MITRA

Partners for Tuberculosis Control in Banten Province, Indonesia

Mid Term Evaluation Report

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ABBREVIATIONS AND ACRONYMS

ACD	Assistant Country Director
ACSM	Advocacy, Communication, and Social Mobilization
BAPEDA	*Badan Perencanaan Daerah* or Planning Board at province level
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
BHS	Basic Human Services
CBO	Community-Based Organization
CBS	Community-Based Structures
CDR	Case Detection Rate
CII	CARE International Indonesia
CNR	Case Notification Rate
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
DAP	Development Assistance Program
Depkes	*Departemen Kesehatan* or Ministry of Health
DHO	District Health Office
Dinkes	*Dinas Kesehatan* or Health Office (can be at province or district level)
DIP	Detailed Implementation Plan
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment Shortcourse
Dukun	Traditional Healer
FA	Facility Assessment
FBO	Faith-Based Organization
FDCs	Fixed Drug Combinations
FO	Field Officer
GFATM	The Global Fund to fight AIDS, Tuberculosis, and Malaria
GOI	Government of Indonesia
HIV	Human Immunodeficiency Virus
HSP	Health Services Project
IDAI	*Ikatan Dokter Spesialis Anak Indonesia* (Indonesian Pediatricians Association
IDI	*Ikatan Dokter Indonesia* (Indonesian Physicians/Medical Doctors Association)
IEC	Information, Education, and Communication
ISTC	International Standards for Tuberculosis Care
Kabupaten	District, Regency
KAP	Knowledge Attitudes Practice
KNCV	*Koninklijke Nederlandse Centrale Vereniging tot Bestrijding der Tuberculose* or Royal Netherlands Tuberculosis Association
Kota	City
KPC	Knowledge Practice Coverage
MDR	Multi-Drug Resistant
MITRA	*Membangun Integrasi Program Tuberkulosis di Republik Indonesia*

MO	Medical Officer
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization
NTP	National Tuberculosis Program
PCI	Project Concern International
PM	Project Manager
PMO	*Pengawas Menelan Obat* or Treatment Observer
Posyandu	*Pos Pelayanan Terpadu* or Integrated Health Post (child growth, monitoring and IMCI- based screening post at village Level)
Polindes	*Pondok Bersalin Desa* or Maternity Hut at Village Level
PKK	*Program Kesejahteraan Keluarga* or Family Welfare Program (Voluntary organization led by wives of administrators)
PKM	*Puskesmas*, sub-district level Public Health Center (urban and rural)
PPs	Private Practioners
PPTI	*Persatuan Pemberantasan Tuberkulosis Indonesia* or the Indonesian TB Association
PS	or *Puskesmas Satelit* or Satellite Health Center (urban and rural)
PVSM	Poor, Vulnerable, and Socially Marginalized people
QA	Quality Assurance
SO	Strategic Objective
TB	Tuberculosis
TBCAP	Tuberculosis Control Assistance Program
TBCTA	Tuberculosis Coalition for Technical Assistance
TC	Training Coordinator
TO	Tuberculosis Officer at DOTS Center (*Puskesmas*)
TSR	Treatment Success Rate
USAID	United States Agency for International Development
WASOR	*Wakil Supervisor* or the District TB Coordinator
WFP	World Food Program
WHO	World Health Organization

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A) Summary

Overview of the Project:
CARE International Indonesia (CII) is working in four districts of Banten province-Tangerang district, Pandeglang district, Cilegon City, and Tangerang City, with the primary implementing partners - Indonesia's National Tuberculosis Program (NTP), KNCV (Royal Netherlands TB Association), participating District Health Offices, primary government health centers (*Puskesmas* with DOTS facility) and government/province planning board (*BAPEDA*). The project named MITRA – ***M****embangun* ***I****ntegrasi Program* ***TB*** *di* ***R****epublik Indonesi****a*** ("Partners for TB control in Indonesia") falls in the "Tuberculosis" grant category and dedicates 100% of its resources to improving TB control and treatment activities. The duration of the project is from October 2005 to September 2009. The project's goal is to support NTP in decreasing morbidity and mortality caused by tuberculosis in the project population of 6,188,365; achieve 85% Case Detection Rate (CDR); and maintain at least 88% Treatment Success Rate (TSR). The project aims to target 47,000 patients in four years, out of which smear-positive or active pulmonary TB cases are expected to be 19,667. About 807 communities are expected to benefit from the project's interventions. The strategic objectives of MITRA are: 1) To create sustainable community-based TB control structures 2) To strengthen the delivery capacity of the district and provincial TB Program; 3) to increase private sector participation in the TB Program.

Main accomplishments:
The project has demonstrated establishment of some innovative community based structures and individuals like the *Paguyubans* who support patients visiting health centers (*Puskesmas*) and promote positive health seeking behaviors; TB posts which enables DOTS provision closer to the community; Community Based Treatment Observer (CBTO) Coordinators who provide supportive supervision to the treatment observers (who are mostly family members) and improve their linkages with the health centers. The proportion of people who thought TB was curable has gone up from 31% at baseline to 50% at midterm. Similarly there has been an 87% (data extrapolated from Quarter 2 data for 2007) increase in suspected patients seeking diagnosis in health centers. The project did well in identifying poor performing areas through a composite score card for initiation of project activities thus providing more than three years of implementation period to these areas.

Progress in achieving project objectives:
MITRA has exceeded targets in terms of identifying and training treatment observers in poor performing areas. MITRA has not expanded beyond 25 health center areas (107 in project area) covered in the first year of project implementation. The Behavior Change Communication Strategy (BCC) has been articulated recently and the use of BCC material is minimal. Therefore the achievements listed above cannot be solely attributed to project efforts. The project is beyond schedule in committed indicators for capacity building of private providers. The committed coverage for communities has not been possible owing to a delay in expansion of project activities. Project does not have any

structured partnership with CBOs (Community Based Organizations) or NGOs to aid expansion of activities. The committed trainings of health center staff could not be executed by MITRA due to the district/provincial health office's requests and availability of the global funds within the government apparatus.

Constraints and Problems and Areas needing further attention:

The trainings that the government said would be conducted with Global Funds could not be carried out due to temporary suspension of funds in Indonesia. Two training coordinators left the project while replacement for one was found; the project is still looking to fill the other position. The CII is working towards a reshuffling of roles and responsibilities of staff and job descriptions to make the project work more responsively to the work plan. Advocacy and relationship between project and the district/provincial health offices need strengthening. Similarly there is a need for strengthening the managerial and community skills of the health center and district TB officers.

Effects of Capacity-Building:

The capacity building of community and the community based volunteers (CBTOs and CBTO coordinators) have been carried out successfully resulting in a growing awareness of the population, improved health seeking and treatment completion. The capacity building for health center staff needs to be reworked owing to changing realities and MITRA may do well to consider enhancing the managerial and community skills capacity of the public providers. Similarly within the capacity building strategy for Private Providers there is a need for training sessions on BCC and partnership modalities.

***Prospects of Sustainability*:**

There is no phase out plan as of yet. The establishment of Community Based Observer (CBO) Coordinators has a high prospect of sustainability as Community Based Treatment Observers (CBTO), who are mainly family members, may not wish to continue their role after the treatment of their kin. The government is highly committed to involving private providers and MITRA support in improving the quality of their trainings will ensure continuing positive TB outcomes. The Child Survival Sustainability Framework (CSSA) workshop has not been carried out as yet.

Conclusions:

In conclusion, the project is behind schedule. The MITRA activities are taking place in 25% of the project areas. Community mobilization efforts have been made in these areas demonstrating some scalable models. Introduction of the cadre of CBTO coordinator presents the possibility of a sustainable structure who can act as a link between the community and the facilities.

Recommendations for the Project and the Grantee's Response

1. Coordinate with Dinkes and Puskesmas

a) Expand activities to cover more than 25 *Puskesmas* areas. Sign MOU's as planned with able local NGO/CBO partners to achieve expansion.

Grantee's response - The project is expected to scale up into the remaining puskesmas in each district, prioritizing the weaker ones.

b) Improve information sharing with the *Puskesmas* through structured methods for better utilization, monitoring and sustainability of strengthened community structures and individuals.
Grantee's response -The project will systematically use the quarterly Monitoring meeting at the puskesmas level for better coordination and utilization of volunteer efforts by linking them to the puskesmas.

c) Rethink the trainings that MITRA wants to give at the *Puskesmas* level. Who will be trained? What will be the content? How will this be done? Drop the indicators pertaining to training of *Puskesmas* staff. Consider managerial and leadership training for *Puskesmas* staff if NTP restarts technical trainings for them through the latest round of GFTAM funding.
Grantee's response -To date the project has worked with the MOH at district and province levels. The project will continue to work together with them as per the unfolding scenario of global funds. It appears that Pandeglang district will justifiably need more support in terms of difficult to reach areas and high staff turnover.

d) Jointly with the *Dinkes*, investigate the use of recommended score cards for pediatric diagnosis to identify reasons for over diagnosis and train providers to address the situation (either through MITRA funded trainings or through NTP). Use quarterly monitoring meetings to underline the need for using standardized pediatric score cards. Assess the need for capacity building and advocate for fulfilling the gaps in capacities.
Grantee's response -The project will work with the Dinkes and the IDAI local chapters to focus attention on proper diagnosis and management of pediatric TB, using the national score cards.

e) Through regular analysis of monitoring reports and field feedback, identify drug/lab/reporting issues and advocate for resolutions at appropriate forums. Advocate for resolution of issues related to sharing of drug boxes and unavailability of streptomycin at provincial and national level.
Grantee's response -The project together with the Dinkes will systematically monitor reports at all levels for early identification of areas of weakness and work with the partners to resolve them.

f) To ensure drug stocks and that individual boxes are meant for only one patient. Seek help at different levels to address this issue.
Grantee's response -As this has been identified as an issue of significance, MITRA will review this immediately in the identified districts and work with the Dinkes to resolve this issue.

g) Conduct CSSA framework workshop and monitor sustainability indicators.
Grantee's response -The project will conduct the CSSA workshop with its partners.

2. BCC Related

a) Conduct a workshop of all key stakeholders to finalize the draft BCC strategy. Quickly adapt, produce and disseminate IEC materials to community based partners and the *Puskesmas*.
Grantee's response -A BCC workshop will be conducted shortly. Points (b) and c) below will be a part of the BCC workshop.

b) Include messages on side effects, HIV – TB linkages and MDR TB to the appropriate extent. Address some of the identified misconceptions about TB (using same utensils will cause TB, TB is sexually transmitted, TB patient should be isolated) which generate stigma.
Grantee's response – Please see point (a) above

c) Advocate for development of linkages between TB-HIV programs, as Banten is deemed as a high HIV prevalence area.
Grantee's response – Please see point (a) above.

d) Remove the indicator "100% increase (from 30% to 60%) in knowledge of symptoms of TB and its curability in the community" as this is already captured in two other indicators and is merely repetitive.
Grantee's response - Accepted

e) Rephrase indicator "at least 20% increase in the number of TB suspects from 6,560 in 2005 to 7,800 by September 2009 combined for the 4 districts." – to read " at least 40% increase in number of suspected TB patients reaching or screened by the *Puskesmas* in four project districts from 27,953 in 2005 to 39,134 in 2009."
Grantee's response -The project accepts the suggestion on the indicators above.

3. Strengthening of CBOs

a) Build on successful experiences of community groups, *Paguyubans* and CBTO coordinators.
Grantee's response -The project will rapidly scale up these experiences in all districts except Cilegon.

b) Utilize the simple monitoring formats to measure outputs and outcomes of CBTO/Volunteer activities.
Grantee's response - Monitoring formats will be revisited and used to measure the outputs and outcomes of volunteer activities.

4. Working with PP - Piggy back with MOH/KNCV initiatives

a) KNCV is planning to work with Hospitals and larger clinics in Indonesia and a collaborative effort with them would be mutually beneficial.
Grantee's response - The project has already sounded out KNCV to work with them in the hospitals of Banten Province.

b) Develop a simple monitoring format for issues not covered by existing TB formats – support required, problems faced – which can be used by the PP to communicate with the *Puskesmas*.
Grantee's response - The project will develop DOTS TB related material for PPs to make their diagnosis, counseling and referral simpler and more systematic.

5. **Improve Coordination with NTP at all levels to expand definition of coordination to include problem solving.**

a) Discuss with NTP the support required to bridge the gaps in quality diagnosis. Identify the role that MITRA can play. In case that NTP does not require MITRA support then, follow up, monitor, share findings and advocate for improving quality.
Grantee's response - The project will coordinate with NTP at national, province and district levels to bridge identified gaps. The project will use the mechanism of the quarterly meeting forum to do so.

b) Develop a specific, written strategy for engaging decision-makers. District, provincial and national level interactions should be utilized to avert possible quality assurance related issues in a timely manner.
Grantee's response – The project will develop a specific written strategy to engage with decision makers.

Recommendations for Scaling up and Down

1. Cilegon has been performing well on the DOTS indicators and the linkages between health centers and the communities are well established. MITRA can consider phasing out community activities in Cilegon and support improvement of quality in private provider trainings.
Grantee's response -Though MITRA was expected to phase out of Cilegon, some activities like PP trainings and BCC related activities especially for HIV and MDR will be undertaken in Cilegon as per the request of the Dinkes team.
2. Consider working with CBTO coordinators as against CBTOs. Since most CBTOs are family members, their interest in continuing as CBTOs beyond the treatment of their kin is moot. Scale up *Pagyubans and TB posts.*
Grantee's response - MITRA will now focus primarily on CBTO coordinators.
3. Drop identified indicators which are either redundant or cannot be achieved (owing to change in government stance)
Grantee's response -We accept this recommendation.
4. Consider dropping COPE for DOTS quality monitoring indicators. For example proportion of providers both government and private who are using BCC principles and IEC materials for TB suspects and patients.
Grantee's response - CARE Atlanta will follow up with EngenderHealth and CRS to see if the TB COPE is possible in given circumstances. If it is found to be difficult in the next 6 months, then MOH quality monitoring indicators for DOTS will be used.
5. Dovetail the government's efforts to train private providers by enhancing the community and managerial aspects of their skills.
Grantee's response - As suggested MITRA in conjunction with the MOH will do some pilots and study outcomes.
6. MITRA has done exceptionally promising work in some areas like working with the religious leaders for BCC. This should be scaled up. However, it is running into obvious impediments in its work with Village Health Committees. MITRA is also considering the PP as only the doctors while in Indonesia the PP includes the

Midwives, who are also doing private practice, or government midwives who can practice privately after office hours. Hence the recommendations are:

a) Scale up work with Religious leaders as what we saw in the field was good and maybe that will be effective for BCC.
b) Reducing the number of PPs to be reached from 150 to 50 and then scale up, if success is met, or clarify the number 150 to include PPs + Bidans + private clinics etc.
c) Reduce the work with village health committees to 30- 50 pilot villages and scale it up based on lessons learnt.
Grantee's response – As recommended MITRA will work more intensively with religious leaders and document the effectiveness of this approach, and will include the bidan training as training of PP and MITRA will draw lessons from both these experiences to scale up. The project will also intensively pilot its work with 30 VHC and study the results before scaling it up.

Point to Ponder for USAID

1. TB programs worldwide are very structured and rigid which makes it difficult for NGO partners to carve a role for themselves. Further the role carved is restricted to some aspects, with no controls on other aspects of DOTS. However, DOTS does not work until all five components come together. There is a need for future project designs to envisage a larger and more active role for local missions and TBCAP partners, to ensure that the factors outside the control of NGO partner can be advocated at a higher level.
2. Consider incorporating an indicator pertaining to 'initial defaulters'. These are people who approach care provider and are diagnosed to be sputum positive, but are not put on treatment. This indicator can act as an indicator to assess quality of service provision within the control of NGO.

Grantee's Responses to MTE recommendations
Please see above

Action Plan

Please See Annex (E)

Note – *Some generic and specific responses have already been noted above. The specific action plan will cover more broad and cover other significant areas in the recommendations as given by the consultant.*

B) Assessment of the Progress – Technical Approach

The Mid Term Evaluation (MTE) MITRA project was carried out between 30 October and 15 November 2007. The evaluation process included a Knowledge Practices and Coverage (KPC) survey and a participatory qualitative analysis. It is important to note while interpreting findings that while the sampling universe for the KPC was the entire project area, the sampling for qualitative analysis was done in those areas where the project has initiated activities.

1. Overview of the Project

CARE International Indonesia is working in four districts of Banten province, located on the country's most populous island, Java: Tangerang district, Pandeglang district, Cilegon City, and Tangerang City (large urban center), with the primary implementing partners - Indonesia's National Tuberculosis Program (NTP), KNCV (Royal Netherlands TB Association), participating District Health Offices, primary government health centers (*Puskesmas* with DOTS facility) and government/province planning board (*BAPEDA*). The project will strengthen tuberculosis (TB) control efforts in these four districts of Banten province, a USAID priority province. The project named MITRA – ***M****embangun* ***I****ntegrasi Program* ***T****B di* ***R****epublik Indonesi****a*** ("Partners for TB control in Indonesia") falls in the "Tuberculosis" grant category and dedicates 100% of its resources to improving TB control and treatment activities. The duration of the project is from October 2005 to September 2009.

The project's goal is to support the NTP in decreasing morbidity and mortality caused by tuberculosis in the project population of 6,188,365; achieve 85% Case Detection Rate (CDR); and maintain at least 88% Treatment Success Rate (TSR).

The project districts accounted for 68.6% of TB cases (all types) in the province and had a CDR of 62.8% at the time of proposal design. The project aims to target 47,000 patients in four years, out of which smear-positive or active pulmonary TB cases are expected to be 19,667. About 807 communities are expected to benefit from the project's interventions.

At the time of DIP preparation it was found that the Cilegon district had exceeded WHO/NTP and MITRA's end of project targets. Therefore, it was decided that activities in Cilegon would focus more intensively on Private Provider and industry collaboration, an intervention proposed under operations research. After deliberations with the CII team, the district MOH/ DOTS team, the provincial MOH/DOTS team, the KNCV representative in Banten, the local USAID mission, and with USAID (Washington, DC) approval, CARE added the Pandeglang district to its geographical working area.

Pandeglang was a larger district and did not have 100% DOTS coverage. Consequently it was decided that the project will focus on the entire district with advocacy and capacity building activities (the latter restricted to the *Puskesmas* staff) and community level activities will be undertaken in 10 to 15 *Puskesmas* areas which had operational zed DOTS strategy.

The project's Strategic Objectives (SO) are:

1. To create sustainable community-based TB control structures
2. To strengthen the delivery capacity of the district and provincial TB program
3. To increase private sector participation in the TB program.

The project commits to addressing three (text in bold) of the five components of the DOTS strategy: (1) Sustained political commitment; **(2) Access to quality-assured TB sputum microscopy; (3) Standardized short-course chemotherapy for all cases of TB under proper case management conditions, including direct observation of treatment;** (4) Uninterrupted supply of quality-assured drugs; and **(5) Recording and reporting that enables outcome assessment**.

2. Progress Report

This section describes the activities planned during the DIP under each Strategic Objectives; progress towards benchmarks; effectiveness of the interventions; successes; constraints and recommendations. The progress on monitoring indicators is presented at the end of this section so that ample perspective could be developed.

***Important methodological note*:** KPC and NTP data are for the entire project area. The qualitative evaluation is restricted to 25 *Puskesmas* areas where project has ongoing activities.

2.1 Strategic Objective 1: To create sustainable community-based TB control structures

2.1.a. Planned Activities and their Effectiveness

The objective of building sustainable community-based structures aims to improve TB care seeking, treatment adherence and decrease default rates among the project population. Baseline KPC surveys revealed that though more than 86% of the respondents knew that TB is curable, only 31% could cite common symptoms of TB. Further the barriers to achieving cessation of TB transmission were related to care seeking. The project found that there are no dedicated sustainable structures for promoting TB awareness, referring suspects, observing treatment; and that the linkages between the community and the health facilities were weak especially in Cilegon city. This was further compounded by care seeking through a chain of traditional healers and private practitioners. Besides being expensive this delayed and worsened the patient's condition. MITRA aimed to address these constraints by improving community TB care

seeking behavior and providing support to patients to complete treatment through trained cadre of observers and volunteers

The Strategic Objective one has the following output level objectives:

a) Build capacity of community-based organizations to implement TB control activities
b) Build capacity of volunteer health workers to generate community awareness and support TB patients and their families to fully participate in DOTS
c) Use Behavior Change Communication (BCC) to increase the TB health-seeking practices of the community.

In the first year, as described in the first annual report, CARE met with key stakeholders and a decision was taken to initiate project activities in poor performing areas of each district. The partners (CARE and local Ministry of Health officials) identified the poor performing areas in each district based on criteria which included TB program data, staff performance, availability of local NGO/CBO/FBOs, availability and capacity of health *kaders* (volunteers at village level), number of TB patients detected (the TB dense pockets), hard to reach populations (accessibility problems) and proportion of poor people living in the area.

A scoring system was developed based on the above mentioned criteria and a total of 25 out of 107 project *Puskesmas* were selected for implementation in the first year, with the distribution as follows: three (out of 8 in Cilegon), six (out of 30 which had DOTS in Pandeglang), six (out of 25 in Tangerang city) and ten (out of 40 in Tangerang *Kabupaten*).

While this was an excellent strategy to reach poor, vulnerable and marginalized populations and provide them the benefit of four years of project implementation, the project did not expand activities beyond these identified the 25 *Puskesmas* areas in the second year of the project. This has resulted in the project falling behind schedule.

In each of the communities where the project has initiated activities, various volunteers and Community Based Organizations (CBOs) have been identified. These include:

- **Community Based Treatment Observers (CBTOs):** Most CBTOs are better educated family members who are expected to ensure that the patient consumes the required medication. The CBTO also supports the patient by commuting to the *Puskesmas* to collect drugs. Prior to project initiation CBTOs were only supervised upon their visit to the *Puskesmas*, leading to drop outs and cessation of treatment.
- ***Kaders***: They are community members who provide voluntary support to the activities at the Integrated Health Pots (*Posyandus*). *Puskesmas* build on the availability of this structure and provide extension/outreach services through this post every month. There are five to six *Kaders* in each *Posyandu* and one of them has been designated as the TB *Kader* by the project.

- ***Bidan Desa*:** These are the village midwives who manage the community level maternal and reproductive posts (*Polindes*). These Bidans also have practice privately after the government duty hours. There are a smaller number of *Bidans* who are exclusively in private practice. The system of private practice by *Bidans* is more common in Pandeglang where there are very few doctor managed private clinics. The project is currently working with the government *Bidans* at the government *Polindes*, but not at their private practices. A larger proportion of *Bidans* in private practice are the government Bidans.
- ***PKKs*** (*Program Kesejahteraan Keluarga* or Family Welfare Program) This is an associations of women, cascading down from national level down to the street-level. The head of each level is the wife of that level's administrator for example - President/Governor/Bupati/Camat/Village head/Sub-village head/Neighborhood head/Street head. The members at the lower level however are all the women in the street. This makes all women in Indonesia (in principle) a PKK member. PKKs have been traditionally involved in developmental activities.
- ***Religious groups*** Many religious congregations have been identified by the project. The Koran recitation meetings (pengajian) are used as an opportunity to interact with the community members.
- ***CBTO Coordinators*** MITRA has created a cadre of CBTO coordinators. They are either *Posyandu* volunteers (*Kaders)* or are community volunteers (PKK members, religious leaders and teachers). leaders, who regularly meet with them to discuss constraints in treatment adherence and to provide appropriate advisory support.
- ***Paguyuban TB*** *Paguyuban* in Bahasa means 'a group of people with the same interest or goals'. *Paguyuban* TB therefore is a group of ex patients, who get together on TB days (for e.g. Monday/Wednesday) at *Puskesmas* and disseminate TB related information. They form a support group as well to the patients currently on treatment. There are four such groups in the project area. The first was formed by the effort of Pulo Merak *Puskesmas*. Owing to its success three more *Paguyubans* were formed. MITRA supports the activities of *Paguyubans* and plans to facilitate expansion of these groups.
- ***Community Groups*** MITRA has facilitated the formation of community level groups which consist of current and ex TB patients, their family members (many of them are the treatments supporters), *Kaders,* and PKK members (a cascading association of women led by wives of local administrators).
- ***Village Health Comittees*** These are village level institutions envisioned under USAID's Health Services Project in Tangerang District and by CARE's BERSIH Program (this is the USAID funded Development Assistance Program). The final vision for this project is the formation of "*Desa Siaga*" or 'alert villages' where village health councils are able to intelligently monitor health issues in the population both in an acute setting like influenza and a chronic setting like TB and to be able to plan and prepare for both.

