deciding on recommendations, the evaluation team took into consideration possible constraints, which are beyond the control of the project, i.e., government transfers of health facility staff. It was important to the group that the recommendations be realistic and doable within the timeframe of the project.

- Strengthen FCHVs counseling skills for communicating with mothers by working with Johns Hopkins University Population Communication Services (JHU/PCS) in Nepal. JHU/PCS has been working in Nepal for many years and has been very successful in communication and behavior change for family planning, HIV/AIDS and these same communication principles can be applied to maternal and child health interventions as well as nutrition.
- Improve IEC materials and teach FCHVs to use them more effectively. Again JHU/PCS could provide the necessary training for the development of IEC materials.
- Encourage communities/VDCs to provide incentives for FCHVs. The Nepali Technical Assistance Group (NTAG) has extensive experience working with communities/VDCs and municipalities to provide incentives and financial support for FCHVs. Their experience could be very helpful to CARE.
- Empower MG members to counsel other mothers who are not attending meetings. JHU/PCS could provide the skills necessary for effective mother-to-mother communication.
- Identify specific strategies to address the needs of marginal groups. Many groups in Nepal claim to be working with marginal groups and it might be worthwhile for CARE to identify those groups and learn from them.
- Continue orientation for husbands and mother in laws and add other topics. This was initiated by CARE and should continue. CARE may want to find out if other PVOs or local groups are doing the same in other districts in Nepal to learn more about what works and what doesn't.
- Orient medical shop owners on the rational use of drugs using the existing MOH curriculum. Dr. Sun Lal Thapa of the Child Health Division of the MOH has been conducting this training for years in the districts with CB-IMCI and it should also be conducted in Kanchanpur.
- Refresh DDC/DPHO/Municipality/NGOs on the project intervention strategies and partnering issues. Local leaders and government personnel need to constantly be updated on project ideas since staff change due to transfers and elections.
- Collaborate every three months with DPHO on the analysis and use of HMIS data.
- Provide further training to local NGOs conducting street dramas including local dialects and expanding coverage area. CARE has already used

someone to do this in other districts where it has projects and should get that person again also JHU/PCS could be of use as they have trained several street drama groups.

- Further orient female ward members on CS Project interventions and encourage active involvement.
- Implement the Community Drug Program in all VDCs. There are already plans to do this through the DPHO and CARE has plans to assist with CDP implementation.
- Provide refresher training in maternal and newborn care to all health workers at all levels including FCHVs. Since maternal and newborn care seems to be the weakest of the interventions, a small informal study may need to be conducted to determine if the interventions are doable and realistic.
- Learn from other newborn care projects in the country such as DFID-funded MIRA Project in Makwanpur.

ATTACHMENTS

A. INFORMATION FROM THE DIP

1. Field Program Summary:

PVO/Country: NEPAL
Program duration: September 30, 1999 to September 29,2003

ESTIMATED PROGRAM EFFORT AND USAID FUNDING BY INTERVENTION

Intervention	% of Total Effort (a)	USAID Funds in $ (b)
Nutrition	20%	$ 200,000
Breastfeeding Promotion	10%	$ 100,000
Control of Diarrheal Disease	20%	$200,000
Pneumonia Case Management	15%	$150,000
Control of Malaria	15%	$ 150,000
Maternal and Newborn Care	20%	$ 200,000
Total	100%	$ 1,000,000

PROGRAM SITE POPULATION: CHILDREN AND WOMEN (c)

Population Age Group	Number in Age Group
Infants (0-11 months)	10,661
12-23 Month Old Children	9,831
24-59 Month Old Children	32,814
Total 0-59 Month Olds	53,306
Women (15-49 years)	66,630

- Estimated annual number of live births in the site: 12,707

- Source of the population estimates: HMG Ministry of Population and Environment, June 1998 report

2. Program Goals and Objectives

Goal:
To reduce maternal and child mortality in Kanchanpur district.

Objectives: By the end of September 2003:

- **Behavioral:** Caregivers of children below five years of age, particularly mothers, will be practicing healthy behaviors and seeking medical care from trained sources when needed.
- **Increased access to services and supplies:** Families will have increased sustainable access to health education, quality care, and essential medicines.
- **Institutional:** Local and community-based institutions and local NGOs with capacity to support child survival activities on a sustainable basis will be developed or strengthened.
- **Quality of Care:** MOH personnel, FCHVs, TBAs and other service providers will be practicing appropriate case management of diarrhea, pneumonia, malnutrition, and maternal and newborn care.

Goal: TO REDUCE MATERNAL AND CHILD MORBIDITY AND MORTALITY IN KANCHANPUR DISTRICT OF NEPAL

Decrease the % of malnourished children below two years (<-2 SDs) in the project area by:

- Weight for height from 16.4% to 14%
- Weight for age 26.5% to 24%
- Height for age from 24.4% to 21%

Decrease the % of children under 2 who have had diarrhea in the past two weeks from 28% to 20%

Decrease the % of children under 2 who have had signs of pneumonia (rapid or difficult breathing, or chest in-drawing) in the past two weeks from 31% to 20%