MITRA developed orientation material and training manual (which also includes sessions on community mobilization and communication skills) and built the capacity of these

identified individuals and groups to disseminate TB information; and support patients on treatment.
However, the BCC strategy workshop which was to be carried out in the beginning of the second year could not take place because the selected consultant was unable to deliver on the contract. A new consultant has been identified, a draft BCC document has been developed prior to the mid term evaluation and a BCC workshop is expected by February 2008. This document has been informed by the NTP's Advocacy, Social Mobilization and Communication (ASMC) strategy and outlines desired behaviors expected from patients, communities and providers. Project has also identified available IEC material. However these material require adaptation as they are verbose, need more illustrations and Sundanese language inputs (one third of project population speaks the Sundanese language).

2.1.b. Knowledge and Treatment Seeking Practices

Although there has been an absence of a clear and written BCC strategy and dearth of IEC material (project has not made available materials to volunteers, providers and health centers), the project has been training its volunteers to disseminate TB messages with some success.

Table 1. Knowledge and Treatment Seeking Indicators for SO 1.

Output Indicators	Baseline to Mid Term	Comments
By the end of the project at least 70% of the population can list 2 common symptoms of TB	31% to 50%	There has been a significant improvement in the knowledge levels of the communities regarding TB symptoms. Whether this is entirely attributable to MITRA's interventions cannot be commented upon. MITRA currently covers 25 *Puskesmas* areas out of the 107 in the project area. Furthermore NTP ran a mass media campaign between March and May this year.
By the end of the project at 100% of the population knows that TB is curable	87% to 94%	This increase though not statistically significant should be seen in the light of the fact that it was already high at baseline, making it difficult to reach significant increase.
100% increase (from 30% to 60%) in knowledge of symptoms of TB and its curability in the community		This is a repetition of the above two indicators and should be deleted hereafter.
At least 20% increase in the number of TB suspects from 6,560 in 2005 to 7,800 by	Total sputum positive cases detected n four project districts:	The indicator has not been worded appropriately. It should either read '20% increase in new sputum

September 2009 combined for the 4 districts. (total number of TB suspects registered in the project area in year 4 or 2009/total number of TB suspects registered in the project area in year 1 or 2005)	source- Provincial NTP reports, Oct 07 2005: 4137 2006: 4487 2007: 2489 **(Q2)** Total patients suspected of TB 2005: 27,953 2006: 35,332 2007: 26,161 **(Q2)**	positive patients put on treatment or registered from year one to year four / **OR** 20% increase in number of suspected TB patients reaching or investigated by *Puskesmas*. If it is the latter then there has been tremendous progress. Patients approaching *Puskesmas* and being investigated for TB has increased 26% between 2005 and 2006. There is an 87% increase in this number when Q2 2007 data is extrapolated for the whole year. This phenomenon of more people seeking TB diagnostic care from the *Puskesmas* has not translated into increased CDRs* except in Pandeglang district. However, since MITRA works in only 25 of the 107 *Puskesmas* areas, results cannot be attributed solely to project. *CDR and other TB indicators are described under quality assurance section.

2.1.c. KPC Findings

A Knowledge Practice and Coverage (KPC) survey using the 30 x 10 cluster sampling technique was carried out parallel to the qualitative evaluation. Enumerators gathered information from 330 (age greater than 17 years) respondents and the survey covered 1629 household members.

Some of the key findings are detailed in table number 2.

Table 2: Key TB Knowledge Indicators in the Community

Variable	Baseline (2005)	MTE (2007)	Other Sources*
Has heard about TB disease	Not asked	88.2%	92.4%
Knows that TB is curable	86.5%	93.7%	88.2%
Aware of TB symptoms[+]	30.8%	50%	24.8%
How is TB transmitted**?** [#]			
Cough & Sneeze	37%	44%	51.1%
Touching of patient	8%	8%	Not Available
Transmitted through food	22%	11%	62.6%

Sharing of utensils	-	36%	Not Available
Sexual Intercourse	0.6%	2%	Not Available
Others	9%	21%	15.6%
Don't Know	21%		Not Available

*TB prevalence survey 2004 (NIHRD – Indonesia MOH);
+MITRA (as does the national survey) defines it as productive cough > 3 weeks as the symptom;
Difficult to compare as TB prevalence survey classifies responses as fully correct, not fully correct and incorrect. KPC does not clarify how many respondents mentioned only the correct answer (exposure to sputum - cough or sneeze)

The findings suggest that there have been positive changes in the knowledge level of the community with regards to certain key information points on TB especially their knowledge regards common symptoms of TB.

About 12% household members were reported to have productive cough suggesting continuing higher prevalence of TB. Whereas the 2004 TB prevalence survey in Indonesia found that 7.7% respondents (in Java-Bali area) had either cough for more than a month or hemoptysis.

2.1.d Qualitative Evaluation Findings

1) Knowledge

The qualitative evaluation teams found that most of the patients and community members knew about TB. They knew that TB is a disease and that it is curable. Many cited prolonged cough, fever and loss of weight as the symptoms of TB. Although most thought that TB spread through exposure to cough, they also thought that TB could be spread through sharing food with the patients. While patients knew that they had to cover their mouths while coughing; and dispose sputum hygienically to prevent the spread of TB; community members in addition to the above mentioned good air and nutrition as means of preventing TB.

Both patients and community members knew that drugs had to be taken regularly for periods between six to eight months. Although most respondents had heard of HIV, only one or two could explain the relationship between HIV and TB. Again very few had heard of MDR TB.

Patients reported getting TB messages from television, radio jingles, through *Kaders* and in Koran recitation meetings. Very few reported seeing any material other than leaflets and they saw flipcharts during meetings conducted by MITRA staff. Patients said they did not receive much information at the *Puskesmas* and had rarely seen IEC material in these centers.

2) Treatment Seeking Behavior

Most patients reported going to the *Puskesmas* for treatment following four to five weeks of symptoms. This is perhaps because project works in the poorer communities of the districts (prioritized project areas for the first year of implementation). Some of them however, though they claimed that they could not afford it, preferred using the services at private clinic as they believe that the drugs provided by the private provider are better in quality. Very few people reported going to the traditional healer (*Dukun)* first as they were closer and cheaper. Interestingly most focus group members said that more or equal

numbers of women as compared to men suffer from TB. However there were no differences in treatment seeking behaviors between the two sexes.
Many focus group members reported having undergone sputum tests for diagnosis, but could not specifically mention the details of follow up sputum test requirements. Many reported having undergone X-Ray examination as well. Patients spend nearly four to five US dollars for an X-Ray examination. The expense for the trip to *Puskesmas* was also stated as being prohibitive. In addition patients pay a registration fee at the *Puskesmas*, a nominal amount of USD 0.30. However, focus group members in Jatiuwung *Puskesmas* area (Tangerang city) reported paying for drugs as well. No other focus group reported paying money for drugs and everyone was aware that the drugs are provided free of cost in the *Puskesmas*.
Although the population in the project districts has grown on an average by 2% annually, the proportion of patients approaching *Puskesmas* and being investigated for TB has increased tremendously – 26% increase between 2005 and 2006. Extrapolating from data for the first two quarters of 2007, this increase in 2007 would be 48% over 2006. This phenomenon of more people seeking TB diagnostic care from the *Puskesmas* has not translated into increased CDRs except in Pandeglang district (detailed in quality assurance section). However, as MITRA works in 25 out of 107 *Puskesmas* areas, this cannot be attributed to project efforts alone.

3) Treatment Adherence
Most patients reported receiving ample support from their CBTO (who is generally a family member) and from the CBTO coordinator or *Kader*. The supporters were credited with inspiring the patients to consume drugs, accompany them to the *Puskesmas* and at times bring back drugs from the *Puskesmas*. Many forms of incentives are available to the patients for adhering to and completing treatment. These range from food (noodles and rice from WFP in Tangerang city) to transport cost reimbursement (in Cilegon city). These were much appreciated by the patients. The project is committed to carrying out operations research on the impact of existing enablers/incentives on CDR and TSR, however, this has not been carried out as yet.

"I must not stop taking medication; if I do then I will have start all over again."-Patient in Kota Tangerang area

There is a huge demand for treatment centers closer to the community; the prohibitive expenses of seeking treatment being one of the two main reasons for discontinuing treatment. Patients suggested that the CBTO coordinator or the *Kaders* should stock the drugs so as to facilitate adherence and completion of treatment. The other most commonly cited barrier to treatment adherence was side effects. Patients have to approach the TB staff in the *Puskesmas* to resolve side effects related issues and many times stop the intake of medicines without approaching the doctor. The trainings for CBTOs and their coordinators include sessions on familiarity of side effects. However, they need to refer patients to the *Puskesmas* for further management for all the side effects except discoloration of urine caused by Rifampicin.

4) Stigma

Most patients did not perceive any overt stigma from the community members and felt they were treated no differently because of their tubercular status. Community members however said that there was a subtle stigma attached to being a tuberculosis patient and some admitted that if they were to get the disease they would hide the fact from others. This however did not seem to affect treatment seeking among the community.
"TB can be spread via plates, glasses and spoon and by using shirts of the patients"
Community member, Labuan *Puskesmas* area, Padeglang

5) Pediatric TB
There were at least one or two care takers of pediatric patients in each FGD group. Children who are in close contact with a patient; have a family member who is a patient; or are malnourished (under the -'red line'- of for underweight) were found to be referred to the *Puskesmas* for diagnosis and treatment by *Posyandus*. An unusual finding was a child aged four years, who was found to be on treatment for the last three years according to the grandmother. The reasons for this prolonged treatment need to be investigated further by MITRA. Some of the *Puskesmas* were found to have more pediatric cases than adult cases, raising the question of over diagnosis. This is further discussed in the section pertaining to health facilities.

2.1.e Community Based Structures and Individuals

The variety of community based structures identified by MITRA was detailed in the previous section. Progress made against monitoring indicators is presented in Table 3. MITRA has identified and trained 956 *kaders,* 471 CBTOs and 152 CBTO coordinators in the project area. It should be noted here that many of the CBTO coordinators are Kaders. While the first two categories (Kaders and CBTOs) have been given one day orientation in DOTS, the latter (CBTO coordinators have undergone a training of trainers for 3 days.

Table 3. Indicators to measure performance of community based structures

PERFORMANCE INDICATORS	**OCT 05 TO SEP-07**	**COMMENTS**
At least 1,284 (25%) of village based institutions like the integrated nutrition and health posts - *Posyandus* (total number 5,136) in project area are disseminating TB information.	113 posts in 26 villages, 6 sub-districts	The qualitative evaluation team found that *Posyandu Kaders* (volunteers) were well trained and were disseminating messages to the community. There are 5-6 *Kaders* in each *Posyandu*. One of these has been trained as a TB *Kader*. These *Kaders* were actively referring suspected patients to the *Puskemas* for diagnosis; and supporting patients to complete treatment. However they did not have any IEC material available to aid their counseling and group discussion sessions.

At least 710 (15%) of all places of worship (total number 4,736) in project area communicate monthly message on TB/DOTS	24 religious groups (places of worship) in 21 villages, 14 sub-districts	The *Kaders* and CBTOs trained by the project were found to be taking the lead in utilizing the Koran recitation meetings for discussing TB related messages. Project monitoring reports however do not capture the number of such meetings conducted or the issues identified and resolved. Again due to overall lack of IEC material in the area, these meetings were found to be relying on group discussions as means of communication.
At least 285 (30%) of (total number of 953 midwives) especially those (*Bidan Desa*) who work at village maternal and reproductive health centers at (*Polindes*) and other identified village health center workers, oriented or trained on DOTS	134 midwives in 22 health centers (*Puskesmas*) areas	Trained *Bidan Desa* were actively disseminating the messages, referring suspected patients, specially those malnourished children who were not improving despite nutritional interventions. Communities were found to have more *Bidans* than those posted at the *polindes.* These *Bidans* have private practices and are expected to be seeing suspected TB patients, due to their close proximity to the community, especially in Pandeglang, which does not have any private clinics. Project has an opportunity to bring these *Bidans* into the fold of DOTS.
By the end of the project, at least one new village committee or existing CBO in each selected project area (*Puskesmas* level) has the capacity to organize the community to implement community-based TB control activities	Need to revisit this indicator. Please see comments for reasons.	CBOs at community level include the *Posyandus.* Therefore this indicator subsumes the first indicator in this table. Other CBOs available in MITRA area are: *Polindes, Paguyuban, PKK,* Health Committees and local governments. MITRA actively involves local governments at village (in rural areas - *Desa*) and Ward (in urban areas - *Kelurahan*) level. Members of *Desa* and *Kelurahan* developmental agencies have been oriented to DOTS and TB control issues. PKKs have been oriented and trained by MITRA and are actively participating in disseminating TB information and supporting patients. Very few village health committees (under the HSP program) have been

		formed and recently, hence MITRA has not been able to intervene to the desired extent here. However, MITRA has involved health committees formed under CARE's BERSIH project.

MTE teams met with various cadres of community level volunteers and groups and through focus groups tried to understand their roles and capacities. All volunteers were found to have good knowledge of TB, its cause, modes of spread, modes of prevention and importance of regular and completed treatment. They were found to be actively supporting patients – accompanying them to *Puskesmas*, following up on the regularity of treatment, preventing default and ensuring treatment is completed. They were cognizant of the side effects and were found to be referring the patients to the *Puskesmas* for appropriate interventions. Detailed sessions on side effects and the actions needed to be taken formed a part of trainings of the volunteers who act as CBTO coordinators.

Different districts have different incentive systems and some involve incentives to the CBTOs and volunteers as well. These come in the form of transportation charges or food packets. As described before very few CBTOs or volunteers have IEC material which affects the quality of their communication, especially with a new audience. Most volunteers were found to be well connected to the *Puskesmas.* This coordination between community volunteers and the *Puskesmas* have the scope for improvement from the perspective of *Puskesmas* and should be structured for measuring the sustainability of efforts.

Most awareness sessions in the community are held at the *Posyandus*. These are the integrated nutrition and health posts at community level. While the set up of the *Posyandu* and its monthly gatherings provides an opportunity in terms of attendance by community members, the *Kaders* are busy with growth monitoring and immunization activities at the same time.

The presence of trained community volunteers means that a suspected patient will receive appropriate advice; however, the possibility of having a regular dissemination of TB information through this post needs to be measured. The project assumes that TB information will be shared with the community but is not currently monitoring outputs from the community volunteers to ascertain this. Simple formats were developed in Jan 2007 for this purpose but have not been utilized as yet. The project team informs that all FOs have been familiarized with the formats as of August 2007.

The volunteers are utilizing various community gatherings (for instance - Koran recitations meetings) to talk about TB. Further owing to the fact that they belong to the community, they are accessible to suspected patients and are aware of local patients on treatment.

MITRA has facilitated the formation of community level groups which consist of current and ex TB patients, their family members (many of them are the treatments supporters),

Kaders, and PKK members (association of wives of local leaders). Four such groups have been formed in Pandeglang (3, of which one is a TB post, discussed in detail in the next section) and Tangerang district (1). The need for the association emanated from the lack of any cohesive community structures dedicated to TB. These associations meet monthly and discuss problems associated with treatment and TB related information. The *Kader* utilizes the opportunity to follow up on current patients and discuss support requirements. This also provides an opportunity for the *Kader* to learn about any community member who has been suffering from a prolonged cough or is suspected of having TB. The participation of the PKKs provides the issue of TB a developmental platform.

In addition MITRA built on the existence of *Paguyuban* TB in Cilegon. This *Paguyuban* first formed in by the Pulo Merak *Puskesmas* has done exemplary work in supporting patients visiting the centers. Members get together on TB days (eg. Monday/Wednesday) at *Puskesmas* and disseminate TB related information. They have been active in TB day campaigns and recently have been registered as a Community Based Organization (CBO) and acknowledged by the local government at the sub-district level. Owing to its success, MITRA facilitated the formation of four (three in Cilegon and one in Tangerang City) more *Paguyubans* in partnership with *Dinkes*. MITRA plans to facilitate expansion of these groups.

These are excellent examples of community involvement in supporting TB treatment, disseminating TB information and reducing stigma by opening up discussions. The groups can be strengthened to take a greater responsibility for networking across the community and expanding awareness activities.

MITRA has initiated collaboration with Village Health Committees (VHC) formed under USAID's HSP and managed by Tangerang and Pandeglang District *Dinkes* and VHC formed by CARE's BERSIH Program. MITRA has started by developing a set of training modules (basically improving the existing CBTO-supervisor modules), which consists of 4 modules for DOTS and TB (diagnosis & treatment, monitoring patients), communication skills for IEC, and community TB activities for the VHC members. So far MITRA has worked with one VHC formed by HSP at Rawakidang village, Sukadiri sub-district, Tangerang district. There are 12 VHCs in Tangerang district and 12 VHCs in Serang district (which is outside MITRA working area).

Lack of IEC materials restricts the activities which can be undertaken currently and absence of monitoring system has resulted in project's inability to measure the outputs and outcomes of such groups.

The rapid expansion of these groups with support from local NGO partners and development of linkages between these groups and *Puskesmas* staff will ensure that sustainable community level structures are available for continuing treatment support and behavior change.

2.1.f Recommendations

1. Expand activities to cover more than 25 *Puskesmas* areas. Sign MOU's as planned with able local NGO/CBO partners to achieve expansion
2. Build on successful experiences of community groups and *Paguyubans*.
3. Improve information sharing with *Puskesmas* through structured methods for better utilization, monitoring and sustainability of strengthened community structures and individuals.
4. Remove the indicator "100% increase (from 30% to 60%) in knowledge of symptoms of TB and its curability in the community" as this is already captured in two other indicators and is merely repetitive.
5. Rephrase indicator "at least 20% increase in the number of TB suspects from 6,560 in 2005 to 7,800 by September 2009 combined for the 4 districts." – to read " at least 40% increase in number of suspected TB patients reaching or screened by *Puskesmas* in four project districts from 27,953 in 2005 to 39,134 in 2009."
6. Carry out the committed operations research on impact of incentives on CDR.
7. Follow up the identified child in Waliwis village and investigate the reasons for continuing treatment even after three years.
8. Utilize the simple monitoring formats to measure outputs and outcomes of CBTO/Volunteer activities.

Please note that the BCC related recommendations are covered under the BCC section.

2.2 Strategic Objective 2. To strengthen the delivery capacity of the district and provincial TB program

2.2a Planned Activities

The key activities planned to achieve this objective include capacity building; and coordination/advocacy for quality assurance (including drug availability and slide cross checking). The capacity building activities were aimed at developing a cadre of CBTO coordinators (called treatment observers supervisors in DIP) in selective geographical areas of the project; in partnership with the *Puskesmas* create TB posts, which are closer to the community; and train identified *Puskesmas* and *Dinkes* staff in DOTS. To ensure that the components of DOTs not addressed directly by the project (continued political commitment and availability of quality assured, uninterrupted supply of drugs) and the components of DOTS which the project chose to support without direct control of the project (quality assured sputum examination for diagnosis), MITRA planned coordination and advocacy activities. The MITRA plans include:

- Identify and ascertain the reasons for high error rates; and train *Puskesmas* laboratory technician who are not preparing the slides for regular cross checking
- Coordinate with KNCV/NTP to ensure availability of drugs, microscopic facility and other infrastructural inputs into DOTS program

- Participate in TB partners forum
- Regularly meet and discuss project issues with stakeholders at National level
- Identify and solve program problems with counterparts at provincial and district level

2.2.b Effectiveness of interventions - Development of New Cadre: CBTO Coordinators

Table 4 Capacity Building of CBTO coordinators – Output Indicator for SO 2

Output Indicators	Oct 05 to Sep-07	Comments
In identified poor performing areas 100% *PMO* supervisors (minimum number 100) receive training in counseling and supportive supervision skills	152 treatment observers' coordinators (supervisors)	MITRA has exceeded targets and has done well in developing the much required community component in the poor performing areas. MITRA has identified one of the *Kaders* to act as CBTO coordinator at each *Posyandu* in the 25 poor performing *Puskesmas* areas, where project was initiated. They have received three days training on DOTS and communication skills. The development of this training manual received assistance from CARE Atlanta's health interns

The CBTO coordinators have an important role to play as most CBTOs are family members although oriented to DOTS through MITRA efforts. The coordinators follow up regularly on treatment adherence, sputum checks and problems, either through the *Posyandu* meetings or through community visits. This is a good mechanism for providing support to a TB patient, especially because current prevalence levels (even when they are high) mean that there are only one or two patients in a community and it is resource intensive to train one person in each community to act as a CBTO. The success of a community member acting as a CBTO is further dependent on this person's interest in supporting the patient. A family member on the other hand is interested in the well being of the patient and can be monitored through the mechanism of a CBTO coordinator who has undergone in depth training. Furthermore the coordinator provides continuing support and education to both the patients and the CBTO (family member).

"I wanted to stop treatment. I was very tired and depressed. I have been able to complete my treatment owing to the support of the Kadre and my sister who is my treatment observer." – Patient in Waliwis *Puskesmas* area, Tangerang District

MITRA has done well in developing this cadre in poor performing areas. The coordinators along with the CBTOs are creating community level awareness about TB control as reported by the MTE team. Though MITRA has committed to this activity in

poor performing areas, it should consider replicating this model across the project area, even if on pilot basis and disseminate the success at *Puskesmas* and *Dinkes* level.

2.2.c Effectiveness of TB Posts

In addition to creating the cadre of CBTO coordinators, MITRA facilitated the formation of TB posts. These are seven DOTS TB drug distribution posts of which three are active. Six are established by MITRA and one by PKM. One TB post is in *Kabupaten Tangerang* and the rest are in Pandeglang district. Once the patient is registered and drug boxes requisitioned, the patient box is transferred to the TB post. The patients visits this community based facility to consume and collect drugs. This strategy overcomes barriers pertaining to transport costs and allows for closer monitoring of patients through trained facility workers. The post is managed by a trained paramedic or the TB officer and is open on scheduled days of the week. Some of the posts' even help carry the sputum samples of patients to the *Puskesmas.*

2.2.d: Effectiveness of Capacity Building at *Puskesmas*

Table 5. Progress on Puskesmas level Trainings – Output Indicators for SO 2

Output Indicators	Oct 05 to Sep-07	Comments
100% of District TB Supervisors total number 5 (*Wasor*) are re-trained in TB DOTS programming	Nil	This indicator was included to reflect a specific request made by *Dinkes* during DIP preparation. However, later *Dinkes* requested that CARE not carry out these trainings as they would be conducted through Global Fund to fight TB AIDS and Malaria (GFTAM) budgets. These have been however not carried out by *Dinkes* owing to temporary cessation of GFTAM funds.
100% of all doctors, nurses TB officers, and laboratory technicians in 107 government health centers (*excluding those who are already trained*) oriented/trained in TB DOTS	37 doctors, 16 TB officers, and 14 lab technicians of 17 *Puskesmas* oriented to DOTS through one day workshops	Similarly the project was not allowed to carry out planned one day orientations to additional *Puskesmas* staff. Project however, trained a few before *Dinkes* requested that CARE not to carry these trainings.
75 (70%) of TB-Leprosy officer in designated health centers (*Puskesmas*) are trained in DOTS	Nil	Because the *Dinkes* requested CARE not to implement these trainings as they had commitment from Global Funds.

It was intended that all DOTS staff (TB and Leprosy Officers) and other non-technical staff in the *Puskesmas* and those in the periphery (Bidans and para medical staff) would be oriented to DOTS through one day workshops. The inclusion of training indicators for Doctors and Nurses means an intention to train them. MITRA, by increasing the number of oriented personnel at each *Puskesmas* hopes to overcome the problem of frequent transfers at the center. Having additional able staff also means that in the absence of the TB officer, patients receive guidance and education. At the time of DIP, NTP had plans to train doctors through NTP/WHO training modules. MITRA however incorporated indicators to reflect that the doctors and the lab technicians would also be oriented to DOTS. While orienting non-technical staff to DOTS ensures better referrals into the DOTS, one-day orientation to doctors who may not have undergone the national 7-day training does not build the capacity of technical staff to dispense medication, monitor patients or help with reporting and does not ensure that DOTS programs continue seamlessly when a trained staff is transferred. As the NTP clearly requested CARE to refrain from the technical trainings for the Puskesmas staff, it is best to consider dropping this indicator.

Besides, managing a DOTS program requires not only technical training but also managerial capacities which were not envisioned as a part of capacity building strategy during design of the project. A training needs assessment was carried out by MITRA in collaboration with NTP and various medical/professional organizations (*IDI*, *PDPI*, *PPNI*, *IBI*). However the needs assessment did not enquire into the managerial capabilities of the providers. MITRA recognized this aspect and suggested to Provincial *Dinkes* a 5day management supervision training for *Wasors.* This was rejected both by the Province and *Dinkes* of Tangerang city because KNCV had done this training throughout Banten from 2004 – 2006, and the Province was planning to hold refresher trainings conducted by the NTP and funded by the Global Fund in 2007.

MTE teams found that there are issues pertaining to management of DOTS across the *Puskesmas* and the *Dinkes*. The quantitative data for health facility assessments are detailed in the Capacity Building section.

Drug Management: By the policy of NTP, no buffer stocks are held in the *Puskesmas*. Drugs are requisitioned once the patient is registered. It takes a week to a month for the drugs to arrive at the *Puskesmas*. Some *Puskesmas* were found to be dipping into designated boxes of registered patients to treat newly registered patients, to overcome the delay in receipt of drugs from the *Dinkes*. Most *Puskesmas* have not put patients on Category II as Streptomycin has not been easily been made available to them. According to TB officers interviewed category II patients are put on Category I drugs. Discussions with *Dinkes* and Wasors revealed that there is a dearth of Streptomycin; however this was not cross checked by the MTE team through a visit to warehouses. NTP at the national level informed that drugs were indeed available and that no warehouse has seen stock outs. NTP also informed that *Puskesmas* lacked the capacity to increase the CDR, do not capture Category II patients, hence do not requisition for the drugs which are evidently available at the national/province level.

The delay in provision of drugs to a diagnosed patient can give rise to the possibility of initial default – that patients default even before being put on treatment. This is being recognized as one of the reasons for CDRs not increasing beyond a point in other parts of the world. Although this point is being made in retrospect and was not investigated in the

field, this forms a good indicator of quality of services which the NGO has direct control over.

IEC material: Similarly while IEC materials were found to be available at *Dinkes*, they haven't been requisitioned either by the *Puskesmas* or by MITRA. MTE teams did health facility assessments in 26 out of the 107 *Puskesmas* across four project districts. Fifteen out of the 26 *Puskesmas* visited did not have any IEC material on display.

Lab related issues: Lab reports continue to be late. Though more labs have started reporting, not all labs submit reports on time. Some lab officers in Pandeglang *Puskesmas* have not been trained and some are not analysts. Currently there is one trained sputum analyst out of nine posted. Due to the high staff turnover of around 30% a year the number of technicians that need to be trained remains high. Details of the lab assessments carried out during the MTE are covered in the health facility assessment section.

Pediatric cases: There seems to be a possibility of over diagnosis of pediatric cases. In *Puskesmas* Jatiuwung, in Tangeran City, nearly one third of the patients on treatment were children. There were 67 children on treatment against 46 Category I adults and 84 Category III adults. A pediatric score card was launched nation wide through revised NTP guidelines and these were released in Aug 2007 and have not gained familiarity in the *Puskesmas*. It was expected that prior to the introduction of this score card (detailed in the DIP) there would be a situation of over diagnosis.

Table 6 Performance Level Indicators for SO 2

Performance Indicators	Oct 05 to Sep-07	Comments
2.1 New DOTS centers or TB posts opened at 60 villages (community level), for example, at the sub-centers, midwife centers, and village health posts	4 TB post in 4 villages	Three of these have been created by MITRA. MTE found that the fourth has been running for four years and is managed from the residence of a *Puskesmas* TB officer. MITRA has actually created 7 TB posts of which three are active.
2.2 100% of *Puskesmas* (total number 88*) had smear slides for cross checking collected by the District Wasors regularly	It is difficult to conclude on this indicator with the available data. Please see comments.	MITRA planned to work with 88 *Puskesmas* with lab facilities. While the las assessments carried out during the MTE revealed that 100% labs visited kept slides for cross checking and that these were picked up by the Wasor, the provincial level TB data reveals that except Cilegon city, information for cross checking of slides is not available for all labs on a quarterly basis for years between 2005 an 2007 (Q2). However, the number of labs sending slides for cross checking has increased over the last two years.
2.3 Special indicator for	25 of 34 (73.5%)	At baseline 13 *Puskesmas* were

Pandeglang district** 100% DOTS coverage (34 health centers)		delivering DOTS services. This has increased at mid term. MITRA has contributed by orienting the *Puskesmas* staff to DOTS and formation of three TB posts.

Note: * Only 15 health centers in Pandeglang will be covered
** All other districts have 100% DOTS coverage

To enable the creation of TB posts across the project, and provide quality DOTS care MITRA will need to consider building managerial capacities at *Puskesmas* level.

2.2.e Advocacy Related Progress

Recognizing the need for comprehensive support for the five-pronged DOTS strategy, the project committed to coordinating with all relevant stakeholders to identify, discuss and bridge gaps in DOTS delivery at the provincial and district level. This intervention was to ensure that issues like drug availability, diagnostic quality and training needs are addressed as and when they affect the project. At the district level, the project and project functionaries are to interact with the District Health Officer, who is responsible for all medical and public health activities; and the *Wasor* who is responsible for the organization of TB activities in the district. At the sub-district/health center (*Puskesmas*) level CARE is to interact with a team of Medical Officer designate, lab Supervisor and Treatment Observer Supervisors, to monitor the quality of the program, build capacity of community partners, NGOs, and Private Practitioners, and implement treatment activities, e.g. timely diagnosis of cases and supply-related issues. Some of the staffing positions detailed above may or may not be present in all *Puskesmas.*

However, MITRA has not been able to resolve identified problems (detailed in previous sections) through its coordination efforts.

Table 7 Advocacy related Output Indicators

Output Indicators	Oct 05 to Sep-07	Comments
2.1 100% (4 per year) attendance of WHO-sponsored TB Partnership meetings at National level	8 meetings attended	The attendance at these meetings have not been utilized to successfully address the identified problems in DOTS implementation throughout the project area
2.2 100% (2 per year) attendance of TB Partnerships meeting in District and Province level	3 meetings attended	
2.3 At least one monitoring and evaluation meeting in each year attended by NTP, Province TB Team, District TB Team, KNCV, and other TB partners	2 meetings conducted	

It can be concluded that MITRA needs to rethink its capacity building strategy for the *Puskesmas* staff and make a concerted effort to identify problems in a timely manner seeking solutions at district, provincial and national level.

2.2.f Recommendations

1. Build on success of CBTO coordinator capacity building strategy
2. Rethink the trainings that MITRA wants to give at *Puskesmas* level. Who will be trained? What will be the content? How will this be done?
3. Drop the indicators pertaining to training of *Puskesmas* staff.
4. Consider managerial and leadership training for *Puskesmas* staff if NTP restarts technical trainings for them through the latest round of GFTAM funding.
5. Jointly with *Dinkes*, investigate the use of recommended score cards for pediatric diagnosis to identify reasons for over diagnosis and train providers to address the situation (either through MITRA funded trainings or through NTP).
6. Through regular analysis of monitoring reports and field feedback, identify drug/lab/reporting issues and advocate for resolutions at appropriate forums. Advocate for resolution of issues related to sharing of drug boxes and unavailability of streptomycin at provincial and national level.

2.3 Strategic Objective 3: To increase private sector participation in the TB program.

2.3.a Planned Activities

Planned project activities to promote and improve participation of Private Practitioners (PPs) are:

- In line with MOH and IDI (Indonesian Association of Doctors) strategy train PPs as per International Standards for TB Care (ISTC)
- Regularly attend quarterly IDI meetings to enable enrollment of PPs into the training program
- Provide the doctors with WHO/KNCV/NTP designed literature like, treatment algorithms, disease diagnosis, classification and the treatment regimens in information capsules in the form of flyers and posters.
- Link them with nearest government health center and support identification treatment observers in the community.
- Facilitate reporting of patients and defaulters to health centers
- Strengthen capacity of health centers staff to partner; provide support in prompt follow up on defaulters through community based treatments supporters and volunteers.
- Identify industrial clinics, orient them in ISTC, support implementation of DOTS and promote TB BCC employees.

2.3.b Effectiveness of Capacity Building for Private Providers

Table 8. Progress on Indicators for Private Participation

Output Indicators	Oct 05 to Sep-07	Comments
At least 330 (30%) of 1,102 Private Practitioners (physicians) receive International Standards of Tuberculosis Care (ISTC)/DOTS orientation	27	Project behind schedule. PPs are oriented to ISTC guidelines. There is no training manual which addresses issues ranging from technical protocols to how to partner with *Puskesmas* and link with the community. PPs await the second round of trainings to enable their linkages with the above-mentioned partners. Furthermore PPs have received copy of ISTC guidelines, but have not received any handouts or IEC materials. Project has plans to incorporate these in their upcoming workshops.
At least 125 private hospitals and clinics management team receive ISTC/DOTS orientation	Nil	Project behind schedule. Initial interactions with hospital managements have taken place.
Identify, orient and help implement in at least 20 industry clinics on ISTC/DOTS	Nil	Project behind schedule. Initial interactions have been held this year.

The MOH through NTP is highly committed to the involvement of PPs in providing DOTS. District *Dinkes* have been organizing several training programs for both individual practitioners and industry clinics/hospital staff. Tangerang *Kabupaten Dinkes* officials informed the MTE team that the district had trained 80 PPs this year. However there are constraints involved in enrolling the PPs. This year the *Dinkes* of Kota Tangerang invited 150 PPs of whom 30 attended trainings and a mere 5 committed to participating in DOTS. The orientation sessions take a day, which keeps the PPs away from practice for a longer duration that they desire. KNCV has been using lunch sessions for orienting PPs, an initiative which will perhaps overcome the problem of low attendance in these trainngs.

The *Dinkes* has introduced a Memorandum of Understanding (MOU) between committed PPs and the MOH. This details the roles and responsibilities of both parties. While the role of MOH/*Dinkes*/*Puskesmas* is to provide training, drugs for each registered patient, IEC material and support with follow up of default patients; the role of PP is to report each patient to the *Puskesmas*, also defaulters for follow up and retrieval and display IEC material along with the fact that the drugs are free of cost.

Many of the PPs are government doctors who by law are allowed to practice after their duty hours. These are the doctors who have been targeted first. MTE teams met trained PPs, some with and some without these MOUs. All of them understand the importance of DOTS in controlling TB and face problems with default retrievals. They feel the need for support from the *Puskesmas* to link patients with treatment supporters and default retrievals.
They also expect to receive IEC material from MITRA/MOH to promote BCC. Those with MOUs also face a problem with delays in drug receipt. It takes them a week to receive drugs from the *Puskesmas* following patient registration. This is because, as described before even for patients treated in *Puskesmas*, drugs have to be requisitioned from *Dinkes*, as per NTP policy.

"The General Practitioners understand DOTS – but we find it difficult to implement it. We need cooperation of the community" – Private doctor from Tangerang District

MOH has been able to successfully enroll some larger hospitals and industrial houses into ISTC orientations.

Parallel to the MTE, MITRA held an orientation for PPs in Cilegon City. The interesting aspect of these trainings were sessions on strengthening partnerships with *Puskesmas* and through them with the community and modalities of managing reporting and default retrieval.

2.3.c Recommendations

- Since MOH has been training more private practitioners and has allocated budgets for the purpose, MITRA can dove tail these efforts by providing quality enhancing inputs – put together a training manual in consultation with IDI and KNCV; help develop training sessions to include action plans, partnership modalities, available community support; put together a kit of treatment algorithms, ready reckoners, IEC material and handouts with information on community/*Puskesmas* contacts.
- In collaboration with local *Dinkes* develop a simple monitoring format for issues not covered by existing TB formats – support required, problems faced – which can be used by the PP to communicate with the *Dinkes* and *Puskesmas*.
- Consider splitting the entire training into one hour lunch hour sessions to increase the participation of PPs.
- PPs are willing to network with their peers. Utilize this willingness to enroll more PPs.

- Dovetail MOH relationship with hospitals and industrial clinics and offer to bring on board the above-mentioned quality enhancing inputs.
- Actively link up volunteers and CBTOs trained by MITRA with the PPs and the *Puskesmas*.

3. Cross-cutting approaches

Some of the background information and analysis for this section has been covered in the above sections. The following sections will build on them to avoid repetition.

3.1 Community Mobilization

Community mobilization activities

Strategic Objective one aims at creating new community based structures for TB control. These structures and individuals are being enabled to generate awareness and improved care seeking behavior in the community.

The project works by building the capacity of the existing volunteers (*Kaders/Bidans)* and groups (religious and developmental – PKK) so as to achieve continuing community conversations on TB control.

The Field Officers (FOs), having identified and trained these individuals and groups, carry out planned discussions with community members either through monthly *Posyandu* gatherings or through Koran recitation meetings. Each meeting is supported by MITRA through provision of refreshments, commuting expenses to the *Kader* and training material (which may include copies of training manuals for CBTOs and IEC material).

Most of the meetings are led by the FOs and it is assumed that some are organized by the active Kaders/PKK members; however, this cannot be quantified as project monitoring data does not measure outputs of volunteers.

Community response to BCC activities

FGDs with community members revealed that they are aware of TB and most believe that TB is curable. Communities could list important symptoms of TB (prolonged cough, blood in cough, fever, weight loss, lymph node enlargement). However, they expressed ignorance about the connection between HIV and TB and had never heard of MDR TB. Many misconceptions continue to exist about how TB spreads. Although most cite exposure to cough or sneeze (key message in the MITRA training modules) as one of the means, they also list, sharing utensils and sexual contact as means of spread. There is also a perception that severely malnourished children may have TB, which while partially correct, may be the cause for exceptionally high pediatric cases registered in the *Puskesmas*. Most admitted to going to *Puskesmas* as a first resort for treatment since MITRA works in poorer communities.

Focus groups in communities admitted to stigmatizing behavior towards patients, though interestingly the patients did not perceive this as stigma. Community members admitted to avoiding close contact with the patient, talking, sharing utensils and not inviting them to community gatherings.

Some respondents expressed problems with the time consuming process of seeking treatment in the *Puskesmas*. More members reported X-ray as means of diagnosis as compared to sputum analysis, which reflects the continuing use of X-rays for diagnosis in private and perhaps public sector. This is important because of the cost implication of x-ray examination to the patient.

Most focus groups consisted of family members of TB patients, which may be the reason for the similarity in knowledge and perceptions. MTE teams also met with religious and community leaders and found similar findings. They also shared information about support provided to TB patients (transport charges, food incentives, forum for discussion of TB related information).

The effort of *Paguyuban*, discussed in earlier sections, is commendable and is an excellent example of community participation in supporting TB treatment. Currently five such groups exist, one in Tangerang district and four in Cilegon. MITRA's plans to facilitate the formation and strengthening of more such associations will indeed benefit the community and help improve quality of services in *Puskesmas.*

Similarly community based groups of ex and current TB patients; *Kaders,* CBTOs and their coordinators, PKK members and community members is yet another example of mobilized community efforts.

MITRA has initiated activities with village health committees formed under the USAID's HSP and CARE's BERSIH programs. There is a scope for expansion of TB control activities wherever these structures are available.

It can be concluded that more people in the community are now aware and mobilized to support TB control activities, albeit the numbers of these groups are small and not across the entire project area. Misconceptions exist which need to be addressed through robust BCC interventions.

3.1.1 Recommendations

1. Expand activities to cover all project areas. Build on the success of *Paguyubans* and community groups.
2. Sign MOUs with identified able local NGO/CBO partners to ensure transfer of expertise and expansion of activities.
3. Plan to withdraw support to mature groups and develop simple monitoring formats to measure the outputs and outcomes of community activities.

3.2 Communication for Behavior Change

3.2.1 BCC Strategy

During the DIP process MITRA presented the key desired behaviors pertaining to TB control and the audience to be addressed through these messages. The BCC workshop along with finalization of a BCC strategy document was slated for October 2006. However, this was however not carried out as planned. A draft BCC strategy document was ready in time for the mid term evaluation and is attached with this report. This draft document is informed by and is in line with the NTP's Advocacy, Communication and Social Mobilization Strategy (ACSM). MITRA has collated available IEC material (leaflets, brochures, flipcharts, posters, CDs of movies and radio jingles etc). These require adaptation as most of the print material is verbose and may not suit the requirements of the largely semi literate and illiterate community. Furthermore, the language used in these tools is Indonesian and is deemed quiet formal. The project communities mostly speak and understand the Sundanese language and have expressed a need for more informal content.

3.2.2 Project's BCC Activities

Community level

In the absence of a BCC strategy document, the project staff have been using messages detailed in the DIP document; training manual for volunteers; and those presented through the NTP/PCI's IEC material to communicate TB messages to the communities.

Flip charts published by PCI's TB project in Indonesia were identified as one of the key tools of communication. These are being used by the FOs. These were not reproduced pending the conduct of the BCC workshop. MITRA received another set of flipcharts from *Persatuan Pemberantasan Tuberkulosis Indonesia* (PPTI -The Indonesian TB Association). Nine of these flipcharts have been given to the volunteers trained by MITRA. The project received 200 additional copies of these flipcharts in June 2007, which were not distributed as they required amendments and adoption. These were not reproduced by MITRA and distributed to all volunteers and groups across the project communities. Furthermore, *Dinkes* staff informed the evaluation team members that they had ample stocks of IEC material, although these are distributed to the *Puskesmas* only when requisitioned. Most *Puskesmas* which were visited during the MTE had very few communication materials available in stock. MITRA has not made any attempt to utilize and disseminate the material available with the district *Dinkes.*

"When I counsel patients without BCC aids its like giving food without the sauce" - Health officer at Bojong *Puskesmas* in Padeglang

The current communication activities do not include messages pertaining to side effects link between HIV and TB and MDR TB.

MOH level

Advocacy at *Puskesmas*, *Dinkes* and Provincial MOH level is done through monthly/quarterly meetings. DIP committed to the formation of a provincial coordinating committee with participation from relevant stakeholders like MOH, KNCV, HSP (USAID) MITRA, IDI/IDAI, District MOH representatives and Industry representatives. However this has not been formed and these meetings are attended by MOH officials and MITRA staff. Most meetings at the *Puskesmas* and district levels are led by mostly by Field Officers (FOs) and sometimes by Trainings Coordinators. Though monitoring visits and routine interaction at *Puskesmas* level may be carried out either by the FO or the Training Coordinator; protocol and culture in Indonesia demand that the interaction and problem-solving meetings at *Dinkes* are attended by the Project Manager. Although the FOs seem to manage the relationship well, they expressed the need for further support from their superiors.

Private Practitioners

Project has been training Private Providers in the DOTS strategy but has not supported them with the provision of IEC material. This was one of the supports requested by the doctors interviewed by the MTE team. There is no articulated strategy to advocate and expand participation of private practitioners in the DOTS program. The key barrier as expressed by the project is the lack of government systems to deal with the integration of PP and DOTS.

3.2.3 IEC Efforts by Other Stakeholders

In addition to having an ACSM working group (members include: NTP, WHO, KNCV and Koalisi untuk Indonesia Sehat or Coalition for a Healthy Indonesia (KuIS – a local NGO), NTP has a developed a strategy for national mass media campaign and launched it on the world TB day this year. The campaigns ran between March and mid May and had to be discontinued due to the cessation of Global Funds. A variety of IEC tools were developed for this campaign – radio shows, jingles (based on the popular *dangdut* form of dance and song style), TV ads, posters for public and for *Puskesmas*, and health seminars. Project areas had the benefit of these campaigns as well.

WHO in partnership with NTP has developed a Health Care Provider Communication Kit which was designed by JHU CCP.

A local Muslim Charity Organization (*Dompet Dhuafa*) hosted a biking event to generate awareness about TB during the World TB day celebrations this year, which received ample media coverage.

3.2.4 Measuring BCC Outcomes

Project captures 'proportion of population who are aware of at least two symptoms of TB and know that TB is curable' at baseline, mid term and end line. Project management information system captures number of community based organizations actively undertaking TB activities along with dissemination of information. Further it utilizes the monthly reports from *Puskesmas* to quantify the number of suspected TB cases seeking care, on treatment and completing treatment. However, MITRA does not collect any data to quantify number and coverage of BCC activities.

3.2.5 Recommendations

1. Conduct a workshop of all key stakeholders to finalize the draft BCC strategy
2. Quickly adapt, produce and disseminate IEC material to community based partners and *Puskesmas*.
3. Include messages on side effects, HIV – TB linkages and MDR TB to the appropriate extent. Address some of the identified misconceptions about TB (using same utensils will cause TB, TB is sexually transmitted, TB patient should be isolated) which generate stigma.
4. Build capacity of the partners to use the material.
5. Develop monitoring formats to quantify coverage with the tools and measure effectiveness.
6. Partner with identified local NGOs to support BCC activities in the community
7. Develop an IEC kit for the private providers who have partnered with MITRA and the DOTS program
8. Utilize project monitoring data and NTP data to share, identify problems and resolve them at *Puskesmas,* district, province and national level
9. Actively coordinate with NTP to be informed by and be able to contribute to the national ACSM activities.

3.3. Capacity Building Approach

3.3.1 **Strengthening the Grantee Organization**

There has been substantial capacity building of the grantee organizations at all levels.

In the field

- The FOs and TC have received the standard DOTS TB training for one week.
- Some of the FOs and TC were also trained in qualitative data gathering and analysis for the DOTS drop out study carried out in Banten Province.

- The project staff underwent a training of trainers' course for DOTS TB.
- Staff have also undergone exposure to specific trainings, like orientation training of PPs, MOH doctors, nursing staff and *bidans* and training of health post staff.
- MITRA staff have been exposed during baseline and MT to qualitative and quantitative data gathering methods like FGD, IDI and KPC and its synthesis and reporting.
- The PM underwent a CORE organized workshop for DOTS TB managers in 2006.
- A TC participated and shared MITRA work with the rest of the CARE CS team in 2007.

In short the staff has benefited and learned about public health project implementation in general and DOTS TB in particular. The staff trainings are slightly behind schedule.

At the HQ in Atlanta
The backstop for HQ is a co-chairman for the TB working group in CORE and that relationship has enhanced capacities on either side.