Goals	Indicators	Measurement Method	Major Activities
Behavioral: Caregivers of children below 5 years, particularly mothers, and pregnant women practicing healthy behavior and seeking medical care from trained source when needed	**Nutrition:** **1.** Increase the % of mothers who initiated breastfeeding within 8 hours of birth from 90% to 95% **2.** Increase the % of mothers practicing exclusive breastfeeding for at least six months from 40% to 60% **3.** Increase the % of mothers introducing complementary foods at six months from 42% to 60% **4.** Increase the % of children 6-24 months who consume vegetables, fruits and foods rich in vitamin A from 55% TO 75% **Control of Diarrheal Disease:** **5.** Increase the % of under 2 children (who had diarrhea in the past two weeks) who were given the same or more: a. Breastfeeding from 80% to 90% b. Liquids from 34% to 75% c. solid/semi solid food from 52% to 75% **6.** Increase the % of children under 2 who had diarrhea in the past two weeks who were treated with ORS from 2% to 50% **7.** Increase % of mothers who can correctly demonstrate how to prepare ORS from 11% to 50%	1. KPC baseline and final 2. KPC baseline and final 3. KPC baseline and final 4. KPC baseline and final 5. KPC baseline and final 6. KPC baseline and final 7. KPC baseline and final	1. Training of TBAs/mothers on importance of breastfeeding soon after birth 2. Training of TBAs/mothers/FCHVs on importance of exclusive breastfeeding for six months 3. Training of mothers/FCHVs on supplementation/weaning practices 4. Training of mothers/FCHVs on supplementation/weaning practices 5. Training to FCHVs, HP and SHP post staff and private sector service providers on diarrheal case management 6. As per #5 7. As per #5

Goals	Indicators	Measurement Method	Major Activities
	Maternal and Newborn Care: **8.** Increase % of mothers from 6% to 40% who consumed iron folic acid supplements for at least 3 months in last pregnancy **9.** Increase % of families having a birth plan* from 28% to 75% **10.** Increase % of mothers having used a Safer Home Delivery Kit (commercial or home made) for last delivery from 16% to 30% **Pneumonia Case Management:** **11.** Increase %of mothers who seek medical care from a qualified, trained provider (HP, SHP, hospital, PHC, trained FCHVs) from 38% to 75% when their child has signs of pneumonia (fast or difficult breathing) **Malaria:**** **12.** Increase the % household having bednets and using them for all household members from … to … in the operations research area	8. KPC baseline and final 9. KPC baseline and final 10. KPC baseline and final 11. KPC baseline and final 12. EHP baseline and KPC final	8. Education/counsel FCHVs/mothers/TBAs on increased need for iron folic acid during pregnancy. 9. Counsel TBAs/FCHVs/pregnant women and family decision-makers on birth planning, including use of SHDK 10. See #9 11. Train mothers/FCHVs/HP and SHP staff/druggists on appropriate pneumonia case management. 12. Promotion of malaria prevention (including bednets) through community volunteers, local leaders and local media
Increased access to services and supplies: Families have	**Nutrition:** 1. Increase % of children 6-24 months receiving vitamin A supplement every six months from 79% to 90% 2. Increase the % of women receiving vitamin A	1. KPC baseline and final; LQAS during mid-term 2. KPC baseline and	1. Educate/counsel mothers/caretakers on GLVs, fuits and Vitamin A rich foods and

Goals	Indicators	Measurement Method	Major Activities
increased sustainable access to health education, quality care and essential medicines	supplements within 45 days after delivery from 25% to 75% **CDD:** **3.** Increase % of FCHVs from 65% to 95% who have ORS for distribution with them **4. Maternal and Newborn Care:** 5. Increase % of mothers who have had 2TT during their last pregnancy based on home-based maternity cards from 3% to 25% **Pneumonia Case Management:** 6. Increase % of communities from 0 to 50% who have Cotrimoxazole access (through FCHV or drug schemes) **Malaria:** 7. Increase the % of communities (through FCHVs or drug schemes) where anti-malarial drugs are available throughout the year from 0 to 75% **General:** 7. Increase in % of wards where ORS, clean birth kits, IFA and cotrim are available year round to 80%	final; MoH records 3. FCHV interviews at baseline, midterm and final 4. KPC baseline and final 5. Rapid assessments, community managed data 6. Rapid assessments, community managed data 7. Rapid assessments, community managed data	requirements of Vitamin A supplementation and promote their participation in National Vitamin A campaigns 2. See #1 3. Training of FCHVs and promote for ward level drug schemes 4. Educate/counsel mothers about the importance of TT, support for static immunization centers and campaigns 5. Promote community revolving drug schemes and facilitate linkages in the community among FCHVs, mothers group, VDC and HP/SHP 6. See #5 7. See #5
Quality of CARE: MoH personnel, FCHVs, TBAs and other service providers	**CDD:** 1. Increase the % of children with diarrhea who receive appropriate case management in the health facility from 12 to 50% 2. Increase the % of FCHVs who can correctly demonstrate preparation of ORS from 71% to	1. Health facility assessment 2. Quality of Care assessments 3. Quality of Care	1. Training of Health Post/Sub health post staff on diarrhea case management, promote supportive supervision