- The use of Elluminate was encouraged by CORE. The TB working group was led in its very first presentation on Elluminate by the CARE HQ TB backstop person, and now this has become a standard practice for the CORE -TB group.

- A web course was designed for CBTO and shared with larger CORE TB group members and its on the CORE TB-Working group web site and is open to use by any PVO working on DOTS TB.

- The new TRM for TB was updated through efforts of the CSTS+ and CORE TB working group and the final editing was done by the backstop person from CARE HQ inAtlanta. Sections on XDR were included for the first time and section on MDR was updated.
- In 2007, CARE presented a paper on training of CBTOs in Banten province at TB-ETN hosted by CDC.

CARE HQ benefited from
- Attending nearly all subsequent Elluminate sessions with the CORE TB working group which has greatly enhanced the knowledge of HQ.
- A proposal written by CORE – TB working group as a joint bid for WHO for evaluation of DOTS TB programs was a very good experience to build capacity on writing joint bids.

- Through CORE TB working group sharing experiences of ACSM between different PVOs, documentation and finally a representation by CORE at WHO STOP TB platform was enriching.
- Finally, the CORE-TB working group hosted a best practices and lessons learned workshop for the USAID TB PVO community. CARE HQ benefited from this exposure.

The project has increased capacities in CII and HQs on DOTS-TB project implementation and management. The project is influencing work on TB in Banten Province and the CORE-TB working group to some extent.

3.3.2 Strengthening Local Partner Organizations

MITRA partners with the government, private health care practitioners and the community based organizations for TB control.

a *MOH and NTP*

The main partner for this project is the MOH and NTP program at *Puskesmas, Dinkes* and Provincial Level.

The NTP, launched in 1979, is delivered through a well designed organization framework, which has been detailed in the DIP. The district level health services are regarded as the basic unit for TB control in the country. Microscopic facilities for TB control are available at the district hospital, microscopic health centers and independent health centers. Treatment services are provided at all these facilities. The treatment register for the entire district is maintained by the tuberculosis officer or the district TB coordinator called "*Wasor*", who regularly visits all facilities to collect data, collate and report treatment and notification outcomes. The Wasor also ensures communication between various facilities and ensures drug supplies.

In a recent policy, following suspension of GFTAM funds, drug boxes are made available to *Puskesmas* by the *Dinkes* upon registration of the patient. *Puskesmas* send a request to *Dinkes* with the sputum and investigation reports of the patient. It takes between a week to a month (quicker in the two cities) to receive the drugs from the *Dinkes*. Drugs are stocked in the warehouses at *Dinkes*, Provincial level and National level.

The reporting is through sets of structured formats. These formats flow from *Puskesmas* and labs to *Dinkes* and Provinces – finally collated at national level.

NTP is highly committed to private – public partnerships and in project districts has been able to forge partnerships with PPs and hospitals. *Dinkes* coverage of private providers in project areas with trainings is far more than that of the project.

The support envisioned from MOH/NTP in MITRA is to provide diagnostic and drug logistics support, human resources for TB control along with continued political commitment.

MITRA committed to building the capacity of additional non-technical staff (those not covered by planned NTP trainings) to increase the depth of TB capacity at *Puskesmas* level. Furthermore MITRA, through active coordination and advocacy forums, planned to support monitoring, problems identification and resolution at all levels.

At the beginning of the project MITRA conducted training needs assessments of *Puskesmas* staff members; however this was restricted to technical areas. Opportunities for informal assessments which could have been possible through regular meetings and project monitoring did not identify capacity of staff to adhere to technical guidelines (e.g. use individual drug boxes) or managerial capacity at *Dinkes* (e.g. proactively manage drug shortages at *Puskesmas* and *Dinkes* level). This failure to either identify or actively support resolution resulted in findings already detailed in previous sections.

MITRA planned to orient *Puskesmas* staff to DOTS. However, following a few trainings they were not given permission to train, as *Dinkes* expected to carry out these trainings through global funds.

MTE teams observed 30 patient consultations (10 suspected and 20 on treatment) both old and new) in all four districts to ascertain the quality of patient-provider interactions. The tool for this observation was adapted from that used by PCI for their Tb project in Mexico.

Some of the positive salient findings are as follow:

- Sputum tests were ordered for all suspected patients.
- X-rays were ordered for 12% of patients (those testing negative for sputum)
- Drugs were prescribed and dispensed appropriately to 20 patients on treatment
- Four patients were asked to get an HIV test done which indicates that there is ample understating of the linkages between TB and HIV

Findings pertaining to education provided are:

- While 64% of patients received education about preventing transmission, about 33% received information about treatment adherence and side effects.
- TB testing of close contacts was discussed with 33% patients and follow up instructions were given to 88% patients.

MITRA has successfully (as described in previous sections) built the capacity of peripheral MOH staff (those closer to the community – *Kaders, Bidans* and paramedics) to address issues pertaining to TB control. Better coordination between these individuals and the *Puskesmas* is required though to improve linkages between centers and communities.

Challenges faced by the project include lack of local NGO or CBO partner to rapidly expand these capacity building activities at community level; and inability to either monitor or highlight identified quality issues discovered through monitoring in advocacy forums.

b ***Private Practitioners***

MITRA has partnered with 27 private practitioners in the project area. This was initiated in June 2007. Capacity building has been so far limited to training. Although MITRA plans to improve linkages of PPs with *Puskesmas* and the communities, this has not taken place successfully. The trained providers await a second round of discussion with MITRA to develop the aforesaid linkages. The training is actually an orientation to the ISTC guidelines as no training manual has been developed. Further, as planned MITRA has not provided PPs with any BCC material.

In a workshop for PPs held parallel to the MTE, these issues were identified and addressed by the project and MITRA plans to focus on strengthening community linkages support to trained PPs.

PPs are keen to partner with NTP, but would need clearly articulated roles and responsibilities, provision of drugs from *Puskesmas* and support with follow up of patients in the community. The MOUs being signed between *Dinkes* and PPs addresses most of these issues. MITRA could play a major role in strengthening linkages.

3.3.3 Strengthening Health Worker Performance

MITRA has identified and trained 956 *kaders,* 471 CBTOs and 152 CBTO coordinators (all volunteer health workers) in the project area. Their performance and capabilities has been discussed in previous sections. This aspect of the project has been effective in providing community level information and services to the community. Further, MITRA oriented 37 doctors, 16 TB officers, and 14 lab technicians of 17 *Puskesmas* in DOTS through one day workshops.

3.3.4 Training

The training strategy has worked for the community based volunteers and workers. It did not work for the *Puskesmas* staff primarily because few were given orientations before they were stopped by the *Dinkes* as a result of the expected role of the global fund. Progress against objectives has been discussed under SO 2 section.

The training strategy for private providers has been discussed in detail under the SO 3 section. The project is behind schedule and needs to make recommended changes in its training strategy for private providers.

3.3.5 Health Facilities Strengthening

The project committed to using COPE for enhancing delivery of quality services through health facilities (*Puskesmas*). This was however not carried out. There are no new tools for health facility assessment. The project collects NTP forms which include monitoring supervisory visit formats of the *Wasor*. This has not been effectively utilized to identify and resolve problems in a timely manner.

MITRA will need to focus on strengthening linkages between facilities and the community further.

MTE teams carried out a health facility assessment and lab assessments. These were carried out by the consultant, national facilitator, CARE Atlanta backstop and Pandeglang *Wasor* using a checklist designed for the purpose.

Salient Findings of the Facility Assessments

- Total of 26 *Puskesmas* were assessed.
- On an average *Puskesmas* investigated 32 suspected TB patients in the last month, excluding four *Puskesmas* who were found to be investigating 150-400 patients.
- Pediatric cases: Two of the twenty six centers visited had equal number of children on treatment as adults.
- Barring three centers, all centers are able to register and hold positive patients detected by them.
- Consistency between number of doses on treatment card and the boxes: 58% .
- 96% of centers are making prompt house visits to retrieve defaulters.
- In two centers drugs had crossed the date of expiry.
- Half of the facilities received supervisory visit within the last three months; most (90%) facilities received supervisory visits in the last five months. Feedbacks provided include improvement of reporting, case finding, quality assurance of slides and community outreach.
- More than half of the centers did not have in their stock TB registers, formats and IEC material.
- Three out of 22 *Puskesmas* reported facing drug shortages for periods ranging from one to three months.

Salient findings from Lab Assessments

- Total of 10 labs were assessed.
- All labs were found to have a separate designated place to operate from; had standard operating procedures, lab registers, binocular microscopes and adequate reagents, slides and other consumables.

- Seven out of nine labs had a trained lab technician performing the sputum examination. Almost all lab technicians met have been trained in the past two years.
- 9 out of 10 labs kept slides and were reviewed by their supervisors. Slides for internal quality analysis were maintained by all labs.
- All labs visited had received supervisory visits by their superior in the last one to three months.
- Reports of site evaluation by supervisor were present in eight labs
- Most labs were disposing waste as per norm
- One lab was performing culture and drug sensitivity tests.
- Error rates of the reporting labs has been discussed under quality assurance section

The primary problem concerns the management of drugs and other consumables. While *Dinkes* and *Puskesmas* have made attempts (not all successful) to borrow drugs from neighboring districts/centers (as reported in the in-depth interviews), their capacity to foresee, negotiate and advocate needs to be built up by the project.

3.3.6 Recommendations

Some recommendations have been covered in the previous sections. Additional ones include:

1. Build the capacity of *Puskesmas* and *Dinkes* in managerial and leadership aspects
2. Use monitoring data to foresee problems and coordinate efforts to find solutions.
3. Build capacity of *Puskesmas* staff to implement BCC interventions with support from structures like *Paguyuban*
4. Advocate for development of linkages between TB-HIV programs, as Banten is deemed as a high HIV prevalence area.
5. Use quarterly monitoring meetings to underline the need for using standardized pediatric score cards. Assess the need for capacity building and advocate for fulfilling the gaps in capacities.

3.4 Quality Assurance

3.4.1 Case Detection by Quality-Assured Sputum Smears Microscopy

Quality here is defined as: all laboratory technicians being trained; being supported with provision of microscopes, reagents and equipment; and random sampling of sputum slides for cross checking. MITRA committed to addressing the issue of quality checks for sputum slides and timely reporting through trainings to lab technicians. MITRA was however requested by the Provincial Health Department to not plan for these trainings as they expected the trainings to be done by the GFTAM. The training matrix in DIP does not describe any planned technical trainings for lab technicians. The lab technicians who have been trained by MITRA so far have received one day orientation to DOTS.

Lab quality assurance data from NTP reports at provincial level are detailed in Table 9.

Table 9 Lab Quality Assurance

		Tangerang C		Tangerang D		Cilegon		Pandeglang	
No. of *Puskesmas* in Districts		**25**		**40**		**8**		**15**	**34**
		2005	**2006**	**2005**	**2006**	**2005**	**2006**	**2005**	**2006**
Number of peripheral lab (*Puskesmas*) had slides cross-checking	Q1	11	20	NA	19	8	8	5	8
	Q2	14	20			8	8	9	
	Q3	6	15		22	8	8		
	Q4	10	18		14	8			
Number of peripheral lab (*Puskesmas*) had error rate more than 5%	Q1	2	8		9	1	1	4	2
	Q2	3	8			1	0	4	
	Q3	3	6		3	0	0		
	Q4	3	6		4	1			

It can be seen from the above table that the except for Cilegon problems continue - is not 100% and error rates continue to be high for some labs. CDR is discussed in the next paragraph.

3.4.2 Treatment of TB Cases with Standard Short-course chemotherapy

Elements detailed in DIP include: Refresher training for *Puskesmas* TB officers in DOTS to ensure important rules of DOTS are not forgotten, patients are correctly categorized and individual drug boxes are maintained for each registered patient.

While refresher training in the form of orientation to DOTS has been provided to *Puskesmas* staff, project has either failed to monitor or successfully advocate for resolutions of problems identified through monitoring. MTE found that Category II patients are put on Category I drug regimen as *Puskesmas* and *Dinkes* have failed to organize streptomycin and many *Puskesmas* are sharing drug boxes between patients.

Table 10 – Key DOTS Implementation Indicators

Impact Indicators	**Year: Jan-Dec (4 districts)**	**Comments**
1.1 increase TB case detection rates (CDR) to **85%** by the end of the project.	2005: 62.88% (baseline) 2006: 67.51%	While the CDR increased significantly in Tangerang city and Pandeglang, it decreased (not significantly) in Cilegon and Tangerang district.
1.2 increase and/or maintain to at least **88%** in the treatment success rate (TSR)	2004: 95.54% (baseline) 2005: 95.82%	Treatment success rates are very high and well maintained.

With expansion of DOTS in Pandeglang the CDR has gone up significantly. The exact reasons for changes in the other districts cannot be explained with available data.

3.4.3 Uninterrupted Supply of Quality Drugs

Dinkes of all four districts reported facing drug shortages between the months of May and July for a period of one to three months. NTP clarified that drugs were available in provincial and national warehouses. *Dinkes* reports dearth of streptomycin. NTP clarifies that category II patients are not captured by *Puskesmas*, hence these drugs are not being requisitioned by *Dinkes*. MITRA has not been able to influence the timely resolution of these issues.

3.4.4 Recording and Reporting

This has improved. Most *Puskesmas* receive supervisory visits regularly and receive supportive feedback from the *Wasors*. Reporting from labs for quality assurance is however low. Some *Puskesmas* faced shortages of reporting formats and TB registers between the months of May 07 and July 07.

3.4.5 Community Defined Quality

MITRA successfully created a cadre of CBTO coordinators and few examples of *Paguyubans* to improve the relationship between communities and the *Puskesmas*. However, the envisioned use of COPE as a tool for quality assurance could not be taken forward. As COPE is a TM protected method CARE along with CRS (TB Philippines project under CSHGP) entered a preliminary understanding for doing COPE TB. This understanding could not be taken forward owing to differences in working modalities between the agencies.

3.4.6 Recommendations

Some of the recommendations have already been covered in previous sections. Additional recommendations include:

1. Discuss with NTP the support required to bridge the gaps in quality diagnosis. Identify the role that MITRA can play.
2. In case that NTP does not require MITRA support then, follow up, monitor, share findings and advocate for improving quality.
3. Support improvement of services provided by *Puskesmas* through structures like *Paguyuban*s.
4. MITRA may decide to either reopen the negotiations to employ COPE or to adopt internal quality parameters instead of COPE TB.

3.5 Sustainability Strategy

MITRA's sustainability strategy is designed to

- Promote governments; community organizations; and the private sector to advocate for higher quality health services
- Enable the effective delivery of health services at the local level; and
- Ensure that improved practices and behaviors are adopted at the community and household level.

It is envisioned that a focus on community TB planning and budgeting at the local government level will build a lasting mechanism for the provision of district-level, high-quality basic human services. Similarly the focus on building behavior change and advocacy capacity of local NGOs, as well as mechanisms to maintain and improve this capacity, will strengthen technical capacity at the level where it is most needed.

Principles for achieving sustainability as detailed in DIP include:

- Build on what already exists.
- Foster capacity to provide technical assistance.
- Focus on institutionalizing planning, budgeting, and management capacity.
- Respect absorptive capacity.

3.5.1 Progress

MITRA through its SO 1 has identified/created and strengthened various community based structures and individuals who are promoting TB awareness, supporting patients to access services and complete treatment. However as the project is behind schedule and has covered 10-25% of committed numbers, it is difficult to comment on the sustainability of behaviour change in the project communities. The few examples of TB associations in the project are good examples of built community capacity to provide support to TB activities. These need to be expanded across the project. Furthermore, the *Puskesmas* or the TB posts need to be linked to these associations so that continued support could be provided and activities are sustained beyond project life.

MITRA does not have any local NGO partner; however it has actively interacted with and involved the PKK (associations of the wives of administrators) and religious leaders through activities in Koran recitation meetings.

Village Health Committees (VHC) have been formed in Tangerang under the USAID's Health Services Program and CARE's BERSIH program. These committees are meant to put health on the village developmental agenda. MITRA has initiated interventions in one VHC and plans to take this forward in the other 12 VHCs formed so far. MITRA has been actively interacting with the village level administrators and orienting them on the importance of TB control and DOTS. There are some examples of monetary support from

the village developmental budgets to poor patients to enable access and completion of treatment.

The government through its NTP is committed to providing quality DOTS services to all patients. MITRA has built the TB capacity of additional staff in the *Puskesmas* to overcome frequent transfers and HR shortages. Through better communication with the *Puskesmas* and by actively promoting the linkages between newly created community structures and groups, MITRA can ensure sustained governmental capacity to provide community level services.

MITRA's design does not have any plans for management or financial strengthening interventions for either community structures, *Puskesmas* or *Dinkes*. When MITRA partners with a local NGO/CBO/FBO partner, for expansion of activities, it will have to be informed by CARE's partnership strategy/framework. Based on initial capacity assessments of partners, MITRA should look at how CARE will enable the partner in being sustainable. This will involve, perhaps, building capacity of the partner in managerial and financial aspects. The management trainings for *Puskesmas* and *Dinkes*, along with the new partners have been identified by MTE team as one of the areas which if implemented will help identify the shortage of crucial inputs into the DOTS program.

Provincial and District *Dinkes* are committed to involving private practitioners, private hospitals and industrial clinics (especially in Tangerang and Cilegon cities). Currently MOH is actively orienting private providers to the ISTC guidelines. No training manual exists for training the providers. The orientation is restricted to technical aspects and is wrapped up with a MOU (when willing) between *Dinkes* and the provider. There are no sessions pertaining to follow up action and set formats for reporting partnership issues. MITRA's recent intervention in Cilegon trainings (detailed in the capacity building section) is a good example of creating meaningful and strengthened partnerships. MITRA can play an active role in incorporating these partnership building and community linkages sessions in all private provider trainings, whether conducted by *Dinkes* or by MITRA.

MITRA has not been able to forge any partnerships so far with industrial clinics and major private hospitals. Since *Dinkes* has proved to be better at inviting and orienting these providers, MITRA could focus on bringing on board the above-mentioned facets to the training therefore contributing to the sustenance of private participation in the project area.

MITRA has been participating in district and provincial level meetings, promoting joint reviews of program and has advocating for the inclusion of a column to identify PVSM population in the TB formats. These advocacy level meetings need to be utilized to identify and avert possible quality assurance related issues in a timely manner (over diagnosis of paediatric cases, drug shortages etc).

3.5.2 Child Survival Sustainability Assessment (CSSA) framework

CII committed to using the CSSA framework for MITRA. All three dimensions of the CSSA sustainability framework are applicable to the project. MITRA intends to use the framework with its partners to assess the current status and track progress on its sustainability efforts.

The CSSA workshop which was slated for January 2007 was not conducted as planned. Project has not developed any phase out plan as yet.

3.5.3 Recommendations

1. Expand formation of TB associations at community level and strengthen their linkages to the *Puskesmas* or the TB posts so that continued support could be provided and activities are sustained beyond the project life.
2. Partner with already identified local NGOs and CBOs (PKK and Village committees) to expand activities and develop local capacitates to implement TB control activities.
3. Build on existing groups to actively advocate for TB control; and link them to strengthened volunteers and TB groups to ensure sustained capacities at the community level.
4. Improve communication with *Puskesmas* and actively promote the linkages between newly created community structures and groups to ensure sustained governmental capacity to provide community level services.
5. Consider managerial and leadership trainings for *Puskesmas* through funds saved under technical trainings to avert shortages of crucial inputs into the DOTS program.
6. Develop a comprehensive training manual based on ISTC guidelines, which builds the technical, managerial and partnership skills of private providers and support the improvement of linkages between community.
7. Actively partner with MOH to expand partnerships with industrial clinics and major private hospitals. MITRA should focus on aspects pertaining to partnership strengthening and community linkages thereby contributing to the sustenance of private participation in the project area.
8. Develop a specific, written strategy for engaging decision-makers. District, provincial and national level interactions should be utilized to avert possible quality assurance related issues in a timely manner.
9. Conduct CSSA framework workshop and monitor sustainability indicators.

C. Project Management System

1. Planning

a) Groups involved in planning

The planning process has involved TB patients and their families, Community Based Treatment Observers, Religious Leaders, *Kaders*, Village Elders, leaders at the local level, midwives and NGOs such as KuIS, , PKK members, and Muhamaddiyah.

The Ministry of Health has supported the project planning process by involving the Health Post workers, the *puskesmas* staff, the district health teams, the district planning teams of all four districts and the province NTP team and the *Bapeda*.
Additionally, the planning process was shaped by inputs from KNCV, WHO, Private Practitioners, and the NTP.

b) DIP work on schedule

Throughout the project implementation has included nearly all activities that it undertook initially. The two crucial activities that MITRA has not addressed yet are:

1) The BCC workshop – However, a BCC strategy has been prepared.
2) COPE TB – This was an activity to be undertaken with EngenderHealth, (who owns the COPE Trademark), but has yet to occur.

MITRA is behind to a degree in working with the PP, although some good pilot work has been done in Cilegon. The project has also moved slower than expected in establishing community-level efforts with TB patient bodies and DOTS TB centers.

c and d) Understanding of project objectives by project partners

The project's objectives are well understood by all partners, and good collaboration on project activities exists among partners. For example, during the training of PP, the Cilegon MOH partnered with MITRA to cost-share the trainings. The *posyandus* have dedicated one of the *kaders* for TB in this grass-root facility. The KNCV at the province level has had a very close collaboration with MITRA since the beginning of the project. The national players, including KNCV/TB-CAP/WHO and USAID local missions, have continuously mentored the project and have participated in DIP planning. The DIP document has been widely shared among these partners.

e) Use of monitoring inputs to revise project implementation

The project has used feedback from its partners to update and revise its implementation strategies. For example, the MOH asked the project not to duplicate the efforts of Global Fund in training the MOH staff. Since that request, CARE has not trained MOH staff on DOTS TB. In another situation, Pandeglang district asked for help from MITRA to initiate the DOTS TB posts, so CARE – MITRA helped the district to initiate this promising activity. Quarterly M&E activities at the district and province level are regularly attended by MITRA staff. Though an official system of documentation of these meetings has not yet begun in MITRA. The review of data and successes/challenges in DOTS TB programming is done at each level, and MITRA staff work with the MOH officials to revise project inputs based on these discussions.

2. Staff Training

a) Effectiveness of Staff Training

The standard, national 1-week DOTS training recommended by the MOH has been imparted to all MITRA staff (excepting one new staff). All field staff also underwent a

training of trainers. These two trainings have helped to boost the confidence of the staff in their technical knowledge, skills, and ability to be effective trainers. The MITRA field staff are now carrying out field trainings and follow up of the trained volunteers/professionals, including doctors, *bidans,* kaders, CBTO etc.

b) Monitoring of Trainee Performance

The performance of the MITRA staff is monitored by their supervisors, the training coordinators, during sessions when the field officers are conducting trainings. The MOH and MITRA staff follow up with former training attendees by monitoring of the volunteers/professionals trained.

c) Are adequate resources dedicated to staff training

MITRA staff are involved in their training needs assessment – one such assessment was done by the technical backstop from Atlanta, which helped to identify that the training of trainers was needed by MITRA staff. MITRA staff are encouraged to identify their training needs and communicate these with the project management.

3. Supervision of Project Staff

a and b) Training coordinators directly supervise the FO work

Each training coordinator is based in the geographical district they supervise to make supervision more direct (Cilegon is supervised by the adjacent district Training Coordinator, but this arrangement may change soon as the involvement in Cilegon will be scaled down as per the DIP). There have been discussions in CII regards changing the supervision structure from a geographical basis to instead be based on individual's specific skills, which means that the Training Coordinators will be designated as DOTS specialist, Training Specialist, and Partnership Specialist, rather than district supervisors. The debate continues and may go past MTE to come to a conclusion. If it comes to fruition, it is expected that this arrangement may 'step up' the areas in which MITRA is lagging behind with more focused inputs from the Training Coordinators.

4. Human Resources and Staff Management

a) *Personnel Management*

In general, all project positions have been filled. The project has continuously had a PM and training coordinators. One training coordinator left the project, so her position was filled in through the promotion of a FO, whose position was filled by hiring a new FO. Two months ago, another Training Coordinator left, and that position remains unfilled, largely because of internal discussions on the possibility of a new managerial-level change as was noted above in the Supervision of project staff section.

b) *Key staffing policies and procedures in place*

All key personnel policies and procedures are in place based on CII policies and procedures.

c) *Morale and Cohesion of staff*

The project is likely to be stressed in the near future because of staffing decisions that must be made. During the evaluation, the FOs in general felt they experience a very good work environment and are receiving capable supervision. The FOs however also felt that project management could be improved and become more aware of issues in the field. There was a similar feeling expressed at the TC level, and CII has taken note of it and is working towards identifying and rectifying the cause of this dissatisfaction. One of the remedies suggested was to have TC work as 'specialists' rather than geographical supervisors as mentioned earlier in point 3, so this is being seriously considered.

d) *Staff Turnover*

Please see section 4 (a)

e) Staff Transition at the end of the project:No plans have been made for staff transition at the end of the project.

5. Financial Management

CII follows the SCALA financial management system, which is a double entry system. This enables the head office to monitor and track expenses in near real time at different levels of account and account tracking. At MTE, burn rate for the project was lower than projected because of slower progress on project activities, as has been noted in earlier sections.

6. Logistics

The project has an adequate number of vehicles for transport, and no bottlenecks are expected. Supplies to the project have been both adequate and timely and are expected to remain so.

7. Information Management

MITRA relies on two sets of systems for its information management

1) The MOH DOTS - TB program information management system – MITRA does not intend to duplicate this well-entrenched and functional system. This system generates the data to be used at both the local and national level and keeps track of a comprehensive set of indicators such as new case detection rate, cure rates, treatment success rates, etc. CARE is encouraging the province MOH to include the PVM in their data systems so that analysis can be done.
2) The internal MITRA monitoring system – This allows the project management to plan and study the work of the FOs in collaboration with partners. The system allows for comparison of the planned and executed activities and expenses. It also tracks the work of individual FO and TCs and checks if targets have been met or not.

a) System to measure progress

Both systems are used in conjunction so as to arrive at a big-picture view of the project achievement, and progress towards targets.

b) A systematic way to collect data at all levels

The information is collected every quarter starting at the health post and *puskesmas* level and is collated at the district level and shared with the province before being widely distributed to partners.

e) What types of data are generated?

Please see 7.1 and 7.2

d) Project is using and supporting existing data systems

The project uses and supports the existing MOH DOTS-TB system and has no plans to establish any other system.

e) Use of data

Please see C.1 (e)

f) Findings and use of assessments

The following project assessments have been done after the baseline:

1) Study of reasons for drop out of TB patients – please see annex
2) Mid term evaluation, KPC and HFA – please see annex F and G

8. <u>Technical and Administrative Support</u>

a) The project has received external technical support from numerous sources

1) Project Manager underwent A CORE organized exposure visit to Chennai in India in 2006.
2) TC participated in the annual child survival workshop in Gadchiroli in India in 2007
3) KNCV personnel trained MITRA staff in DOTS – TB. Consultants were hired to help start the process for BCC related activities.
4) FOs were trained by DAP (USAID) staff in training of trainers.
5) MITRA staff was trained on qualitative survey design, data gathering and preliminary analysis by Emory Intern.
6) During MTE the staff was exposed and learnt from the qualitative tool designing, data collection and presentation. Some staff also learnt the 30x10 cluster sampling technique from design to analysis.
7) Specifically Atlanta back stop visited MITRA in June/July 2007 for preparation of MTE and staff training needs assessment. Atlanta backstop has had monthly phone calls to help project in budget, staffing and field implementation issues.

b) Te project anticipates training needs for

1) COPE – TB.
2) Improving the training of PP to make it more implementation friendly.
3) Supportive supervision training with MOH to link volunteers to MOH DOTS program.
4) Working with hospitals and clinics.

d) The Atlanta backstop supported the project on the DIP and the annual CS workshop. A special visit to support the project for a smooth MTE was done in June/July of 2007. Regular monthly phone calls with project management were done to help out with the day to day work. Names and contacts of BCC consultants and others were shared to facilitate the project to move forward.

10. Mission Collaboration

MITRA contributes to USAID's strategic plan for Indonesia 2004-2008, specifically to SO 2, *which aims to achieve an improvement in health, education environment and other conditions for the global population; with intermediate results of*
-Governments, community organizations and the private sector mobilized to advocate higher quality basic health services.
-Basic human services delivered effectively at local level.
-Improved practices and behaviors adopted at the community and household levels.

Through MITRA, CARE responds to the Global Health Bureau's strategic objective 5: *Increased use of effective interventions to reduce the threat of infectious disease of major public health importance.*

The USAID local mission provides need based support to the project. CARE works with the Mission in Banten Province through BERSIH and the Safe Water System (SWS) in Tangerang District and City. MITRA coordinates with these projects and with USAID's flagship program - Health Services Program in Tangerang District. The mission staff participated in and provided valuable inputs to the DIP process. The CII team meets with the local mission regularly and attends meetings pertaining to USAID evaluation of the KNCV project in Banten, thus keeping abreast of the latest developments in TB programming. Similarly, MITRA Project Manager met the evaluators from the USA at the PCI office in Pandeglang. Updates on the project progress are done on an annual basis. Furthermore, interactions are also held with the mission personnel via telephone and e-mail.

The evaluation team met with Ms. Lisa Baldwin, MPH, Senior HIV/AIDS Technical Advisor and Ms. Gretchen Antelman, ScD, MPH, Senior MCH Advisor, Basic Human Services; and shared the findings of the evaluation. CII utilized this opportunity to make a brief presentation about MITRA and CII's health programs in Indonesia.

D. Other Issues Identified by the Team

No other issues were identified by the MTE team.

E. Conclusions and Recommendations

In conclusion, the project is behind schedule. The MITRA activities are taking place in 25% of the project areas. Community mobilization efforts have been made in these areas with demonstration of some scalable models. MITRA has exceeded targets in terms of identifying and training treatment observers and has done well in developing the much required community component in the poor performing areas. BCC strategy is not in place and needs to be finalized rapidly. While trainings of the Puskesmas staff have could not been carried out owing to the reluctance of *Dinkes,* the introduction of the cadre of CBTO coordinator project has demonstrated the possibility of a sustainable structure that can be a link between the community and the facilities. The activities pertaining to private provider involvement are behind schedule and a clear cut strategy to make this sustainable is emerging now. The project has not been able to advocate successfully at the provincial, district or facility level to resolve identified issues. There are project management issues which have resulted in delays in implementation of planned activities.

Recommendations for the Project

Increasing and Strengthening Community based TB control Structures

1. Expand activities to cover more than 25 *Puskesmas* areas. Sign MOU's as planned with able local NGO/CBO partners to achieve expansion
2. Build on successful experiences of community groups and *Paguyubans.*
3. Improve information sharing with *Puskesmas* through structured methods for better utilization, monitoring and sustainability of strengthened community structures and individuals.
4. Remove the indicator "100% increase (from 30% to 60%) in knowledge of symptoms of TB and its curability in the community" as this is already captured in two other indicators and is merely repetitive.
5. Rephrase indicator "at least 20% increase in the number of TB suspects from 6,560 in 2005 to 7,800 by September 2009 combined for the 4

districts." – to read " at least **40%** increase in number of suspected TB patients reaching or screened by *Puskesmas* in four project districts from 27,953 in 2005 to 53,111 in 2009."

6. Carry out the committed operations research on impact of incentives on CDR.
7. Follow up the identified child in Waliwis village and investigate the reasons for continuing treatment even after three years.
8. Utilize the simple monitoring formats to measure outputs and outcomes of CBTO/Volunteer activities.

Strengthen District Capacity of District and Provincial TB Program

1. Build on success of CBTO coordinator capacity building strategy
2. Rethink the trainings that MITRA wants to give at *Puskesmas* level. Who will be trained? What will be the content? How will this be done?
3. Drop the indicators pertaining to training of *Puskesmas* staff.
4. Consider managerial and leadership training for *Puskesmas* staff if NTP restarts technical trainings for them through the latest round of GFTAM funding.
5. Jointly with *Dinkes*, investigate the use of recommended score cards for pediatric diagnosis to identify reasons for over diagnosis and train providers to address the situation (either through MITRA funded trainings or through NTP).
6. Through regular analysis of monitoring reports and field feedback, identify drug/lab/reporting issues and advocate for resolutions at appropriate forums. Advocate for resolution of issues related to sharing of drug boxes and unavailability of streptomycin at provincial and national level.

Participation of Private Providers

1. Since MOH has been training more private practitioners and has allocated budgets for the purpose, MITRA can dove tail these efforts by providing quality enhancing inputs – put together a training manual; help develop training sessions to include action plans, partnership modalities, available community support; put together a kit of treatment algorithms, ready reckoners, IEC material and handouts with information on community and *Puskesmas* contacts.
2. Develop a simple monitoring format for issues not covered by existing TB formats – support required, problems faced – which can be used by the PP to communicate with the *Puskesmas*.
3. Consider splitting the entire training into one hour lunch hour sessions to increase the participation of PPs.
4. PPs are willing to network with their peers. Utilize this willingness to enroll more PPs.
5. Dovetail MOH relationship with hospitals and industrial clinics and offer to bring on board the above-mentioned quality enhancing inputs.
6. Actively link up volunteers and CBTOs trained by MITRA with the PPs and the *Puskesmas*.

Community Mobilization

1. Expand activities to cover all project areas. Build on the success of *Paguyuban*s and community groups.
2. Sign MOUs with identified able local NGO/CBO partners to ensure transfer of expertise and expansion of activities.
3. Plan to withdraw support to mature groups and develop simple monitoring formats to measure the outputs and outcomes of community activities.

BCC

1. Conduct a workshop of all key stakeholders to finalize the draft BCC strategy
2. Quickly adapt, produce and disseminate IEC material to community based partners and *Puskesmas*.
3. Include messages on side effects, HIV – TB linkages and MDR TB to the appropriate extent. Address some of the identified misconceptions about TB (using same utensils will cause TB, TB is sexually transmitted, TB patient should be isolated) which generate stigma.
4. Build capacity of the partners to use the material.
5. Develop monitoring formats to quantify coverage with the tools and measure effectiveness.
6. Partner with identified local NGOs to support BCC activities in the community
7. Develop an IEC kit for the private providers who have partnered with MITRA and the DOTS program
8. Utilize project monitoring data and NTP data to share, identify problems and resolve them at *Puskesmas*, district, province and national level
9. Actively coordinate with NTP to be informed by and be able to contribute to the national ACSM activities.

Capacity Building

1. Build the capacity of *Puskesmas* and *Dinkes* in managerial and leadership aspects
2. Use monitoring data to foresee problems and coordinate efforts to find solutions.
3. Build capacity of *Puskesmas* staff to implement BCC interventions with support from structures like *Paguyuban.*
4. Advocate for the development of linkages between TB-HIV programs, as Banten is deemed as a high HIV prevalence area.
5. Use quarterly monitoring meetings to underline the need for using standardized pediatric score cards. Assess the need for capacity building and advocate for fulfilling the gaps in capacities.

Quality Assurance

1. Discuss with NTP the support required to bridge the gaps in quality diagnosis. Identify the role that MITRA can play.
2. In case that NTP does not require MITRA support then, follow up, monitor, share findings and advocate for improving quality.

3. Support improvement of services provide by *Puskesmas* through structures like *Paguyubans.*
4. MITRA may decide to either reopen the negotiations to employ COPE or to adopt internal quality parameters instead of COPE TB.

Sustainability

1. Expand formation of TB associations at community level and strengthen their linkages to the *Puskesmas* or the TB posts so that continued support could be provided and activities are sustained beyond project life.
2. Partner with already identified local NGOs and CBOs (PKK and Village committees) to expand activities and develop local capacities to implement TB control activities.
3. Build on existing groups to actively advocate for TB control; and link them to strengthened volunteers and TB groups to ensure sustained capacities at the community level.
4. Improve communication with *Puskesmas* and actively promote the linkages between newly created community structures and groups to ensure sustained governmental capacity to provide community level services.
5. Consider managerial and leadership trainings for *Puskesmas* through funds saved under technical trainings to avert shortages of crucial inputs into the DOTS program.
6. Develop a comprehensive training manual based on ISTC guidelines, which builds both technical, managerial and partnership skills of private providers and support the improvement of linkages between community
7. Actively partner with MOH to expand partnerships with industrial clinics and major private hospitals. MITRA should focus on aspects pertaining to partnership strengthening and community linkages thereby contributing to the sustenance of private participation in the project area.
8. Develop a specific, written strategy for engaging decision-makers. District, provincial and national level interactions should be utilized to avert possible quality assurance related issues in a timely manner
9. Conduct CSSA framework workshop and monitor sustainability indicators.

Scaling up and Down

1. Cilegon has been performing well on the DOTS indicators and the linkages between health centers and the communities are well established. MITRA can consider phasing out community activities in Cilegon and support improvement of quality in private provider trainings.

2. Consider working with CBTO coordinators as against CBTOs. Since most CBTOs are family members, their interest in continuing as CBTOs beyond the treatment of their kin is moot. Scale up *Pagyubans and TB posts.*
3. Drop identified indicators which are either redundant or cannot be achieved (owing to change in government stance)
4. Consider dropping COPE for some internal quality monitoring indicators. For example proportion of providers applying BCC with their patients.
5. Dovetail the government's efforts to train private providers by enhancing the community and managerial aspects of the skills.

Points to Ponder for USAID

1. TB programs worldwide are very structured and rigid which makes it difficult for NGO partners to carve a role for themselves. Further the role carved is restricted to some aspects, with no controls on other aspects of DOTS. However, DOTS does not work until all five components come together. There is a need for future project designs to envisage a larger and active role for local missions and TBCAP partners, to ensure the factors outside the control of NGO partner can be advocated at a higher level.
2. Consider incorporating an indicator pertaining to 'initial defaulters'. These are people who approach care provider and are diagnosed to be sputum positive, but are not put on treatment. This indicator can act as an indicator to assess quality of service provision within the control of NGO.

F. Results Highlight

1. *Online course for Treatment Observers*

CARE has developed an online course for Treatment Observers. The url for the course is:
http://www.careacademy.org/health/tb/tuberculosis_e_training1_24_tb_course_p001.htm
The course is divided into five modules covering definition; diagnosis; treatment; role of treatment observers; and counseling skills. The sessions are interactive and include numerous role plays and frequently asked questions. It has a separate tools section which details checklists for side effects, counseling, treatment and diagnosis. The site provides links to other external resources and offers a forum for sharing information and discussing issues of interest.

2. Monitoring Inclusion of Poor Vulnerable and Socially Marginalized (PVSM) People

The NTP in Indonesia has programmed DOTS as a free medicine provision service through the government health delivery system. But as decentralization has taken root, and more and more decisions are being taken at the local level, a few government primary health centers have opted for a one-time patient registration fee which varies between centers and districts, ranging from USD 0.2 – 0.5. Few centers

also levy a revisit fee which is minimal. MITRA plans to identify these centers and use its advocacy skills to make registration for all its project patients as free. *'Kartu Miskin'* or *'Surat Keterangan Tidak Mampu'* is a government identity card given to poor families which identifies the poor in the administrative area. Holders of these cards get subsidized or free health services.

As a first step towards this intention, MITRA had a series of successful discussions with the Provincial MOH to include a column on the TB formats identifying a patient with *Kartu Miskin.* During the MTE CII team was informed that the Province will need support to print the new formats until funds from the latest round of Global Funds become available. MITRA has agreed to support the printing of the formats which will perhaps be the stepping stone to negotiating for free registration of these patients into DOTS services and improving monitoring of access to TB treatment by PVSM population.

G. Action Plan is attached as Annex E.

Annexes

Annex A: *Evaluation Team members and their Designation*

Name	Designations
Dr. Ranjani Gopinath	Consultant, external evaluator
Dr. Abdul Manaf	National Consultant MTE and Ex Director, NTP, Indonesia
Dr. Beatricia Iswari	Program Manager, MITRA
Dr. Khrist Roy	CARE USA Headquarters; Technical Advisor, Child Health
CARE Indonesia	
Ms. Diyan Ratnasari	Field Officer, MITRA
Ms. Ika Suciani	Field Officer, MITRA
Mr. Jordan Jempormase	Training Co-ordinator, MITRA
Ms. Nurlaili	Field Officer, MITRA
Ms. Humairoh Anahdi	Field Officer, MITRA
Mr. Kaji	Field Officer, MITRA
Ms. Umi Kulsum	Field Officer, MITRA
Mr. Samsudin	Field Officer, MITRA
Ms. Ani Kristanti	Field Officer, BERSIH Project
Ms. Lani Indrayanti	Field Officer, BERSIH Project
Mr. Dodi Ardiansyah	Field Officer, BERSIH Project
Mr. Ibnu Aji	Field Officer, BERSIH Project
NTP and MOH Staff	
Ms. Meiyetti Burina, SKM	Chief of Technical Service Unit for Pulmonary Diseases (UPTD), *Dinkes*, Cilegon.
Mr. Yudi Hermawan, SKM	District TB Supervisor (*Wasor),* Pandeglang
Mr. H. Mudhar	District TB Supervisor *(Wasor),* Cilegon
Ms. Fatmawati	*Kader* of *Paguyuban* Pulo Merak, Cilegon
Ms. Iis Nurmayasari	*Kader* of Pandeglang District
Ms. Suwarni	*Kader* of Jatiuwung *Puskesmas*
Ms. Nuchyatul Aliya	*Kader of Tangerang District*
NGO Members	
Dr. Loekman Hakim Siregar	Senior Technical TB Officer, PPTI also ex Chief in Banten Province for KNCV
Mr. Asep Surjana	LAZ-harfa
Ms. Jaorana Amiruddin	Vice TB Coordinator for Aisyah (Central Unit)
Others	
Ms. Yuliana Tansil	Translator and Interpreter for Khrist Roy
Mr. Widodo Guntarto	Interpreter for Ranjani Gopinath

Annex A.1 *KPC Team Members and their Designation*

Name	**Designations**
Ms. Listya Permana Hapsari	Enumerator
Ms. Devi Lestari	Enumerator
Ms. Yudhiani	Enumerator
Ms. Jayanti	Enumerator
Ms. Rina Yuga Utami	Enumerator
Ms. Evi Nilawati	Enumerator
Ms. Nur Akmalia	Enumerator
Mr. Bobby Anggi Putra H.	Data Entry
Ms. Ira Akhira Mardiani	Field Officer MITRA
Ms. Lidya Fanida	Field Officer MITRA
Mr. Luly Arfan	Field Officer MITRA
Mr. Yosef Heribertus Turut	Field Officer MITRA
Mr. Sutan Royansyah	Monitoring and Database Officer MITRA/Data Entry and Analysis
Dr. Lutfi Syeban	Training Coordinator MITRA/MTE coordinator for KPC and Health Facility Assessment

Annex B: ***Assessment Methodology***

The Mid Term Evaluation of MITRA project involved

a) KPC survey;
b) qualitative survey; and
c) Internal debriefing of team members, CARE Senior Management; debriefing of local USAID Mission, and NTP. The detailed schedule of the evaluation is in Annexure D.

Qualitative Survey

Preparing the tools
To carry out the qualitative survey, CII shared key documents with the consultant and provided clarifications for questions arising out of review of these documents. Consultant discussed and listed key stakeholders who were to be contacted for assessments. Based on this listing draft tools for the community level FGDs/IDIs/meetings/facility assessments and clinical observations were shared first with CII team and the National MTE Consultant for review and translation.

Key Partner Inputs
The tool designs were informed by additional inputs from NTP, KNCV and WHO at national level. These meetings helped understand the questions national stakeholders needed answered through the evaluation process.

Survey Workshop and participants
Two days were slotted for the workshop of which the first had to be spent familiarizing with the tools, the second day was used for facility assessments and practice skills through role plays. To overcome the paucity of time, senior technical team members were given the responsibility of carrying out the health facility assessments and guide their district teams through the other tools in the field. The Project Manager and CARE Atlanta back stop guided two teams while the Team leader and National Consultant guided the other two district teams.

CARE invited various stakeholders to be part of the evaluation team and managed the logistics. The participants of the tool finalization workshop were oriented to the objectives of the workshop, given an overview of the project strategies and KPC findings and oriented to the qualitative methodology. They were informed about the differences between the questions asked during a quantitative and a qualitative survey. They were also oriented to various participatory evaluation methodologies like FGDs, IDIs and Key informant interview. MOH officials (mainly *Wasors* from each districts), *Kaders*, one ex TB patient and local NGO members participated in the tool finalization workshop. On the second day of the workshop, district teams were constituted (comprising of CARE staff and ample representation of stakeholders on each team) and they underwent training in interviewing techniques through role play.

Not many team members had prior experience in survey methodology, however, each district team leader was asked to spend time with their teams to review the tools further. Each team was given a synthesis format so as to maintain consistency on district reports. List of various tools used is at the end of this section.

Since the qualitative teams were to cover a total of twelve health facilities it was decided that the KPC team would carry out additional facility assessments in order to provide ample quantitative data on facilities.

Sampling

Purposive sampling was carried out to identify field areas. Three *Puskesmas* areas - some functioning well and some performing poorly were selected. Teams visited villages and communities in these areas to carry out discussions and interviews.

Conducting the survey

Over the next five days, four teams with 4-5 members each visited 22 Villages and 4 urban wards in the four project districts and met a total of 297 people. These included TB patients, TB associations, community members, religious leaders, volunteers, CBOs, *Puskesmas* staff, Private providers and District/Province level MOH officials. Consultant visited communities in two project areas - Tangerang City and District; details of tasks carried out are listed in the evaluation schedule. The full list of communities and health facilities visited, and list of persons interviewed is included in the annex C “Interviews, Contacts and Participants”.

Synthesis of data

Each district team synthesized the findings in a participatory manner and listed the key findings, lessons learnt and recommendations. The district reports were presented to the entire evaluation team. These presentations were attended by Junior and Senior Technical Program Leader Health and Assistant Country Director Programs, CARE Jakarta.

KPC

The KPC survey was conducted parallel to the qualitative evaluation and was designed and led by Pak Abdul Manaf the local consultant and Dr. Lutfi. The collection of data was carried out by external enumerators. A 30 x 10 cluster sample technique was employed to collect data on three to four knowledge indicators. The final report of the survey is being submitted as a separate document. While KPC covered the entire project area the qualitative survey included only those areas where MITRA had initiated activities.

Debriefing

Separate meetings were held to debrief Senior Project and CII staff, local USAID Mission and NTP at Jakarta. The project is expected to share the district level findings with key district stakeholders at a later date.