Goals	Indicators	Measurement Method	Major Activities
practicing appropriate case management of diarrhea, pneumonia, malnutrition and maternal and newborn care	95% and those who practice proper standard case management of diarrhea according to MoH protocol to 85 % 3. Increase the % of private health care providers & pharmacists who practice standard case management of diarrhea according to MOH protocol to 50% **Maternal and Newborn Care:** 4. Increase the % of women who have had at least two prenatal visits during their last pregnancy from 19% to 40%(based on recall) & from 3% to 25% (based on cards) 5. Increase the % of mothers who had their last delivery attended by a trained provider from 19% to 30%. 6. Increase % of TBAs providing neonatal care as per protocol 7. 85% of MCHW and VHW are trained & practice protocol for antenatal delivery and post natal care 8. 85% of TBAs practicing obstetric first aid and making appropriate referrals for complications **Pneumonia Case Management** 9. Increase % of FCHVs, health post/sub-health post staff private health care providers and pharmacists who correctly diagnose and manage pneumonia cases according to protocol to 50% **Malaria:**** 10. Increase the % of FCHVs and health post/sub-health post staff (VHW) who correctly diagnose	assessments 4. KPC baseline and final; community-managed data 5. KPC baseline and final; community-managed data 6. Quality of care assessments 7. Health worker skill assessment 8. Community-managed data 9. Health facility assessment, quality of care assessments 10. Health facility assessment, quality of care assessment 11. Health facility assessment	2. Training of FCHVs and supportive supervision 3. Training and follow up of druggists 4. Educate/counsel FCHVs/TBAs, mothers and other family members about the danger signs and importance of antenatal care and birth plan 5. Educate/counsel TBAs, FCHVs, mothers, family members on safer motherhood, basic newborn care and birth planning 6. Training of TBAs on neonatal care and safer motherhood 7. See #6 and supportive supervision to TBAs 8. Training of FCHVs, druggists, health post/sub health post staff on pneumonia case management and supportive supervision 9. Training of FCHVs,

Goals	Indicators	Measurement Method	Major Activities
	high, low or no risk of malaria and manage according to protocols **General** 11. 85%of community level MoH staff (VHW and MCHW) and volunteers (FCHV and TBAs) receive at least one supervisory visit in the last quarter		druggists, health post/sub health post staff on malaria case identification and management and supportive supervision

Goals	Indicators	Measurement Method	Major Activities
Institutional: Local and community-based institutions and local NGOs developed/strengthened which have capability to support child survival activities on a sustainable basis	1. 90% of wards have at least one Mothers Group with demonstrated history of health promotion activities and plans for future IEC activities 2. 80% of wards have at least 3 operational Mothers Groups 3. 50% of Mothers Groups are able to plan and monitor (through analysis of community level data) local health activities 4. 50% of Mothers Groups are linked with other development resources and skills 5. 30% of wards (through MGs, FCHVs or other mechanisms) have established functional community health funds (for EOC and possibly other purposes) and mechanisms for cost-recovery for SHDKs, ORS and Cotrimoxazole 6. 75% of FCHVs are involved in health education and community mobilization efforts 7. FCHV associations supporting their members with strong links to the VDCs and MoH health facilities are established and operational in 60% of VDCs 8. All NGO partners (2-3) have project planning processes and a monitoring plan in place. 9. 90% of VDCs commit some financial support to CS activities at the community level 10. 50% of health post and sub-health posts have revolving drug scheme in place	1. Community-managed data, rapid assessments 2. Community managed data, rapid assessments 3. Review of community managed data, rapid assessments 4. Rapid assessments 5. Rapid assessments 6. Quality of care assessments 7. Rapid assessments 8. NGO reports and visits 9. Review of VDC budget allocations 10. Health facility assessments	1. Mothers groups reformed/formed, trained and supported 2. See #1 3. Training on data management 4. Support for developing functional linkages with VDC, NGOs and other agencies/schemes 5. Community education of need for emergency health funds and support for establishing the community health funds/cost recovery mechanisms 6. Training of FCHVs and supporting supervision 7. Support FCHVs to be united to form FCHV Association and promote supportive supervision from HP/SHP and linkages with VDCs 8. Training of NGOs on planning processes and monitoring/evaluation

Goals	Indicators	Measurement Method	Major Activities
			9. See #5 and support Health Post and Sub Health Post Management Committees to establish drug schemes

* birth plan definition can be found on page # 80
** Malaria indicators will be finalized after the EHP baseline is complete.

3. Program Location

The CARE NEPAL Child Survival XV project is located in the Kanchanpur district, which is in the Far Western Terai, a lowland area. The district shares its southern border with India and occupies an area from 28.33^{o} to 29.8^{o} north latitude and 80.3^{o} to 80.33^{o} east longitude. It is oval in shape and covers a land area of 1,610 square kilometers (163,377 hectors). It ranges in altitude from about 159 meters to 228 meters above sea level. The temperature can reach a high of 42^{o} C in the summer and a low of 14.7^{o} C in the winter. The annual mean rainfall is approximately 155 millimeters. Until fifty years ago, the area was considered unfit for habitation due to malaria, with only an indigenous population of Tharu in the jungle environment. The malaria eradication program has opened up the area for settlement and today there are more than 343,440 people in the district.

The rural areas are divided into 19 Village Development Committees (VDCs) and a semi-urban municipality of Mahendranagar. Each VDC is further divided into nine Wards, each of which comprises a cluster of 3-4 villages/communities. There are 19 wards in the municipality. The literacy rate of Kanchanpur is 39%. Male and female literacy rates are 41% and 23% respectively. Local self-government structures are present and active from ward to the district level but are dominated by men. There is reservation for 1 women representative in the elected ward development committees but beyond that data from five VDCs show that there is not a single women VDC chairperson or vice-chairperson and even at the ward level there is only one women chairperson in 45 ward.