Annex C: List of Persons Interviewed and Contacted

Name	Designation
CARE International Indonesia	
Dr. Khrist Roy	Technical Advisor Child Health, CARE Atlanta
Ms. Heather Van Sice	Assistant Country Director, Programs
Dr. Damayanti D Soekarjo	Technical Program Leader, Health and Nutrition
Mr. Frank Page	Urban Program Manager
Dr. Sri Kusuma Hartani	Junior Technical Program Leader, Health
All MITRA staff	
Central NTP/KNCV/WHO	
Dr. Carmelia Basri	Head NTP, Sub- Directorate TB, MOH
Mr. Cecep Slamet Budiono	National Technical Officer, KNCV
Mr. Sjoerd Postma	Country Representative, KNCV
Ms. T. Candyana Yohan	ACSM Partnership Officer
USAID Local Mission	
Ms. Lisa Baldwin	Senior HIV/AIDS Technical Advisor
Ms. Gretchen Antelman	Senior MCH Advisor, Basic Human Services
Provincial Level	
Mr. Akhmad Zubaidillah	Chief of Social and Cultural Division of Banten Province Planning Commission
Ibu Nurmetia	Staff member

Tangerang District

Respondent	Tool	Number	Area
TB Patients	FGD/IDI	2	Kosambi Dalem and Salembaran Jati
Community members including religious leaders	FGD	2	Pisangan Jaya village and Kosambi Dalem
Volunteers	FGD	2	Salembaran Jati, Kosambi Dalem
TB Post staff	IDI	1	PKM* Sepatan
Puskesmas staff	IDI	7	PKM Kosambi, PKM Sepatan, PKM Walwis
Facility assessments	Checklist	3	PKM Kosambi, PKM Sepatan, PKM Walwis
Lab assessments	Checklist	3	PKM Kosambi, PKM Sepatan, PKM Walwis
Clinical Observations	Checklist	3	PKM Kosambi, PKM Sepatan, PKM Walwis and *Dinkes* lab
District *Dinkes* Staff	IDI	2	Tangerang District
Provincial *Dinkes* Staff	IDI	-	-
Private Practitioners	IDI	2	Pamulang Barat

*PKM: *Puskesmas*

Tangerang City

Respondent	Tool	Number	Area
TB Patients	IDI	7	Jatiuwung, Sukasari, Pabuaran Tumpeng and Karawaci Baru PKM
Community members including religious leaders	FGD	2	Karawaci Baru and Jatiuwung PKM
Volunteers	FGD	2	Jati Uwung, *Posyandu* Aster, Sudimara selatan village and Cileduk ward
TB Post staff	IDI	-	-
Puskesmas staff	IDI	13	Jatiuwung, Sukasari, Pabuaran Tumpeng and Karawaci Baru
Facility assessments	Checklist	4	Jatiuwung, Sukasari, Pabuaran Tumpeng and Karawaci Baru
Lab assessments	Checklist	4	Jatiuwung, Sukasari, Pabuaran Tumpeng Karawaci Baru
Clinical Observations	Checklist	5	
District *Dinkes* Staff	IDI	4	Tangerang City *Dinkes*
Provincial *Dinkes* Staff	IDI	-	-
Private Practitioners	IDI	-	-
Industrial Clinic	Meeting With management	1	Sulin Dufin Industry

Cilegon City

Respondent	Tool	Number	Area
TB Patients	IDI	1	PKM Ciwandan
Community members including religious leaders	FGD	1	PKM Cibeber
Volunteers	FGD	1	Kel. Banjar Negara
TB Post staff	IDI	--	-
Puskesmas staff	IDI		PKM Cibeber and PKM Pulo Merak
Facility assessments	Checklist	2 + 1	PKM Cibeber, PKM Pulo Merak and RSKM hospital or the Krakatua Medika Hospital (this private hospital belongs to the Krakatua Steel)
Lab assessments	Checklist	2	PKM Cibeber, PKM Pulo Merak
Clinical Observations	Checklist	6	
District *Dinkes* Staff	IDI	4	
Provincial *Dinkes* Staff	IDI	-	-
Private Practitioners	IDI	2 + 3	Cilegon City + 3 hospital staff
Industrial Clinic	IDI	2	Indonesia Power

Pandeglang District

Respondent	Tool	Number	Area
TB Patients	IDI	1	Labuan PKM
Community members including religious	FGD	2	Village of Batu Ranjang Sub-District of Cipeucang and BKB of Caringin Sub-District of Labuan
Volunteers	FGD	3	Labuan, Bojong, Panimbang PKM
TB Post staff	IDI	1	Village of Mogana Sub-District of Banjar
Puskesmas staff	IDI	9	Labuan, Bojong, Panimbang PKM
Facility assessments	Checklist	3	Labuan, Bojong, Panimbang PKM
Lab assessments	Checklist	3	Labuan, Bojong, Panimbang PKM
Clinical Observations	Checklist	5	
District *Dinkes* Staff	IDI	1	Pandeglang District
Provincial *Bapeda*	IDI	2	Pandeglang

Annex D: Evaluation Schedule and Activities

Date	Activity
Wednesday 31 Oct 2007	Consultant arrival in Tangerang Meeting with MITRA team; preparation for tools workshop
Thursday 1 Nov 2007	Meetings with NTP, WHO, KNCV and CII senior management Team led by Urban Program Manager was split into small groups to review tools
Friday 2 Nov 2007	Tools finalization; orientation to qualitative methodologies; practicing techniques through role plays; district team formation and logistics
Saturday 3 Nov 2007	Additional sessions with MITRA staff and KPC enumerators
Sunday 4 Nov	Team took off, Consultant reviewed draft BCC strategy
Monday 5 Nov - Friday 9 Nov	Field work, places visited and people met in Annex C
Saturday 10 Nov	Orientation to evaluation team on process of synthesis
Sunday 11 Nov	Team took off, consultant reviewed national TB survey document
Monday 12 Nov	Synthesis workshop – to collate findings and recommendations in a participatory manner
Tuesday 13 Nov	Findings and recommendation sharing by district evaluation teams
Wednesday 14 Nov	Sharing of findings with USAID local mission; Internal debriefing for CII senior management and meeting with KPC team
Thursday 15 Nov	Debriefing with Dr. Carmelia Basri, NTP and consultant's departure from Indonesia

E. Action Plan

The following Action Plan was developed by CARE MITRA staff and managers based on preliminary recommendations following the MTE in November 2007.

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
Key Strategies				
1) Coordinate with Dinkes and Puskesmas to ensure drug stocks and that individual boxes are meant for only one patient. Seek help at different levels to address this issue.	Some Puskesmas have reported stock outs temporarily and sporadically. To cope some of them have reached to other HF to share medicines and or started sharing medicine boxes of patients	As this matter is both Important and Urgent – MITRA will use the dissemination meeting platform at district and province level to share the finding and making aware the DOTS guidelines do not permit sharing of medicines and will strive to find the cause of disruption of supplies and address the gap at all levels. MITRA will include in all quarterly M&E agenda at all levels – sub-district, district and province – DOTS stock issues. Thus ensuring sustainability of stock supplies issues Facilitating access of the formats at community and	All MITRA staff and reporting centers for DOTS	Feb 2008

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
		health facility levels.		
2) Pediatric TB diagnosis is according to national guidelines.	Almost all puskesmas have Pediatric TB patients enlisted for DOTS. Very few puskesmas have more pediatric TB patients than adult TB patients.	a) Orientation of HF staff on use of national score card b) Bring the issue up in the dissemination and quarterly M&E meetings at all district level.	all MITRA staff.	February 2008
3) BCC related a) Existing and Available IEC material to be used by HW and volunteers b) Come out with MITRA BCC strategy which is line with NTP and includes HIV/TB intersection c) Use Sundanese language IEC materials as needed	a) MITRA to help distribute existing BCC material in the 4 districts b) Draft BCC strategy is ready – BCC workshop needed to garner consensus on strategy and material	a) MITRA will facilitate use of currently available BCC material. b) MITRA will organize BCC workshop c) Material in Sudanese language will be made	a) PM/TC to identify currently existing IEC material and FO to use and distribute in the community b) PM organizes BCC workshop c) All MITRA staff to help facilitate its use and monitor BCC activities that ensue in the community	a) December 07 b) BCC workshop January 2008 c) BCC material distribution in March 2008
4) Strengthening of CBOs a) Increase number of *Pagubayans* *b)* Work with local CBOs, FBOs, NGOs to increase geographical coverage	a) Currently 4 pagubayans active. b) A few Religious leaders are working with MITRA. c) Many CBOs are	a) More pagubayans will be formed. b) Work with PMO coordinators Kaders will be increased c) Where ever possible work with religious	a) TC will take lead on work on pagubayan formation. b) FO will take lead on work with PMO Coordinators c)PM will	a) Ongoing activity b) Ongoing activity c) Partnership strategy approved by Feb 2008 d) Based on lessons learnt from partnership formal contracts

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
	working with MITRA informally like KuIS, PKK etc.	leaders will be increased.	lead on religious leaders and NGOs by outlining a partnership strategy which will be translated into action by TC and FO d) Other opportunities to work with partners will be identified	will be entered into.
Information sharing and use				
5) Piggy back with MOH/KNCV initiatives to work with PP a) PP b) Private Bidans c) Industries and Hospitals	MITRA is already holding discussions with KNCV and MOH regards work with all of the mentioned private players and has MOU with some of these independently or with their agencies.	a) Use successes of Cilegon for working with PPs and industries in other districts. b) Pandeglang to try this model after referral from the puskesmas. c) Again use the Cilegon model for work with industries in Tangerang Kota, and work in tandem with KNCV on hospitals. Review C-HIS, strengthen the <u>feedback route</u> for use of information at community level.	a) TC b) TC Pandeglang c) All TCs	Ongoing activity

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
6) Improve Coordination with Dinkes and expand definition of coordination to include problem solving	Regular quarterly meetings are held with MOH	1) Joint supervision visits to be made regular and focus on problem solving using supportive supervision checklists 2) MITRA to support all M&F meetings at all levels	1) PM responsible for generation of Supportive supervision checklist 2) All staff to attend M&F meetings at their levels	Ongoing activity

Attachment F - MTE Health Facility Assessment – MITRA Project – Banten Province November 2007

Objectives of the Health Facility Assessment

The main purpose of conducting this health facility assessment in CARE's project areas in Indonesia is to assess the performance of DOTS treatment centers for TB patients and to obtain information on key indicators for health services, including availability of laboratory facilities and adequate supervision in the district. The findings of the health facility assessment will be compared to baseline data for CARE's project area to assess if project activities and interventions helped to achieve original targets for given health indicators.

Specific Objectives of the Health Facility Assessment:

1) To assess and determine quality of health care delivered to TB patients at DOTS treatment and outreach facilities
2) To assess and determine availability of key health system supports that are required for treatment of TB patients, such as laboratory equipment and adequate supervision
3) To assess and determine the availability of correct treatment practices for TB patients in DOTS treatment centers, including adequate drugs and treatment supporters
4) To make comparisons between the baseline and current survey findings

Methodology

Selection of HF

HFA was planned to be done in conjunction with the KPC 30x10 survey.
Hence the closest *puskesmas/HF* to the selected KPC village was chosen for the survey making the selection of HF random. For the lab facility only 10 sites were chosen where all the team leaders would go individually and report it themselves, this was done to ensure quality reporting for the laboratories which in some districts were considered to be weaker and needed strengthening.

Training of Survey team

The survey training team was led by the external consultant and re-enforcement was done by individual district team leaders who included Pak Manaf, Pak Lukeman, Dr. Ranjini, Dr. and Dr. Khrist. The teams were exposed to the standardized tools, their inputs taken and lead by the team leader the first few days.

Tools used

Standardized tools were used by all team members as checklists to ascertain the current practices in the HF. Initially three sets were designed to be used for the HF

a) The DOTS facility tool
b) The laboratory tool
c) Patient observation and exit interview – as there were very few patients in the facilities visited, the survey did not get significant numbers to do an analysis of the numbers. We would like to recommend that greater number of days are needed per facility to get adequate numbers of patients for observation

Table One: DOTS TB Center Performance (n=26)

(Missing values are not show but add to 100%)

Measured Indicator	Frequency	Percent
DOTS Facilities Clean		
Yes	17	73.9
No	6	26.1
Adequate Arrangement for Provision of Injectable SM		
Yes	20	87
No	3	13
Prompt Home Visits Made to Bring Irregular Patients Back to Treatment		
Yes	23	95.8
No	1	4.2
Any Drugs in Patient Boxes Past Expiration Date		
Yes	2	9.5
No	19	90.5
Home Address Verification Done for Patients Before Treatment Starts		
Yes	21	95.5
No	1	4.5
Timing of Last Supervisory Visit of TB Officer		
> 1 month ago	2	10
1-3 months ago	8	40
3-5 months ago	8	40
5-7 months ago	1	5
9-11 months ago	1	5
Drug Boxes are Being Marked and Maintained for Outpatients Receiving Treatment at the DOTS Center		
Yes	19	82.6
No	4	17.4
Consistency between Doses on Treatment Card and Doses in Patient's Box		
Yes	11	57.9
No	8	42.1

Summary Findings from Table One: The majority of drugs that are provided to patients appear to be recent drugs that are not expired, indicating that available drugs are being used by health facilities. However, less than 60% of the drugs being disbursed to patients are being effectively tracked to see that they are used according to the treatment regimen prescribed. The drugs prescribed versus the drugs in the box of the patient are matching exactly in over 40% of those facilities surveyed.

Prompt home visits are being made to keep patients in treatment, and home addresses are most often collected prior to treatment to enable these home visits. Other services listed above appear to be available in most sites, and supervisory visits are occurring on a mostly quarterly or less than quarterly basis it appears.

Table Two: Lab Facilities Assessment (n=10)

Measured Indicators	Frequency	Percent
Existence of Distinct Lab Space	10	100%
Existence of Standard Operating Procedures	10	100%
Presence of Lab Register	10	100%
Functional Binocular Microscope	10	100%
Trained lab technician performing sputum microscopy	Yes-7 No-2	Yes-77.8% No-22.2%
Adequate reagent, slides, and consumables for one month's time	10	100%
Monthly summary of microscopy activities	Yes-9 No-1	Yes-90% No-10%
Lab technician preserving slides for review by supervisor as per quality assurance protocol	Yes-8 No-1	Yes-88.9% No-11.1%
Is biomedical waste disposed as per norms	Yes-8 No-1	Yes-88.9% No-11.1%
Lab engages in Mycobacterium culture and drug susceptibility testing	10	100%
Slides maintained for internal quality	10	100%

Table Three: Supervision Assessments (n=10)

Measured Indicators	Frequency	Percent
Occurrence of lab supervisory visit	Yes-9 No-1	Yes-90% No-10%
Supervisor is reviewing preserved slides onsite	Yes-9 No-1	Yes-90% No-10%
Monthly supervisory reports available onsite for at least one month	Yes-8 No-2	Yes-80% No-20%
Correction actions recommended by reports being carried out	Yes-7 No-2	Yes-77.8% No-22.2%

Summary of Findings from Table Two and Three: Out of eleven indicators to assess adequate laboratory facilities, seven are being met in all health facilities surveyed. Of the four that remain, the two of greatest concern are that only 7 facilities report having a trained technician perform sputum microscopy; this could

potentially create problems with diagnosis, especially since only 8 facilities report actually keeping slides for review as per the quality assurance protocol, again brining into question possibly flawed diagnoses.
None of the indicators to assess adequate supervision were met by all health facilities. Most notable among these indicators however is that the lowest percentage is reported for the indicator of "corrected actions recommended by reports being carried out." Even if supervisory visits are occurring, if no changes are being made accordingly, then these visits are wasted time and resources.

Table Four: Stock Out Table (n=26)

Measured Indicators	Frequency	Percents
Registers		
Yes	14	58.3%
No	10	41.7%
TB Forms		
Yes	14	58.3%
No	10	41.7%
IEC Material		
Yes	14	56%
No	11	44%
Counseling Material		
Yes	11	45.8%
No	13	54.2%

Summary of Findings from Table Four: Stock outs appear to be a huge problem in these health facilities surveyed. In all cases, nearly half of the facilities report not having adequate supplies.

Table Five: Prevalence of TB in Patients

Name of Puskesmas	TB suspects examined for diagnosis in the last month	TB suspects found to test positive
PKM Waliwis	414	52
PKM Sepatan	NA	NA
PKM Kosambi	127	65
PKM Bokang	26	5
PKM Banjar	379	48
PKM Sukasari	60	5
PKM Karawaci baru	28	5
PKm Babuaran Tumpeng	303	61
PKM Pulau Merak Cilegon	NA	48
PKM Cikole	NA	NA
PKM Bangkonol	4	3
PKM Ciputat	57	2
PKM Rajeg	44	9
PKM Kronjo	15	4
PKM Jambe	27	7
PKM Karawaci Baru	28	5
PKM Tigaraksa	40	13
PKM Jombang	43	3
PKM Cisoka	37	5
PKM Pagadungan	7	4
PKM Cisauk	21	2
PKM Cikedal	9	5
PKM Carita	15	5
PKM Cikupa	55	6
PKM Mauk	67	4
PKM Pakuhaji	41	7

Summary finding of Table 5
There is a huge variation in the numbers of TB suspects being referred and diagnosed, while a lot maybe explained by differing catchment population, the project needs to take a closer look at the wide variability.

Table Six: Prevalence of Positive TB Slides

Sub District	Total examined slides	Total positive slides	Total negative slides	Total positive slides (%)	Total negative slides (%)
Sepatan					
Kosambu	127	5	3	3.9%	2.4%
Labuan	54	13	41	24.1%	75.9%
Banjar	165	27	138	16.4%	83.6%
Sukasari	180	15	165	8.3%	91.7%
Karawaci Baru	30	15	15	50.0%	50.0%
Pabuaran Tumpeng	144	71	73	49.3%	50.7%
Pulo Merak	118	12	103	10.2%	87.3%
RSKM Cilegon	320	22	298	6.9%	93.1%
Cibeber	336	117	219	34.8%	65.2%

Note that the range of percent positive slides ranges from less than 7% to 50%, indicating the existence of a wide range of infection depending upon sub-district location.

Summary of findings of Table 6
Again a wide variation is seen in the slide positivity rate, some centers are showing only 4% positive rate while others are showing around 50%. This can be explained by differences in numbers and type of suspects being referred to the facilities.

Table Seven: Patient Performance and Treatment

Name of Puskesmas	Number of patients registered (I.17)	Number of dedicated drug boxes (I.18)	Adequate Drug Boxes (Y/N)	Number of defaulters (I.19)	Number with treatment supporters (I.20)	Adequate Treatment Supporters (Y/N)
PKM Waliwis	52	52	Y	0	52	Y
PKM Sepatan	153	123	N	0	153	Y
PKM Kosambi	65	55	N	3	65	Y
PKM Bokang	21	8	N	1	6	N
PKM Banjar	38	38	Y	10	38	Y
PKM Sukasari						
PKM Karawaci baru	84	84	Y	3	84	Y
PKm Babuaran Tumpeng	144	112	N	10	114	N
PKM Pulau Merak Cilegon	30	62	Y	0	62	Y
PKM Cikole	25	25	Y	1	25	Y
PKM Bangkonol	20	2	N	0	1	N
PKM Ciputat	171	150	N	14	106	N
PKM Rajeg	13	117	Y	3	117	Y
PKM Kronjo	118	118	Y	0	118	Y
PKM Jambe	81	5	N	3	81	Y
PKM Karawaci Baru	84	84	Y	3	84	Y
PKM Tigaraksa	40	10	N	0	13	N
PKM Jombang	43	10	N	0	3	N
PKM Cisoka	37	15	N	1	5	N
PKM Pagadungan	21	2	N	0	5	N
PKM Cisauk	6	116	Y	0	115	Y
PKM Cikedal	5	6	Y	0	5	Y
PKM Carita	15		N	0	5	N
PKM Cikupa	128	135	Y	5		
PKM Mauk	139	139	Y	3	139	Y
PKM Pakuhaji	175	175	Y	1	175	Y

Summary of Findings from Table Seven: Out of 26 total health facilities surveyed for the patient treatment indicators noted above, 12 facilities report not having adequate drugs and 9 report not having adequate treatment supporters for TB-positive patients. These both indicate major deficiencies in the supplies and personnel at DOTS treatment centers.

Conclusion

The above results from surveyed health facilities indicate that major problem still exist with DOTS treatment centers not having adequate drug supplies and health personnel. Laboratory facilities are adequate for the most part, and patient follow up through the treatment centers appears to be adequate as well. DOTS centers do need to improve upon implementing recommendations made by supervisory visits and also improve upon tracking exactly how drugs distributed to patients are being used.

Attachment G - Results of Knowledge Attitude and Practice for TB using the 30x10 cluster technique at the community level in four districts of Banten Province

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RESULTS OF RAPID QUALITATIVE ASSESSMENT
AT THE COMMUNITY LEVEL

Prepared by Dr. Manaf
March 11, 2007
For CARE's MITRA TB project program, Tangeran

Background

CARE International Indonesia works in four districts and municipalities in Banten province on the island of Java, the most populated area of the country. These include Tangerang District, Pandeglang District, Tagnerang City, and Cilegon town. Funded by USAID under CSHGP (2005- 2009), CARE's MITRA project worked towards the goals of reducing morbidity and mortality due to TB in project areas by increasing community knowledge and promoting behavior change in regards to healthy TB practices.

Tuberculosis was declared an emergency disease by the World Health Organization in 2003. Worldwide, TB kills approximately 2 million people annually. Indonesia ranks third globally for the highest TB burden, with an estimated incidence of smear-positive cases of 107 per 100,000 population. Regional variances in this number range from 64 per 100,000 in Bali to 210 per 100,000 in the Eastern provinces. An annual total of approximately 100,000 deaths occur, the majority of which are in the economically productive age groups. CARE's MITRA project aims to combat this serious TB problem in the project areas by working with the NTP to increase the case detection rate (CDR) while holding the TSR to their currently high levels.

Since 2005, the project has undertaken the following activities to accomplish its strategic objectives:

1.1 Built capacity of community-based structures (CBS) to implement TB control activities. The volunteer groups will implement TB control activities and act as community based treatment observers (CBTOs, also called as *kaders, PMO coordinators and PMO).* The project will also build the capacity of places of worship for awareness building on TB/DOTS, services available and stigma reduction messages.
1.2 Built the capacity of volunteer health workers to generate community awareness and support TB patients and their families to fully participate in DOTS. These volunteer health workers will generate awareness for early health care seeking behavior in the community, support patients and families for treatment regularity and success and link with treatment observer supervisors (identified staff at *puskesmas.*

2.1 Untrained TB/DOTS health staff oriented/trained on DOTS at the district and health center levels.
2.2 Developed working partnerships with the NTP, KNCV, WHO, district and provincial tuberculosis officials and other stakeholders like the Indonesian Physicians Association (IDI), Indonesian Pulmonologists Association (PDPI), and Indonesian Pediatricians Association (IDAI)
3.1 Built capacity of Private Practitioners (PP) to adopt the DOTS strategy for TB treatment.

These activities at the community level are expected to increase correct and healthy TB knowledge, attitudes, and practices in the population with the ultimate goal of reducing morbidity and mortality from this devastating disease in project areas.

Objectives:

The objectives of the survey undertaken were as follow:

1. To describe the knowledge, attitude, and practice regarding TB among the community in two districts and two municipalities of Banten Province.
2. To compare findings about community-level factors that might have either positive or negative influence on the success of the TB control program between the baseline and MTE surveys.
3. To inform MTE on project progress and give recommendations for future direction of the project.

Methodology:

The latest data on the total population of the four districts provided by the Provincial Health Office of Banten Province is as given below.

- Total population of Tangerang City was 1,488,666
- Total population of Tangerang District was 3,317,331
- Total population of Cilegon City was 319,555
- Total population of Pandeglang District was 1,062,813

Thus, the total coverage population was 6,188,365. All four districts were divided into cluster proportional to size, with each cluster being represented by one village chosen randomly. Within each village (cluster), 10 households were chosen randomly using the method outlined below:

1. Sampling Interval and random numbers were generated using standard methodology.
2. In the village the bottle spin technique was used to select the direction from the center of the village.
3. Along the selected street of the village, households having a door closest to each other were interviewed till 10 such houses were covered.
4. If the respondent was not available, enumerators went to the next closest door.

5. Only one village was substituted (closest to the chosen village) as the first randomly selected village was not motor able.

The tools used in the MTE were the same as those used to complete the baseline survey, with minor changes to the general socio – demographic indicators and the addition of a variable on poverty status (percentage of Gakin cards, also known as poor cards).

Findings and Results:

Table One: Socio-demographic status of families

SN	Variable	Baseline (2005)	MTE (2007)	Other Sources TB prevalence survey 2004 (NIHRD – Indonesia MOH)
1.	Total number of respondents	363	330	708
2.	Gender distribution of respondents		Women 69%	(51.57%);
3.	Total number of family members		1629	72,705
4.	Poverty Status (*Gakin Card or poor card*)		18.2%	This specific info is not available
5.	Type of House	Permanent – 73% Semi Permanent – 16% Non- Permanent – 10%	Upper Class – 14% Middle Class – 53% Lower – 37%	This specific info is not available
6.	Distance from Puskesmas			This specific info is not available

The total number of respondent households for the MTE KPC was 330 (age greater than 17 years) 69% of whom were women. The total number of individuals covered in the

households through the survey was 1629, with a subpopulation of 828 women. This sample over represented females slightly compared to national surveys where only 51.57% of the sampled population was female.

A new poverty variable was added to the MTE, measuring the prevalence of poor card holders in the population since TB is known to be both a cause and an effect of poverty. *Gakin card* or poor card holders were 18% of the sample, which closely mirrors the national level of poverty, but this percentage could be expected to be higher in poorer districts like Tangerang, Kabupaten, and Pandeglang. The poverty level might be better reflected by the type of housing or social class, and it appears that 37% of housing could be classified as dwellings for the poor in this sample.

Table 2: Presence of TB symptoms in the families

SN	Variable	Baseline (2005)	MTE (2007)	Other Sources **TB prevalence survey 2004 (NIHRD – Indonesia MoH)**
1.	Productive cough persisting greater than 3 weeks	16%	15%	8.3%
2	Fever	5%	9%	30.4%
3	Weight Loss	10%	Not Mentioned	25,9%
4	Haemoptysis	5.8%	8%	Not available
5	Night Sweat	12.7%	13%	28,6%
6	Lack of appetite	9.1	Not Mentioned	30,9%
7	Difficulty in breathing	3.3%	Not Mentioned	47,3%
8	Chest Pain	Not Mentioned	22%	42,6%

About 15% household members were reported to have productive cough for greater than 3 weeks. This number was very different from the findings of the National Health

Survey. In 2001, the National Health Survey found 37% of the respondents complained of coughing (not productive cough however). This frequency of productive cough in households was not significantly different however from the percentage found in the baseline survey in the same project areas, although symptoms frequencies did change somewhat but lower than the national survey and might be explained by the survey conducted in different seasons.

Table 3: Known Causes of TB disease

SN	Variable	Baseline (2005)	MTE (2007)	Other Sources TB prevalence survey 2004 (NIHRD – Indonesia MoH)
1.	Bacteria	9%	12%	51.1%
2	Hereditary	1.1%	11%	12.6%
3	Smoking related	0.6%	26%	Data not available,
4	Alcohol intake		3%	62.6% (includes transmission through food)
5	Fatigue	1%	2%	Data not available
6	Others	20.7%	23%	17.8%

Though the understanding of the actual cause of the disease does not seem to be clear, the category of bacterial infection seems to have improved during project duration in intervention areas (though still far below the prevalence in the national survey), the findings are not consistently positive. Causes such as hereditary, smoking, and alcohol intake were all reported as major causes of the disease. This survey can suggest that levels of knowledge about the disease and its potential causes are increasing; it does not have sufficient strength to suggest however that the changes or significant or positive, nor to claim that the changes are due to MITRA project activities alone.

Table 4: Key TB Knowledge Indicators in the community

SN	Variable	Baseline (2005)	MTE (2007)	Other Sources TB prevalence survey 2004 (NIHRD – Indonesia MOH), for Banten province in Annex A.
1.	Have heard about TB disease	Not done in baseline	88.2%	92.4%
2	If TB disease is curable	86.5%	93.7%	88.2%
3	Common Symptoms of TB*	30.8%	50%	72%
4	How is TB transmitted	Cough & Sneeze - 37% Touching of patient – 8% Transmitted through food – 22% Sharing of utensils - Sexual Intercourse – 0.6% Others – 9% Don't Know – 21%	Cough & Sneeze - 44% Touching of patient – 8% Transmitted through food – 11% Sharing of utensils -36% Sexual Intercourse – 2% Others – 21%	Violence (been hit on the chest: 1,1%; Curse/ Magic: 1,2%; Hereditary: 12,6%; Food: 62,6%; Droplet: 51,1%; Pollution: 43,4%; Others: 15,6%.

*NIHRD – defines it as one main symptom. MITRA defines it as productive cough > 3 weeks as the symptom.

The findings here suggest that there have been real and positive changes in the level of knowledge in the community in regards to certain key TB information. Especially positive results were found with increased knowledge of common symptoms of TB,

awareness of TB being a curable disease, and knowledge of modes of transmission for TB.

These results indicate that despite a persistent prevalence of the disease and poverty in CARE intervention areas and lack of complete knowledge concerning the cause of TB, the project has made progress on educating the community on the recognition of TB as a curable disease and on ways in which it can spread throughout their villages. Increased knowledge on recognition and how to prevent transfer are likely to contribute to decreased transmission and incidence in the future.

Conclusion

A major objective of this MTE survey was to compare results from the baseline survey to these findings in order to outline future directions for CARE's project. After comparison of the baseline and MTE KPC surveys, we note that there are certain key aspects of TB knowledge and understanding in the community which have improved in the last two years, including the following:

1) More people understand that TB is a curable disease.
2) More people identify and can recognize the common symptoms of TB.
3) More people correctly identify the mechanism of transmission of TB in their communities.

However, we also acknowledge the existence of certain areas where the improvement is not so clear, including:

1) The number of community members that can correctly identify the true cause of TB
2) The connection between gakin card holders (defined poverty-level households) and the incidence of TB in the community is not clear but also does not appear to be declining.

The ultimate conclusion of this MTE is that efforts should be continued in areas where project interventions are likely having a positive effect and that CARE should increase BCC efforts to change misconceptions that still exist, in particular to clarify the true cause of TB. Stigma is likely to continue interfering with critical treatment and control

efforts in the community as long as the population does not understand the true cause; this will work against the progress that has been made in increasing knowledge of how the disease spreads and in recognition of cases in the community and will ultimately work against the goal of decreasing morbidity and mortality due to TB.

Therefore MITRA should increase efforts in BCC to change the misconceptions regards the areas found to be weaker and continue on efforts in areas which are considered to be strong. Stigma in community is less likely to go away till the population is not clear on critical communication aspects of TB disease.

Selected clusters in the four districts

City / District	Sub District / Village
Kota Tangerang	Tajur
	KARAWACI BARU
	GEBANG RAYA
Kab. Tangerang	Budi Mulya
	Dukuh
	Sarua
	Cipayung
	Rengas
	Cisauk
	Selapajang
	Kadu
	Kutruk
	Rawa Burung
	Tamiang
	Kronjo
	Kedung Dalem
	Cihuni
	K o h o d
	Pondok Cabe Ilir
	Mekar Bakti
	Gelam Jaya
	Pondok Kacang Barat
	Jurang Mangu Barat
	Mekarsari
	Pondok Jaya
	Rawa Buntu
	Gintung
	Tegal Angus
	Cileles

Kab, Pandeglang	
	Pagadungan
	kawoyang
Kota Cilegon	
	Kalitimbang

Child Survival and Health Grants Program Project Summary

Dec-26-2007

CARE
(Indonesia)

General Project Information:

Cooperative Agreement Number:	**GHS-A-00-05-00008**
Project Grant Cycle:	**21**
Project Dates:	**(9/30/2005 - 9/30/2009)**
Project Type:	**TB Control**
CARE Headquarters Technical Backstop:	**Khrist Roy**
Field Program Manager:	**Beatricia Iswari Santoso**
Midterm Evaluator:	**Ranjani Gopinath**
Final Evaluator:	
USAID Mission Contact:	**Dr. Musalkazim Ali**

Field Program Manager Information:

Name: **Beatricia Iswari Santoso**
Address:
Tangerang , Banten
Phone:
Fax:
E-mail:

Funding Information:

USAID Funding:(US $): $1,500,000 **PVO match:(US $)** $500,000

Project Information:

Description:

This is a 100% TB Control Program
Program Goals:

To support Indonesia's National Tuberculosis Program to decrease morbidity and mortality caused by tuberculosis in the Banten Province of Indonesia.

Interventions:

Tuberculosis treatment and control activities

Strategies:

- Build capacity of community-based structures
- Build capacity of volunteer health workers
- BCC
- Build capacity of district health workers
- Develop working partnerships
- Build capacity of private practitioners

Location:

The project is located in 4 districts/municipalities of Banten province, northwest of Jakarta in Indonesia.
The districts are:
1) Pandglang
2) Tangerang Kabupaten
3) Cilegon
4) Tangerang Kota (large urban city)

Project Partners	Partner Type	Subgrant Amount
Ministry of Health	Collaborating Partner	
National Tuberculosis Program	Collaborating Partner	
Royal Tuberculosis Association (KNCV)	Collaborating Partner	

General Strategies Planned:

Private Sector Involvement
Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) CS Project Team	Local NGO	Private Providers	Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs

Interventions/Program Components:

Tuberculosis (100 %)

(CHW Training)
(HF Training)
- Facility based treatment/DOT
- Microscopy
- Community IEC
- Advocacy/Policy
- Community based care/DOT
- Pediatric TB

Target Beneficiaries:

Number of Suspected TB Cases:	47,000
Population of Target Area:	6,188,365

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of new smear positive cases who were successfully treated	3970	4143	95.8%	3.0

Comments for Rapid Catch Indicators

TEST

Focus Group Discussion Topic Guide for TB Patients
MITRA (TB Project) Mid Term Evaluation
CARE International Indonesia

Topic	Discussion/Transitions
Introduction and Greeting	Facilitator's and Observer's name, appropriate greetings
Purpose of FGD	We are from CARE and have been working on a project to improve treatment and cure of TB in (Name of the Kaleruhan). Since you are a TB patient your ideas and feelings can help us understand how our project is performing and inform us about any changes that we can incorporate to improve TB care. May we begin the discussion? (Allow for those who do not want to participate in the discussion leave).
No right or wrong answers	We would just like to know your frank opinion. There is no right or wrong answers to any of the questions. This is not a test. We just want to learn from you
Length of time	The discussion would take about an hour
Talking to one another	As we will be discussing about each of your opinions, it will be important that we do not talk at once because we will want to hear each other so we should not talk together. Every body should try and participate and every body will be given a chance to put forth their views. If you have any queries they would be addressed at the end.
Explain note taking Confidentiality	(Name of Observer/reporter) will be writing down some of the things that we will be talking so we can remember later. Does anyone object? We are the only ones who will know your names, we will not use any names in our reports
Checking understanding **Clarify**	Does everyone understand what I have said? Does anyone have any questions?
Participants introductions (Warm up)	**Please introduce yourselves**
Let us begin:	
General	Did you know about TB before you contracted it?
	When do we say that a person is suffering from TB?
	Do you know of any others who have suspected TB either in your family or in your community?

	Have these people sought care or are on treatment? If yes from where?
Knowledge	• How is TB caused?
	• What are the main symptoms of TB?
	• How does TB spread?
	• What can be done to control the spread of TB
	• Can TB be cured?
	• What can be done to cure TB?
	• Have you heard of DOTS, if yes from where?
	• Have you heard of HIV?
	• What is the association between TB and HIV
	• Can TB be cured in people with HIV
	• Have you heard of MDR TB? Why is it caused? Can this be prevented?
Access to care	• How many days of having got the symptoms did you seek care? • If response indicates a delayed seeking pattern then ask - When should you have sought care? • Whom did you approach for diagnosis and treatment • Why did you choose this particular facility or provider? • If the interviewee prefers a private provider then ask - Why don't you access a government facility? • Is there a TB provider (this may be a bidan, private doctor, or a community worker) near your house? • What was done to diagnose TB? Probe for various tests • What additional information did you receive from the provider? • After being diagnosed of TB, how long it took to start the treatment? • Did you face any problems in treatment? Describe the problems. (distances, time, loss of wages, side effects, drug shortage, behavior of staff etc) • Do women in your community seek care the same way as men?
Adherence to treatment	• How long did your treatment last, if still on treatment then since how long have you been taking the medicines? • How long does it take to cure the disease? • Can treatment be stopped if you are feeling better? • What happens when the treatment is not completed? • How often do you take the medicine? What happens when you forget to take medicine? • When do you think the patient is called as cured? • What are the symptoms of being cured? • Have you ever stopped taking your medicines or know of a

	person who has? • If so what were the reasons? • Is there anyone who supports you to take treatment? • If yes what has been this person's role • Did you have to undergo any tests during treatment, how many times and why? • Have you received any enablers to complete your treatment (incentives)
Stigma associated with TB	• What reactions did you face once family and friends came to know of your tubercular status? Please describe • If there is a cured patient in your group ask him/her – would you feel comfortable talking about your success in cure to others?
About project MITRA	• Have you heard about CARE or MITRA? • If yes what are the activities being carried out under the project • How have the activities helped TB patients and community at large? • What are some of the activities you liked? • What are some of the activities you did not like? • What can be done to further fight the problem of TB? A) to increase knowledge of the community, b) to improve care seeking, c) to regularly ingest drugs and complete treatment, d) to improve services at facilities, e) to reduce stigma in the community
IEC/BCC	• Has someone ever shared any information regarding TB with you, if yes please describe some of the IEC material you may have seen? • Have you received any counseling or attended any talks about TB? If yes please describe what was discussed during these talks.
Summary	Mention main themes discussed and participant's responses. Is there anything else that we talked about that I forgot to mention?
Closure	Thank you for your time. Do you have any questions that you would like to ask? I am not sure that I will be able to answer all of them, but I will try (Record all questions do not lecture)

During FGD

Recorder should keep notes by making cards for each section. Note responses on each card of respondents by numbering them as R-1 from the left of the facilitator and going clockwise around the room. Note if participants seem to all be agreeing with a statement or if there is a visible disagreement among participants when someone is speaking. Write down any quotes on a separate sheet provided for quotes. Note those quotes which are

emphatic, well articulated and summarize the general feelings of the group for a particular topic. Responses during the introduction (all questions from introduction of facilitators through participant introductions) can be grouped together.

After conducting the FGD

Immediately after the session the facilitators should:

a. Review the notes for clarity and understanding
b. Compare and record observations about the group not readily clear from the notes
c. Discuss and record any insights or ideas that the interview created while they are fresh in your mind
d. Prepare a summary of the FGD for your team

Panduan Topik Focus Group Discussion untuk Pasien TBC
***MITRA* Project (TB Project) Mid Term Evaluation**
CARE International Indonesia

Topik	Diskusi/ Transisi
Perkenalan	Nama fasilitator dan pengamat Selamat pagi, siang, ...
Tujuan Diskusi	Kami dari CARE dan bekerja dalam proyek ini untk memperbaiki pengobatan TB di (nama kelurahan). Karena Bapak/Ibu berada dalam wilayah proyek dan mungkin mengenal beberapa pasien TBC, ide dan perasaan Bapak/Ibu dapat membantu kami untuk memahami bagaimana proyek ini berjalan dan memberitahukan kami perubahan apa yang bisa kami lakukan untuk meningkatkan perawatan TBC. Bisa kita mulai diskusinya? (Berikan kesempatan bagi yang tidak ingin ikut diskusi untuk pergi).
Tidak ada jawaban benar atau salah	Kami hanya ingin mengetahui pendapat Bapak/Ibu secara jujur. Tidak ada jawaban yang benar atau salah. Ini bukan ujian. Kami hanya ingin belajar dari Bapak/Ibu
Rentang waktu	Diskusi ini akan memakan waktu sekitar satu atau dua jam
Berbicara satu sama lain	Karena kita akan membicarakan mengenai pendapat Bapak/Ibu, sangat penting kita tidak bicara pada saat yang bersamaan karena kita ingin mendengar satu sama lain, jadi kita tidak boleh bicara bersamaan. Semua orang harus berusaha untuk ikut serta dan semua orang akan diberikan kesempatan untuk mengutarakan pendapatnya. Apabila ada pertanyaan, bisa ditanyakan pada bagian akhir.
Sampaikan mengenai kerahasiaan catatan	(Nama Observer/reporter) akan menuliskan beberapa hal yang kita bicarakan jadi kami bisa mengingatnya kembali nanti. Apakah ada yang keberatan? Kami ingin mengetahui nama Bapak/Ibu, kami tidak akan menuliskan nama pada laporan.
Memeriksa pemahaman **Klarifikasi**	Apakah semuanya sudah memahami apa yang saya katakan? Ada yang punya pertanyaan?
Perkenalan peserta (Pemanasan)	**Silahkan memperkenalkan diri**
Mari kita mulai:	
Umum	Selain bapak/ibu, adakah orang lain di lingkungan bapak/ibu yang menderita TB?
	Sebelum bapak ibu tertular, apa yang Bapak/Ibu ketahui mengenai

	TB/TBC?
	Menurut bapak/ibu kapan seseorang dikatakan sakit TBC?
	Apakah Bapak/Ibu mengenal seseorang yang menderita TBC baik di keluarga Bapak/Ibu ataupun di lingkungan Bapak/Ibu? Apakah orang ini sudah mendapatkan perawatan? Apabila iya, dari mana?
Pengetahuan	• Menurut bapak/ibu, bagaimana TBC bisa terjadi?
	• Apa tbapak/ibu atau gejala utama TBC?
	• Bagaimana TBC bisa menular?
	• Apa yang bisa dilakukan untuk mencegah penularan TB?
	• Apakah TBC bisa disembuhkan?
	• Apa yang bisa dilakukan untuk menyembuhkan TBC?
	• Apakah Bapak/Ibu sudah pernah mendengar mengenai DOTS? Bila ya, dari mana?
	• Apakah Bapak/Ibu pernah mendengar mengenai HIV?
	• Apa hubungan antara TBC dengan HIV?
	• Apakah TBC pada ODHA bisa disembuhkan?
	• Apakah Bapak/Ibu pernah mendengar mengenai MDR TB? Apa yang menyebabkan hal ini? Apakah hal ini dapat dicegah?
Akses untuk Berobat	• Jika Bapak/Ibu dan keluarga sakit, di mana memperoleh pengobatan/obat? • Setelah menunjukkan gejala TB, berapa lama Bapak/Ibu menunggu sampai akhirnya berobat? • (Apabila respon menunjukan pola penundaan) Tanyakan kapan sebaiknya Bapak/Ibu mencari perawatan? • Jika sakit, dimana biasanya mencari pengobatan? • Jika bapak/ibu pergi ke tempat berobat, siapa yang ingin di temui? • Mengapa ke sana? • (Apabila responden lebih memilih pelayanan kesehatan swasta) Tanyakan, mengapa mereka tidak berobat atau datang ke fasilitas pemerintah? • Apakah ada tempat pengobatan TB di dekat rumah Bapak/Ibu? • Apa yang biasanya dilakukan untuk memeriksa orang yang diduga TBC, di tempat pelayanan kesehatan tersebut? • Informasi tambahan apa yang Bapak/Ibu dapatkan dari unit pelayanan kesehatan tersebut? • Setelah didiagnosis TBC, berapa lama sebelum memulai pengobatan? • Permasalahan apa yang dihadapi dalam mendapatkan diagnosis dan pengobatan? • Apakah Bapak/Ibu mengetahui bahwa laki-laki lebih banyak

	menderita TB daripada wanita? • Apakah perempuan di lingkungan Bapak/Ibu juga berobat dengan cara yang sama dengan laki-laki?
Kepatuhan terhadap pengobatan	• Sudah berapa lama bapak/ibu berobat? • Menurut ibu/bapak, seperti apa pengobatan TB itu? • Bagaimana jika pengobatan tidak di selesaikan? • Berapa kali bapak/ibu minum obat dalam sehari? • Menurut bapak/ibu bagaimana pasien TB dikatakan sembuh? • Apa yang bapak/ibu ketahui, apabila pengobatan tidak diselesaikan? • Dukungan seperti apa yang bapak/ibu dapatkan untuk menyelesaikan pengobatan? • Tes atau pemeriksaan apa yang bapak/ibu lakukan dan berapa kali selama pengobatan? • Bantuan apa yang bapak/ibu dapatkan untuk menyelesaikan pengobatan?
Stigma yang dihubungkan dengan TBC	• Apa yang bapak/ibu lakukan jika keluarga dan teman bapak/ibu mengetahui bahwa bapak/ibu menderita TB? • Bagaimana jika ibu/bapak menceritakan pengalamannya setelah sembuh dari TB, kepada orang lain?
Tentang Program MITRA	• Apakah Bapak/Ibu pernah mendengar mengenai CARE atau MITRA? • Apabila iya, kegiatan apa saja yang dilakukan di bawah proyek ini? • Bagaimana kegiatan ini membantu pasien TBC dan masyarakat? • Kegiatan apa saja yang Bapak/Ibu sukai? • Kegiatan apa saja yang tidak Bapak/Ibu sukai? • Apa lagi yang bisa dilakukan untuk mengatasi permasalahan TBC? a) untuk meningkatkan pengetahuan masyarakat, b) untuk memperbaiki pencarian perawatan, c) menelan obat secara teratur dan menyelesaikan pengobatan d) memperbaiki pelayanan pada fasilitas, e) mengurangi stigma di masyarakat
KIE/ KPP	• Apakah ada yang pernah memberikan informasi TBC kepada Bapak/Ibu, apabila ya tolong ceritakan mengenai informasi TB yang pernah Bapak/Ibu lihat? • Apakah Bapak/Ibu pernah mendapatkan konseling atau mengikuti penyuluhan mengenai TBC? Apabila ya tolong ceritakan apa saja yang dibahas pada saat diskusi penyuluhan tersebut.
Ringkasan	Sebutkan tema utama yang dibicarakan dan respon peserta. Apakah ada hal lain yang kita bicarakan tadi yang saya lupa sampaikan?
Penutup	Terima kasih atas waktu Bapak/Ibu. Apakah ada pertanyaan? Saya

	tidak yakin saya bisa menjawab semuanya, tetapi saya akan mencoba (catat semua pertanyaan jangan berceramah)

Selama FGD

Recorder harus mencatat dengan cara membuat kartu untuk setiap bagian. Catat respon pada setiap responden pada kartu-kartu yang diberi nomor mulai dari R-1 untuk responden yang duduk langsung di sebelah kiri fasilitator dan bergerak searah jarum jam. Catat apakah semua peserta sepertinya setuju akan satu pernyataan atau adakah ketidaksetujuan yang jelas terlihat diantara peserta pada saat seseorang berbicara. Tuliskan semua pernyataan pada kertas terpisah yang disiapkan untuk pernyataan. Catat pernyataan yang bersifat empati, disampaikan dengan baik dan ringkas perasaan umum kelompok untuk topik tertentu. Respon selama perkenalan (semua pertanyaan dari perkenalan fasilitator sampa peserta) dapat digabungkan.