TARGET POPULATION AND BENEFICIARIES

The target population of the project is 53,306 children under five and approximately 66,630 women of reproductive age.

INTERVENTIONS	TARGET BENEFICIERIES
Maternal Nutrition/Breast Feeding, complementary feeding (women of reproductive age and children under 5)	119,934
Diarrhea Case Management	53,306
Pneumonia Case Management	53,306
Maternal & Newborn Care	66,630 women + 10,661 infants =77,291
Malaria*	119,934 *
Total	119,934

*For health education activities, all VDCs will be targeted but operational research will be undertaken in only three VDCs.

HEALTH INSTITUTIONS/FACILITIES IN THE CS XV WORKING AREAS

Although the region has experienced massive in-migration and population growth, it has not seen a corresponding increase in health facilities. As a result, communities do not have easy access to treatment and the network of other facilities, such as pharmacies and private providers, is poor. The MOH is the primary provider of preventive health services and curative care is divided equally between the MOH and a network of trained or untrained private care providers (49% according to the baseline survey). According to the Department of Health Services, the Sub-Health Post (SHP) is the first contact point for basic health services. Each SHP is staffed by three categories of health service providers: Community Medical Assistants (CMAs), Maternal and Child Health Workers (MCHWs), and Village Health Workers (VHWs). CMAs are responsible for facility-level activities, while MCHWs and VHWs provide community-based outreach services such as primary health care and home visits. The SHP also acts as a referral center for the TBAs and FCHVs.

This referral hierarchy is designed to ensure that the majority of clients have access to public health care and minor treatment at a price they can afford (DHS, Annual Report 1997/98). The hierarchy starts with the SHP then proceeds to the HP, the PHC, the district hospital, the zonal hospital, and finally the tertiary care centers in Katmandu.

In Kanchanpur, the one zonal government hospital with 50 beds is fairly well equipped, but is grossly understaffed (67% or 64/96 of positions filled) especially in categories of medical officers. There is no obstetrician or anesthesiologist and inadequate drug supplies. Although medicines for preventive health care (deworming, IFA, Vitamin A etc) and first line antibiotics and essential obstetric drugs (cotrimoxazol, ampicillin, amoxycillin, syntocinon , ergometrine, IV fluids) are available, second line antibiotics are in short supply. There are two PHCs, with limited in-patient facilities (3 beds and no laboratory facilities or functioning X-ray equipment). Overall, in the two PHCs, 77% (10/13) of staff positions are filled.

Every VDC has either a Health Post (HP) or a Sub Health Post (SHP) covering a population of 16,000 to 22,000. There are eight HPs, eleven SHPs and two Ayurvedic hospitals. The HPs and SHPs in this district are at the same level and cover separate population jurisdictions, leaving the referral chain with less one link. A HP has five categories of staff: Health Assistant (HA), Auxiliary Health Worker/Community Medical Assistant (AHW or CMA), Auxiliary Nurse Midwife (ANM), Village Health Worker (VHW) and Peon. SHPs have four categories of staff: AHW, VHW, Maternal Child Health Worker (MCHW) and Peon. There are also Female Community Health Volunteers (FCHVs) and Traditional Birth Attendants (TBAs), who are community level volunteers. HPs and SHPs are having 94% positions filled and lack of drugs seems to be the main problem. Access to health facilities is not adequate in the district . Although waiting time at health facilities is not excessive, travel time varies greatly. Some families in remote villages can access health facility only by foot even that maybe difficult during rainy season. Antibiotics are generally free in MOH facilities, but there are stock-outs about three-fourths of the year.

An MOH investigation found that mothers gave the following barriers to access:

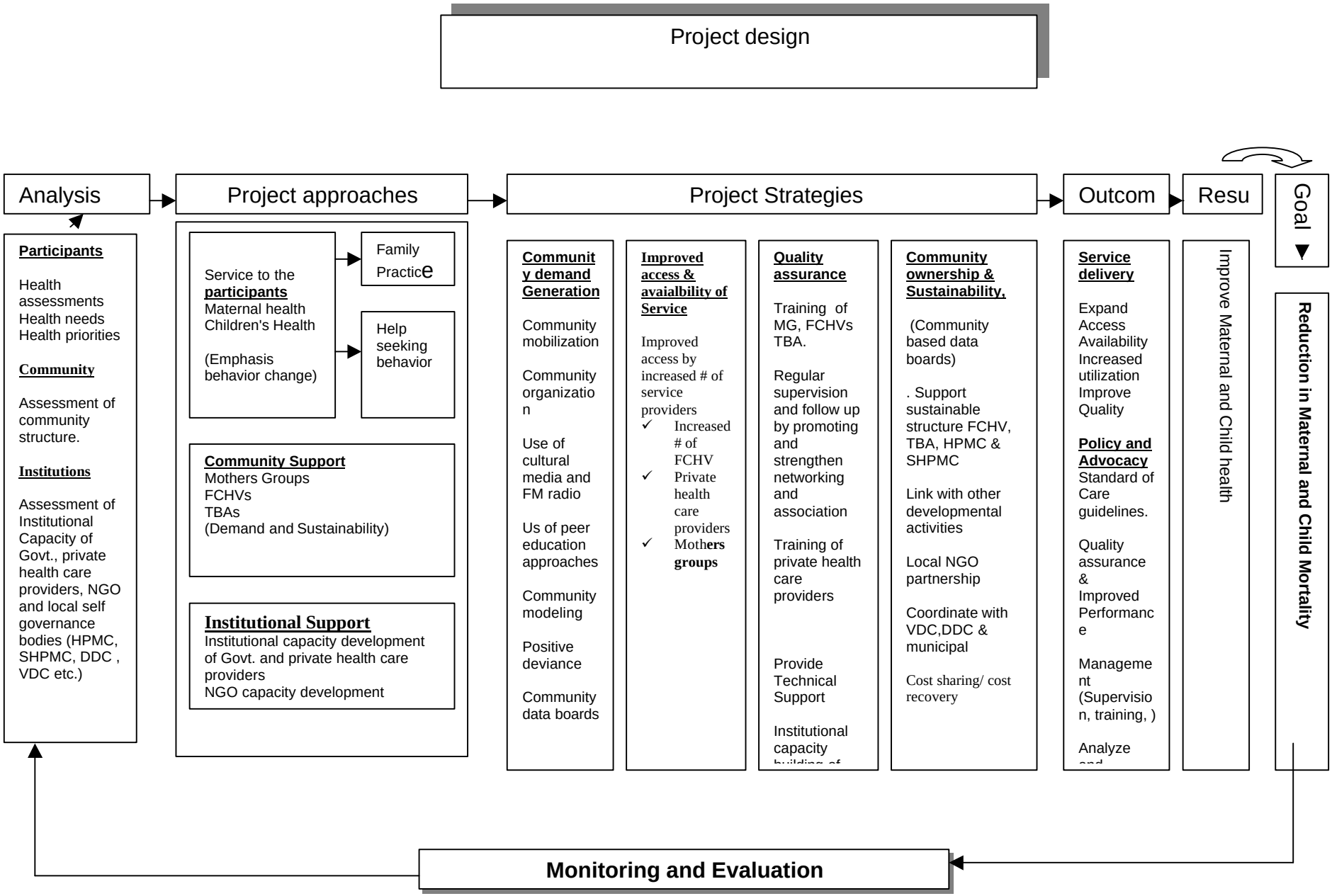
- No one else in the house could assume their responsibilities while they were away from home.
- No money for treatment.

- The health facility was located too far away.
- Mothers inability to identify danger signs or recognize the seriousness of situation .

Subsequently the government focus was changed to train FCHVs and allow them to prescribe drugs

4. Program Design

The project design assumes that if families and communities are shown that healthy home-based practices and care-seeking behaviors reduce morbidity and mortality, they will adopt the healthy behaviors. However, adoption of behaviors in such situation is dependent on availability and accessibility of affordable quality services, as well as a supportive community environment. Based on these assumptions, four strategies have been incorporated: community demand generation, improving access and availability of services, ensuring quality and developing mechanisms to sustain these services.


Project design
Analysis
Project approaches
Project Strategies
Outcom
Resu
Goal
Participants
Health assessments
Health needs
Health priorities
Community
Assessment of community structure.
Institutions
Assessment of Institutional Capacity of Govt., private health care providers, NGO and local self governance bodies (HPMC, SHPMC, DDC , VDC etc.)
Service to the participants
Maternal health
Children's Health
(Emphasis behavior change)
Family Practice
Help seeking behavior
Community Support
Mothers Groups
FCHVs
TBAs
(Demand and Sustainability)
Institutional Support
Institutional capacity development of Govt. and private health care providers
NGO capacity development
Community demand Generation
Community mobilization
Community organization
Use of cultural media and FM radio
Us of peer education approaches
Community modeling
Positive deviance
Community data boards
Improved access & avaialbility of Service
Improved access by increased # of service providers
✓ Increased # of FCHV
✓ Private health care providers
✓ Mothers groups
Quality assurance
Training of MG, FCHVs TBA.
Regular supervision and follow up by promoting and strengthen networking and association
Training of private health care providers
Provide Technical Support
Institutional capacity
Community ownership & Sustainability,
(Community based data boards)
. Support sustainable structure FCHV, TBA, HPMC & SHPMC
Link with other developmental activities
Local NGO partnership
Coordinate with VDC,DDC & municipal
Cost sharing/ cost recovery
Service delivery
Expand Access
Availability
Increased utilization
Improve Quality
Policy and Advocacy
Standard of Care guidelines.
Quality assurance & Improved Performance
Management (Supervision, training,)
Analyze
Improve Maternal and Child health
Reduction in Maternal and Child Mortality
Monitoring and Evaluation

5. Strengthening of Local Partner Organizations

The Social Welfare Council (SWC) is the national coordinating counterpart for all international NGOs, including CARE in Nepal. It is an independent body created by Government of Nepal to regulate and monitor activities of all INGO/NGO in Nepal.

For this project, CARE has both government and non-government partners. The government partners are the Child Health Division in the Ministry of Health at the national level and the District Public Health Office at the district level.

The project will work for development of technical, managerial and supervisory capability of the health care delivery system. Since health care services at the outreach level are dependent on village level health workers and community volunteers (FCHVs and TBAs), the project will focus on developing their technical capabilities and developing FCHV associations at VDC and DDC levels. Federating FCHVs at different levels will provide a community-based structure to support sustainability beyond the stipulated life of the project.

The project advisory committee will also identify two or three local NGOs as local partners in collaboration with SWC. Objectives for this partnership will be institutional development for local NGOs to improve their capabilities for implementation of child survival activities on a sustainable basis. Local NGOs will be strengthened for overall implementation of the project in designated geographical areas. Their responsibilities will include all or some of following actions:

- ✓ Community mobilization and social sanction for project activities from community leaders
- ✓ Formation and strengthening of mothers groups
- ✓ IEC activities at the ward, VDC and municipality level
- ✓ Training of Female Community Health Volunteers (FCHVs), TBAs and other private health care providers
- ✓ Community-based data management
- ✓ Project monitoring and supportive supervision

Building Capacities of Ministry of Health and Other Health Service Providers

According to the organizational structure of the Ministry of Health the Sub Health Post (SHP) functions as the first contact point for basic health services such as immunizations, antenatal check ups, and first-line management of basic ailments. But in reality, the SHP provides these services only to the communities living in the ward in which it is located. For other wards, the SHP acts as a first referral center and basic health care services are provided by village-based volunteers (FCHV/TBA), private health service providers and traditional healers. The referral hierarchy goes from the SHP to the Health Post, the Primary Health Centers, Zonal Hospital, Regional Hospitals and finally to the specialty tertiary care centers in Katmandu. This structure is designed

to ensure that the majority of public health and minor health problems receive attention in an accessible place at an affordable price.

HUMAN RESOURCE BASE OF GOVERNMENT IN KANCHANPUR

Institution	Sanctioned	Filled
A. ZONAL HOSPITAL (1)	96	64
Dist. Public Health Office (1)	31	27
Primary Health Center (2)	26	20
Health Posts (8)	56	50
Sub Health Posts (11)	44	44

In Kanchanpur district, the Department of Health Services provides preventive, promotional and curative health services through one Zonal Hospital (fifty beds), one District Public Health Office, two Primary Health Care Centers, eight Health Posts (HP) and eleven Sub Health Posts (SHP). The District Public Health Office manages all the HPs, SHPs and Primary Health Centers (PHC) in the district. The Zonal Hospital has an annual budget of around US$84,000. Similarly, the annual budget of the DPHO, including PHC, HPs and SHPs, is around US$53,000. The budgets for medicine for each PHC, HP and SHP are around US$700, US$400 and US$200 respectively.

Health Posts and Sub Health Posts are managed by Health Management Committees comprising six members each, including the VDC Chair, the person in charge of the facility (Member Secretary), one headmaster of a local school, the nearest Ward Chair, a social worker and a politician.

The District Public Health Office implements activities related to child health (immunization, nutrition, control of diarrheal diseases, acute respiratory infection), reproductive health (family planning, safer motherhood,) and disease control (malaria, tuberculosis, leprosy, HIV/AIDS) through PHC, HPs and SHPs. About 94% of the total sanctioned positions of Health Posts and Sub Health Posts are filled.

There are 171 trained Female Community Health Volunteers (FCHVs) in the area and half are estimated to be active by DPHO and other sources. There are 172 trained TBAs in the district actively conducting safer home deliveries and provision of other maternal and neonatal health care services, but the services are of very poor quality. The functional relationship between different levels is not clearly defined e.g., DPHO with PHC, PHC with HP/SHP, HP with SHP. The supervision and monitoring mechanisms, especially at community health facilities (TBA, FCHV and HP/SHP), are very poor.

The Zonal Hospital provides out and in-patient clinical services and maternal and child health services. It has 18 sanctioned positions for medical doctors, but only six are currently filled. Similarly, out of the 27 sanctioned nursing positions, only 10 are presently filled.

Government health services are generally poor in terms of quality and coverage. Although each of the five project interventions are addressed at each level, the coverage rates and utilisation is abysmal due to poor quality of services, poorly-trained and unmotivated staff, lack of effective supervision, and insufficient supplies and drugs. Due to systemic and structural problems, the nature and scope of the services depend on the motivation of the individual providers. In addition, retention of trained staff is a problem,

especially at the district level. The project will advocate with central, regional and district authorities for recruitment, training and posting of local staff, in the belief that they are more likely to remain in the area. An agreement will be sought from local authorities that staff will not be transferred during the life of the project or for at least two years, except in extraordinary circumstances.

Building capacities of local NGOs

This project will assist two or three local NGOs to develop the necessary skills in promoting behavioral changes for improved child survival and developing sustainable systems at VDC and Municipality level. These NGOs will mobilise community structures for improved community surveillance mechanisms to bring accountability in government health services. Bringing increased community awareness about child survival issues can help in mobilisation of additional community resources (VDC fund and savings generated by mothers' groups) that government does not control.

The PAC will select two or three local NGOs for partnership, using CARE Nepal's partnership guidelines (see Annex VIII). The partnership manager based in CO will also participate in the selection process. Steps followed will include

- ✓ Development of specific selection criteria for this project
- ✓ Call for letter of interest
- ✓ Preliminary screening of the organisations
- ✓ Request for proposals from the selected organisations
- ✓ Review by the PAC
- ✓ Final selection.

Capacity of the selected organizations (participatory decision making, mission and vision of the NGO, gender policy, transparency in fund management, planning, implementation and management skills of the staff etc) will be assessed.

There are 360 registered local NGOs in the district but only 19% are actively involved in developmental activities. A large number are involved in non-formal education. Six are also involved in reproductive health, HIV/AIDS education, nutrition and health education activities related to child survival objectives. . These NGOs are uniquely placed to provide efficient and sustainable services. However, these organisations are new and hence lack analytical problem solving skills and project management and accounting experiences, in spite of strong commitments to developmental causes. CARE will provide institutional developmental support to these NGO to develop into strong, sustainable community-based institutions over time.

The project will closely co-ordinate with NNSWA, FPAN and the Nepal Red Cross for improved access to clinical services.

Capacity Building of Local Self-governance Bodies and Community-based Associations

With passing of new laws related to local government (Village Development Committees, District Development Committees and Municipality) in mid-1999, these bodies have greater authority, resources and responsibilities and are in a better position to address community needs. The VDCs are also responsible for managing village level health centers, health post and sub health posts through the Health Management Committees. There is a lack of a sense of ownership of health services at local government level as the local government bodies (VDC, DDC) are not properly oriented in the management of HP and SHP. In addition, at present they lack the capacity to adequately manage and do not fully appreciate their roles, responsibilities and authority. The project will work with the DDC and VDCs to develop their capacity in health planning, decision-making, management, monitoring and evaluation.

Kanchanpur District Development Committee has decided to assign the elected Woman Ward Member in each VDC as the Ward Coordinator for health activities. However,

health-related technical knowledge and leadership skills of those women are very limited. With the assistance of experience local and national NGOs, the project will enhance the capabilities of Ward Coordinator through Leadership Development and Participatory Planning and Management training. The project will also help the Ward Coordinator establish linkages among FCHVs, the FCHV Association, mothers groups and Ward Level Coordinators.

The VDC's funding comes from the annual Rs. 500,000 received from HMG for rural development, and receivables from local charges, levies, rents and fines. The main financial sources of the Municipality are land taxes, service fees, charges, duties and grants from the government.

The project will assist the FCHVs to organize their own associations at theVDC level. The project will support the FCHV Association in developing an institutional development plan and motivate the DPHO, Health Post/Sub Health Post and VDC to support the FCHV Association. The project will provide support to implement the institutional development plan of FCHV Association.

6. Health Information System:

To avoid duplication of data collection, the project will support the government HMIS by building their capacity. The project will not develop any new formats for facility level unless the govt. HMIS does not supply needed information. The project will explore possibility of piloting MER in Kanchanpur. The project will focus on at collecting information on outcomes and developing systems for collecting population-based data. Only those data that can be used for decision making will be collected. Project participants, community groups and government health care providers will be trained in data analysis at every level so that it can be used for decision making. All data will be fed back to the community through community-level organizations, such as mothers groups, VDC, DDC and the governmental systems. The information will be displayed prominently in every ward on community data boards. The possibility of using household mapping, pictorial depiction of this data and use of pocket charts by the members of mothers group will be explored.

Data collection by mothers groups: Community-based data collection will start with members of mothers group collecting information monthly from the 4-5 mothers in their neighborhood. Data will be collected orally and verbally reported at monthly meetings, where they will be compiled and recorded by literate members, and shared with other members. Mothers groups (especially the ward coordinator and FCHV/TBAs) will be trained to analyze information and use it for decision making.

Data collation at the ward level: By the time 2-3 mothers groups will be formed in a ward, responsibility for data collation will rest with the senior FCHV. By this time, the project would have recruited sufficient new FCHV to support individual mothers groups. Collated information will be shared with other members of the ward committee for

making an action plan. Most of these ward committees are non-functioning. The project will try to reactivate them and submit a copy of the information to project staff as well.

Data collation at the VDC level: During the initial phase, the CHE/ FHE will collate information at the VDC level and give it to the HP and SHP management committees. Responsibility will gradually be handed over to FCHV/TBA associations, as well as MCHW and VHW. The information will also be provided to the project health supervisors and put on the agenda of management committee meetings. The HPMC will be trained to analyze the data for use in decision making, and to compare the community-based data with health facility records. Initially project staff may participate in management committee meetings, but gradually this responsibility will be handed over the FCHV associations.

Collation of information at the project level: The health supervisors will collate the information and give it to the DPHO and DDC. The CHO and the project manager will try to participate in district level meetings and develop a mechanism whereby population-based data will be used to validate the facility-based data routinely collected by district HMIS. Over time this community-based information should be an integral component of district level health planning.

Community data boards: Information collected by the mothers groups will be compiled and prominently displayed on community data boards for one full year so that trends can be effectively analyzed and proactive measures initiated. This is based on the assumption that communities must analyze their own problems based on actual data and develop pragmatic and feasible action plans in order to control their own health in a sustainable manner. The mothers groups will decide with support from FCHV on the information to be collected and how it should be depicted. The following tables gives an example of possible structure of the data board.

Start date		Male Female
# of Pregnant women	0-6 months	
# of women aged 15-49 years	6-12 months	
	1-5 years	
	# of children measured for MUAC*	
	# malnourished using MUAC	

Indicator	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
General # of new pregnancy registered # of births #of maternal deaths # of children(below 5 years) deaths												
Diarrhea # of cases												

#of cases having used ORS												
PCM # of cases with ARI # of cases of Pneumonia # of cases having received treatment from trained personnel using Cotrimoxazole												
Nutrition # of pregnant women having one extra food at least for 15 days in a month # of mothers who put the child to breast immediately after birth # of mothers who give only breast milk to their child aged less than 6 months during last month # of mothers starting appropriate complementary foods at 6 month of age												
MNC # of mothers who received 2 antenatal check up # of pregnant women in second and third trimester who took IFA tablet for at least 15 days in the last month # of pregnant women who received second TT dose during the current pregnancy or 5 doses in their lifetime. # of deliveries conducted by trained personnel # of antenatal cases who have birth plan # of women who used SDK during their deliveries # of postnatal women who received a dose of Vit A.												
Malaria # of cases with fever # of cases visiting trained worker/health facility												

Data analysis, use and dissemination: At monthly mothers meetings, information will be compiled and handed over to the next level (CHE/FHE or VHW and ward committees).

It will be compiled and sent to the S/HP management committees as well as project health supervisors. Health supervisors will submit it to project staff, where it will be computerized and analyzed quarterly. This quarterly report will be shared with the PAC, DDC and the DPHO office, and used to make major project decisions. Computerized reports of the whole project will also be sent to the Child Health Division of MOH and the VDC.

The project accepts the monitoring and evaluation guidelines provided by the USAID and does not proposes any changes.

B. TEAM MEMBERS AND THEIR TITLES

1. Kimberly Allen, Consultant
2. Lyndon L. Brown, Advisor for Child Health and Nutrition, USAID/Nepal
3. D. P. Raman, Program Specialist, USAID/Nepal
4. Krishna Poudel, CHD – Representative, CDD / ARI Section, Ministry of Health, Kathmandu
5. Purushottam Acharya, Health Sector Coordinator, CARE Nepal
6. Namita Kukreja, Program Associate – Children's Health, CARE Atlanta
7. Sanjay Kumar, Technical Specialist – Research Method, CARE India
8. Sita Ram Devkota, Community Health Specialist, CARE Nepal
9. Madan Raj Thapa, Project Manager, CARE Child Survival Project, Kanchanpur
10. Indra Ghimire, Community Health Officer, CARE Child Survival Project, Kanchanpur
11. Pradeep Adhikari, Social Mobilization Officer, CARE Child Survival Project, Kanchanpur
12. Indra Shah, Health Supervisor, CARE Child Survival Project Kanchanpur
13. Ganga Sapkota, Health Supervisor, CARE Child Survival Project Kanchanpur
14. Tanka Pant, Child Health Field Officer, JSI Dhangadi Office
15. Til Kumari Gurung, Project Manager, Child Survival Project, Save the Children USA, Nepal

C. ASSESSMENT METHODOLOGY

Objectives of the mid term evaluation

According to USAID guidelines, the purpose of the midterm evaluation is to:

- Assess strengths and weaknesses of the project
- Make recommendations to revise the strategies in the remaining project period

Methodology

Using qualitative and participatory methodologies, 15-member multi-disciplinary team undertook the evaluation process. The team was comprised of representatives from USAID, MOH Child Health Division, CARE Nepal, CARE India, CARE Atlanta, JSI, Save the Children US and independent consultant. Field visits were conducted in the following 6 VDCs and the Municipality area of Kanchanpur District from August 15, 2001 to August 20, 2001 –

- VDCs - Dodhara, Chandani, Krishnapur, Suda, Shreepur and Kalika
- Municipality – Mahendranagar

A variety of qualitative methods including group discussions, individual interviews, in-depth interviews and observations were used to gather information related to project activities in terms of their processes and progress. The evaluation process at the district level were conducted as per the following plan-

Day 1	Developing tools (approximately 15 sub-groups for interviews/checklists)
Day 2 – 4	Field visits to 6 VDCs by different teams for conducting interviews (group and individual), observations, discussion
Day 5	Information processing session
Day 6	Debriefing with partners in Kanchanpur

D. LIST OF PERSONS INTERVIEWED AND CONTACTED AND DOCUMENTS REVIEWED

During the field visits the following people were interviewed –

- 63 mothers in 5 Mother Group meetings
- 21 FCHVs in 5 groups
- 14 members of the Village Development Committee in 4 groups
- 3 TBAs
- 3 HP / SHP staff
- 5 MCHW / VHW
- 5 CARE's CHE / FHE
- 2 Trained husbands
- 1 Untrained husbands
- 4 Trained mothers-in-law
- 2 Untrained mothers-in-law
- 3 Medical shop owners
- Staff of 3 local NGO partners
- 6 staff from DPHO office
- Chairman and vice-chairman of DDC
- Mayor

During the field visits the following additional project activities were observed –

- 2 street dramas
- 2 community data boards
- 1 social map

Persons contacted at Kathmandu –

- H. D. Shah, Director of Child Health Division
- Sun Lal Thapa, In-charge, CDD/ARI Section, Child Health Division
- Panduka M. Wijeyaratne, Director, USAID - Environmental Health Project

List of documents reviewed –

- Child Survival in the Kanchanpur District of Nepal: New Project Proposal Submission to USAID PVO Child Survival Grants CSXV. December 4, 1998. CARE
- Child Suvival in Kanchanpur District, Nepal: Detailed Implementation Plan. Submitted to USAID/BHR/PVC March 31, 2000. CARE
- CARE Nepal Child Survival XV Project: Knowledge, Practice and Coverage Baseline Survey in Kanchanpur District. January 2000.
- Child-Feeding: Traditions, Practices and Beliefs. CARE Nepal Child Survival Project, Kanchanpur District. July 2000.

- CARE Nepal Child Survival XV Project Kanchanpur District First Annual Report. October 1999 to September 30, 2000.