Setelah Melakukan FGD

Segera setelah sesi, fasilitator harus:

a. Mereview catatan untuk kejelasan dan pertanyaan
b. Membandingkan dan mencatat observasi mengenai kelompok yang belum jelas dari catatan
c. Mendiskusikan dan menuliskan setiap insight atau ide dari wawancara selama masih jelas di pikiran Bapak/Ibu
d. Siapkan ringkasan FGD untuk tim Bapak/Ibu

Focus Group Discussion Topic Guide Community Support Structures/Individuals
***MITRA* (TB Project) Mid Term Evaluation**
CARE International Indonesia

This guide may be used for Kadres, PMOs, Bidans, PKK etc

Topic	Discussion/Transitions
Introduction and Greeting	Facilitator's and Observer's name Appropriate greetings (Selamat)
Purpose of FGD	We are from CARE and have been working on a project to improve treatment and cure of TB in (Name of the Kaleruhan/sub-district). Since you belong to the project area and may be familiar with some TB patients, your ideas and feelings can help us understand how our project is performing and inform us about any changes that we can incorporate to improve TB care. May we begin the discussion? (Allow for those who do not want to participate in the discussion leave).
Length of time	The discussion would take about an hour
No right or wrong answers	We would just like to know your frank opinion. There is no right or wrong answers to any of the questions. This is not a test. We just want to learn from you
Talking to one another	As we will be discussing about each of your opinions, it will be important that we do not talk at once because we will want to hear each other so we should not talk together. Every body should try and participate and every body will be given a chance to put forth their views. If you have any queries they would be addressed at the end.
Explain note taking Confidentiality	(Name of Observer/reporter) will be writing down some of the things that we will be talking so we can remember later. Does anyone object? We are the only ones who will know your names, we will not use any names in our reports
Checking understanding **Clarify**	Does everyone understand what I have said? Does anyone have any questions?
Participants introductions (Warm up)	**Please introduce yourselves**
Let us begin:	
General	• Since when have you been involved in volunteering activities?
	• Since when have you been supporting TB activities?

	• When do we say that a person is suffering from TB?
	• What are activities you support? If supports treatment observation, then how many patients does he/she support?
	•
Knowledge	• How is TB caused?
	• What are the main symptoms of TB?
	• How does TB spread?
	• What can be done to control the spread of TB
	• Can TB be cured?
	• What can be done to cure TB?
	• Have you heard of DOTS, if yes from where?
	• Have you heard of HIV?
	• What is the association between TB and HIV
	• Can TB be cured in people with HIV
	• Have you heard of MDR TB? Why is it caused? Can this be prevented?
Access to care	• When should a person with suspected TB symptoms seek care? In your community when do people generally do so? • Whom do the patients generally approach for diagnosis and treatment? • Why this particular provider? • If the interviewee prefers a private provider then ask - Why don't they access a government facility? • Is there a TB provider (this may be a bidan, private doctor, or a community worker) near your house? • What is generally done to diagnose TB? Probe for various tests • What are the problems faced to get diagnosis and treatment? What can be done to address these problems? • Do women in your community seek care the same way as men?
Adherence to treatment	• What is the cure for TB? • How long does it generally take for TB to be cured? • Can treatment be stopped if one is feeling better? • What happens when the treatment is not completed or irregular? • When do you think the patient is called as cured? • What are the symptoms of being cured? • Do you know of any patient who did not complete the treatment? • If so what were the reasons for stopping medication? • What actions did you take to ensure that the patient continues and completes the treatment? • Do patients receive any incentives to complete treatment?

	• Tell us some of the barriers faced to complete treatment and what can be done to address this?
Stigma associated with TB	• How do you feel when you hear that a family or a community member has contracted TB? • How does the community generally socially treat a TB patient? • What can be done to ensure that TB patients are not socially shunned?
About project MITRA	• Have you heard about CARE or MITRA? • If yes what are the activities being carried out under the project? • Did you receive any direct support from the project? • What benefits did the community receive? • Was there any support that should have been provided and was not?
IEC/BCC	• Has someone ever shared any information regarding TB with you, if yes please describe some of the IEC material you may have seen? • Have you received any orientation or attended any talks about TB? If yes please describe what was discussed during these talks.
Summary	Mention main themes discussed and participant's responses. Is there anything else that we talked about that I forgot to mention?
Closure	Thank you for your time. Do you have any questions that you would like to ask? I am not sure that I will be able to answer all of them, but I will try (Record all questions do not lecture)

During FGD

Recorder should keep notes by making cards for each section. Note responses on each card of respondents by numbering them as R-1 from the left of the facilitator and going clockwise around the room. Note if participants seem to all be agreeing with a statement or if there is a visible disagreement among participants when someone is speaking. Write down any quotes on a separate sheet provided for quotes. Note those quotes which are emphatic, well articulated and summarize the general feelings of the group for a particular topic. Responses during the introduction (all questions from introduction of facilitators through participant introductions) can be grouped together.

After conducting the FGD

Immediately after the session the facilitators should:

a. Review the notes for clarity and understanding

b. Compare and record observations about the group not readily clear from the notes
c. Discuss and record any insights or ideas that the interview created while they are fresh in your mind
d. Prepare a summary of the FGD for your team

Panduan Topik Focus Group Discussion untuk Community Support Structures/Individuals
***MITRA* (TB Project) Mid Term Evaluation**
CARE International Indonesia

Panduan ini dapat digunakan untuk Kader Posyandu, PMOs, KPMO, Bidan, PKK dll

Topik	Diskusi/ Transisi
Perkenalan dan salam	Nama fasilitator dan pengamat Selamat pagi/siang, assalamualaikum
Tujuan FGD	Kami dari CARE dan bekerja dalam proyek ini untk memperbaiki pengobatan TB di (nama kelurahan). Karena anda berada dalam wialayh proyek dan mungkin mengenal beberapa pasien TBC, ide dan perasaan anda dapat membantu kami untuk memahami bagaimana proyek ini berjalan dan memberitahukan kami perubahan apa yang bisa kami lakukan untuk meningkatkan perawatan TBC. Bisa kita mulai diskusinya? (Berikan kesempatan bagi yang tidak ingin ikut diskusi untuk pergi).
Tidak ada jawaban benar atau salah	Kami hanya ingin mengetahui pendapat anda secata jujur. Tidak ada jawaban yang benar atau salah. Ini bukan ujian. Kami hanya ingin belajar dari anda
Rentang waktu	Diskusi ini akan memakan waktu sekitar satu jan
Berbicara satu sama lain	Karena kita akan membicatakan mengenai pendapat anda, sangat penting kita tidak bicara pada saat yang bersamaan karena kita ingin mendengar satu sama lain, jadi kita tidak boleh bicara bersamaan. Semua orang harus berusaha untuk ikut serta dan semua orang akan diberikan kesempatan untuk mengutarakan pendapatnya. Apabila ada pertanyaan, bisa ditanyakan pada bagian akhir.
Sampaikan mengenai kerahasiaan catatan	(Nama Observer/reporter) akan menuliskan beberapa hal yang kita bicarakan jadi kami bisa mengingatnya kembali nanti. Apakah ada yang keberatan? Hanya kami yang akan mengetahui nama anda, kami tidak akan menuliskan nama pada laporan.
Memeriksa pemahaman **Klarifikasi**	Apakah semuanya sudah memahami apa yang saya katakan? Ada yang punya pertanyaan?
Perkenalan peserta (Pemanasan)	Silahkan memperkenalkan diri
Mari kita mulai:	

Umum	• Sejak kapan anda terlibat dalam kegiatan penanggulangan penyakit TBC?
	• Kegiatan apa saja yang anda dukung?
	• Apabila PMO, siapa pasien yang anda awasi?
	• Apabila PMO, berapa pasien yang anda awasi?
Pengetahuan	• Apa itu penyakit TBC ?
	• Apa gejala-gejala utama TBC?
	• Bagaimana terjadinya penularan penyakit TBC ?
	• Apa yang bisa dilakukan untuk mencegah penularan TBC
	• Apakah TBC bisa disembuhakan ?
	• Bagaimana proses penyembuhannya ?
	• Apakah ada sudah pernah mendengar mengenai DOTS, dari mana?
	• Apa itu DOTS ?
	• Apakah anda pernah mendengar mengenai HIV?
	• Apa hubungan antara TBC dengan HIV
	• Apakaha TBC pada ODHA (Orang Dengan HIV AIDS) bisa disembuhkan ?
	• Apakah anda pernah mendengar MDR TB ? Mengapa itu bisa terjadi ? Apakah hal ini dapat dicegah?
Akses ke perawatan	• Kapan sebaiknya seseorang yang dicurigai dengan gejala TBC mendapatkan perawatan? Dalam lingkungan anda kapan biasanya seseorang melakukan hal tsb? • Kemana biasanya pasien TBC mencari pelayanan pemeriksaan dan pengobatan ? • Mengapa ke sana? • Apabila responden lebih memilih swasta, tanyakan- Mengapa mereka tidak mengakses fasilitas pemerintah (Puskesmas, RS Pemerintah)? • Apakah ada perawatan TBC(mungkin bidan, DPS, atau kader) di lingkungan anda? • Apa yang biasanya dilakukan untuk mengetahui seseorang itu menderita TBC? Probing untuk berbagai tes • Permasalahan apa yang dihadapi dalam mendapatkan pelayanan pemeriksaan dan pengobatan ? • Menurut pengamatan anda, apakah laki-laki atau perempuan yang lebih banyak menderita penyakit TBC dilingkungan anda? • Apakah perempuan di lingkungan anda juga mencari perawatan dengan cara yang sama dengan laki-laki?
Kepatuhan terhadap Pengobatan	• Apakah anda tahu obat TBC? Sebutkan jenisnya? • Biasanya berapa lama waktu yang dibutuhkan untuk menyembuhkan TBC? • Apakah pengobatan bisa dihentikan apabila seseorang merasa lebih baik?

	• Apa yang terjadi apabila pengobatan tidak diselesaikan atau tidak teratur? • Menurut anda kapan pasien dikatakan sembuh? • Apa tanda-tanda kesembuhan? • Apakah ada dilingkungan anda pasien TBC yang tidak menyelesaikan pengobatan? • Apa alasan mereka untuk menghentikan pengobatan? • Apakah pasien TBC di lingkungan anda mendapatkan dukungan untuk menyelesaikan perawatan mereka? • Siapa yang mendukung ? • Apa peran dari orang yang memberikan dukungan ini? • Apakah pasien mendapatkan insentif untuk menyelesaikan pengobatan?
Stigma yang dihubungkan dengan TBC	• Bagaimana perasaan anda pada saat mendengan keluarga atau warga dilingkungan anda tertular TBC? • Bagaimana masyarakat pada umumnya memperlakukan pasien TBC?
Mengenai Proyek MITRA	• Apakah anda pernah mendengar mengenai LSM CARE atau Program MITRA? • Apabila iya, kegiatan apa saja yang dilakukan ? • Keuntungan apa yang didapatkan oleh masyarakat? • Apakah ada dukungan yang seharusnya diberikan tetapi tidak diberikan? • Apa lagi yang bisa dilakukan untuk mengatasi permasalahan TBC? a) untuk meningkatkan pengetahuan masyarakat, b) untuk memperbaiki pencarian perawatan, c) menelan obat secara teratur dan menyelesaikan pengobatan d) memperbaiki pelayanan pada fasilitas, e) mengurangi stigma di masyarakat (lingkari sesuai jawaban responden)
KIE/ KPP	• Apakah ada yang pernah memberikan informasi TBC kepada anda, apabila iya tolong ceritakan informasi tersebut? • Apakah anda pernah mendapatkan konseling atau mengikuti penyuluhan mengenai TBC? Apabila iya tolong ceritakan apa saja yang dibahas pada saat diskusi penyuluhan tersebut ? Media apa yang digunakan (leaflet, brosur, pamphlet, lembar balik, dsb)
Ringkasan	Sebutkan tema utama yang dibicarakan dan respon peserta. Apakah ada hal lain yang kita bicarakan tadi yang saya lupa sampaikan?
Penutup	Terima kasih atas waktu anda. Apakah ada pertanyaan? Saya tidak yakin saya bisa menjwab semuanya, tetapi saya akan mencoba (catat semua pertanyaa jangan berceramah)

Selama FGD

Recorder harus mencatat dengan cara membuat kartu untuk setiap bagian. Catat respon pada setiap responden pada kartu-kartu yang diberi nomor mulai dari R-1 untuk responden yang duduk langsung di sebelah kiri fasilitator dan bergerak searah jarum jam. Catat apakah semua peserta sepertinya setuju akan satu pernyataan atau adakah ketidaksetujuan yang jelas terlihat diantara peserta pada saat seseorang berbicara. Tuliskan semua pernyataan pada kertas terpisah yang disiapkan untuk pernyataan. Catat pernyataan yang bersifat empati, disampaikan dengan baik dan ringkas perasaan umum group untuk topik tertentu. Respon selama perkenalan (semua pertanyaan dari perkenalan fasilitator sampa peserta) dapat digabungkan.

Setelah Melakukan FGD

Segera setelah sesi, fasilitator harus:

a. Mereview catatan untuk kejelasan dan pertanyaan
b. Membandingkan dan mencatat observasi mengenai kelompok yang belum jelas dari catatan
c. Mendiskusikan dan menuliskan setiap insight atau ide dari wawancara selama masih jelas di pikiran anda
d. Siapkan ringkasan FGD untuk tim anda

Focus Group Discussion Topic Guide for Community and Family Members
***MITRA* (TB Project) Mid Term Evaluation**
CARE International Indonesia

Topic	Discussion/Transitions
Introduction and Greeting	Facilitator's and Observer's name Appropriate greetings (Selamat)
Purpose of FGD	We are from CARE and have been working on a project to improve treatment and cure of TB in (Name of the Kaleruhan). Since you belong to the project area and may be familiar with some TB patients, your ideas and feelings can help us understand how our project is performing and inform us about any changes that we can incorporate to improve TB care. May we begin the discussion? (Allow for those who do not want to participate in the discussion leave).
No right or wrong answers	We would just like to know your frank opinion. There is no right or wrong answers to any of the questions. This is not a test. We just want to learn from you
Length of time	The discussion would take about an hour
Talking to one another	As we will be discussing about each of your opinions, it will be important that we do not talk at once because we will want to hear each other so we should not talk together. Every body should try and participate and every body will be given a chance to put forth their views. If you have any queries they would be addressed at the end.
Explain note taking Confidentiality	(Name of Observer/reporter) will be writing down some of the things that we will be talking so we can remember later. Does anyone object? We are the only ones who will know your names, we will not use any names in our reports
Checking understanding **Clarify**	Does everyone understand what I have said? Does anyone have any questions?
Participants introductions (Warm up)	**Please introduce yourselves**
Let us begin:	
General	• Have you heard of TB?
	• When do we say that a person is suffering from TB?
	• Do you know of anybody who have TB either in your family

	or in your community?
	• Have these people sought care or are on treatment? If yes from where?
Knowledge	• How is TB caused?
	• What are the main symptoms of TB?
	• How does TB spread?
	• What can be done to control the spread of TB
	• Can TB be cured?
	• What can be done to cure TB?
	• Have you heard of DOTS, if yes from where?
	• Have you heard of HIV?
	• What is the association between TB and HIV
	• Can TB be cured in people with HIV
	• Have you heard of MDR TB? Why is it caused? Can this be prevented?
Access to care	• When should a person with suspected TB symptoms seek care? In your community when do people generally do so? • Whom do the patients generally approach for diagnosis and treatment? • Why this particular provider? • If the interviewee prefers a private provider then ask - Why don't they access a government facility? • Is there a TB provider (this may be a bidan, private doctor, or a community worker) near your house? • What is generally done to diagnose TB? Probe for various tests • What are the problems faced to get diagnosis and treatment? • Do women in your community seek care the same way as men?
Adherence to treatment	• What is the cure for TB? • How long does it generally take for TB to be cured? • Can treatment be stopped if one is feeling better? • What happens when the treatment is not completed or irregular? • When do you think the patient is called as cured? • What are the symptoms of being cured? • Do you know of any patient who did not complete the treatment? • If so what were the reasons for stopping medication? • Do TB patients in your community receive any support to complete their treatment from anyone? • If yes what has been this person's role • Do patients receive any incentives to complete treatment?

Stigma associated with TB	• How do you feel when you hear that a family or a community member has contracted TB? • How does the community generally socially treat a TB patient?
About project MITRA	• Have you heard about CARE or MITRA? • If yes what are the activities being carried out under the project • What benefits did the community receive? • Was there any support that should have been provided and was not? • What can be done to further fight the problem of TB? A) to increase knowledge of the community, b) to improve care seeking, c) to regularly ingest drugs and complete treatment, d) to improve services at facilities, e) to reduce stigma in the community
IEC/BCC	• Has someone ever shared any information regarding TB with you, if yes please describe some of the IEC material you may have seen? • Have you received any counseling or attended any talks about TB? If yes please describe what was discussed during these talks.
Summary	Mention main themes discussed and participant's responses. Is there anything else that we talked about that I forgot to mention?
Closure	Thank you for your time. Do you have any questions that you would like to ask? I am not sure that I will be able to answer all of them, but I will try (Record all questions do not lecture)

During FGD

Recorder should keep notes by making cards for each section. Note responses on each card of respondents by numbering them as R-1 from the left of the facilitator and going clockwise around the room. Note if participants seem to all be agreeing with a statement or if there is a visible disagreement among participants when someone is speaking. Write down any quotes on a separate sheet provided for quotes. Note those quotes which are emphatic, well articulated and summarize the general feelings of the group for a particular topic. Responses during the introduction (all questions from introduction of facilitators through participant introductions) can be grouped together.

After conducting the FGD

Immediately after the session the facilitators should:

a. Review the notes for clarity and understanding
b. Compare and record observations about the group not readily clear from the notes

c. Discuss and record any insights or ideas that the interview created while they are fresh in your mind
d. Prepare a summary of the FGD for your team

Panduan Topik Focus Group Discussion untuk Masyarakat dan Anggota Keluarga
***MITRA* (TB Project) Mid Term Evaluation**
CARE International Indonesia

Pmo, Koordinator PMO, anggota keluarga.

Topik	Diskusi/ Transisi
Perkenalan dan salam	Nama fasilitator dan pengamat Selamat pagi/siang, assalamualaikum
Tujuan FGD	Kami dari CARE dan bekerja dalam proyek ini untk memperbaiki pengobatan TB di (nama kelurahan). Karena anda berada dalam wialayh proyek dan mungkin mengenal beberapa pasien TBC, ide dan perasaan anda dapat membantu kami untuk memahami bagaimana proyek ini berjalan dan memberitahukan kami perubahan apa yang bisa kami lakukan untuk meningkatkan perawatan TBC. Bisa kita mulai diskusinya? (Berikan kesempatan bagi yang tidak ingin ikut diskusi untuk pergi).
Tidak ada jawaban benar atau salah	Kami hanya ingin mengetahui pendapat anda secata jujur. Tidak ada jawaban yang benar atau salah. Ini bukan ujian. Kami hanya ingin belajar dari anda
Rentang waktu	Diskusi ini akan memakan waktu sekitar satu jam
Berbicara satu sama lain	Karena kita akan membicatakan mengenai pendapat anda, sangat penting kita tidak bicara pada saat yang bersamaan karena kita ingin mendengar satu sama lain, jadi kita tidak boleh bicara bersamaan. Semua orang harus berusaha untuk ikut serta dan semua orang akan diberikan kesempatan untuk mengutarakan pendapatnya. Apabila ada pertanyaan, bisa ditanyakan pada bagian akhir.
Sampaikan mengenai kerahasiaan catatan	(Nama Observer/reporter) akan menuliskan beberapa hal yang kita bicarakan jadi kami bisa mengingatnya kembali nanti. Apakah ada yang keberatan? Hanya kami yang akan mengetahui nama anda, kami tidak akan menuliskan nama pada laporan.
Memeriksa pemahaman **Klarifikasi**	Apakah semuanya sudah memahami apa yang saya katakan? Ada yang punya pertanyaan?
Perkenalan peserta (Pemanasan)	**Silahkan memperkenalkan diri**
Mari kita mulai:	

Umum	• Sejak kapan anda terlibat dalam kegiatan penanggulangan penyakit TBC?
	• Kegiatan apa saja yang anda dukung?
	• Apabila PMO, siapa pasien yang anda awasi?
	• Apabila PMO, berapa pasien yang anda awasi?
Pengetahuan	• Apa itu penyakit TBC ?
	• Apa gejala-gejala utama TBC?
	• Bagaimana terjadinya penularan penyakit TBC ?
	• Apa yang bisa dilakukan untuk mencegah penularan TBC
	• Apakah TBC bisa disembuhakan ?
	• Bagaimana proses penyembuhannya ?
	• Apakah ada sudah pernah mendengar mengenai DOTS, dari mana?
	• Apa itu DOTS ?
	• Apakah anda pernah mendengar mengenai HIV?
	• Apa hubungan antara TBC dengan HIV
	• Apakaha TBC pada ODHA (Orang Dengan HIV AIDS) bisa disembuhkan ?
	• Apakah anda pernah mendengar MDR TB ? Mengapa itu bisa terjadi ? Apakah hal ini dapat dicegah?
Akses ke perawatan	• Kapan sebaiknya seseorang yang dicurigai dengan gejala TBC mendapatkan perawatan? Dalam lingkungan anda kapan biasanya seseorang melakukan hal tsb? • Kemana biasanya pasien TBC mencari pelayanan pemeriksaan dan pengobatan ? • Mengapa ke sana? • Apabila responden lebih memilih swasta, tanyakan- Mengapa mereka tidak mengakses fasilitas pemerintah (Puskesmas, RS Pemerintah)? • Apakah ada perawatan TBC(mungkin bidan, DPS, atau kader) di lingkungan anda? • Apa yang biasanya dilakukan untuk mengetahui seseorang itu menderita TBC? Probing untuk berbagai tes • Permasalahan apa yang dihadapi dalam mendapatkan pelayanan pemeriksaan dan pengobatan ? • Menurut pengamatan anda, apakah laki-laki atau perempuan yang lebih banyak menderita penyakit TBC dilingkungan anda? • Apakah perempuan di lingkungan anda juga mencari perawatan dengan cara yang sama dengan laki-laki?
Kepatuhan terhadap Pengobatan	• Apakah anda tahu obat TBC? Sebutkan jenisnya? • Biasanya berapa lama waktu yang dibutuhkan untuk menyembuhkan TBC? • Apakah pengobatan bisa dihentikan apabila seseorang merasa lebih baik?

	• Apa yang terjadi apabila pengobatan tidak diselesaikan atau tidak teratur? • Menurut anda kapan pasien dikatakan sembuh? • Apa tanda-tanda kesembuhan? • Apakah ada dilingkungan anda pasien TBC yang tidak menyelesaikan pengobatan? • Apa alasan mereka untuk menghentikan pengobatan? • Apakah pasien TBC di lingkungan anda mendapatkan dukungan untuk menyelesaikan perawatan mereka? • Siapa yang mendukung ? • Apa peran dari orang yang memberikan dukungan ini? • Apakah pasien mendapatkan insentif untuk menyelesaikan pengobatan?

Selama FGD

Recorder harus mencatat dengan cara membuat kartu untuk setiap bagian. Catat respon pada setiap responden pada kartu-kartu yang diberi nomor mulai dari R-1 untuk responden yang duduk langsung di sebelah kiri fasilitator dan bergerak searah jarum jam. Catat apakah semua peserta sepertinya setuju akan satu pernyataan atau adakah ketidaksetujuan yang jelas terlihat diantara peserta pada saat seseorang berbicara. Tuliskan semua pernyataan pada kertas terpisah yang disiapkan untuk pernyataan. Catat pernyataan yang bersifat empati, disampaikan dengan baik dan ringkas perasaan umum group untuk topik tertentu. Respon selama perkenalan (semua pertanyaan dari perkenalan fasilitator sampa peserta) dapat digabungkan.

Setelah Melakukan FGD

Segera setelah sesi, fasilitator harus:

a. Mereview catatan untuk kejelasan dan pertanyaan
b. Membandingkan dan mencatat observasi mengenai kelompok yang belum jelas dari catatan
c. Mendiskusikan dan menuliskan setiap insight atau ide dari wawancara selama masih jelas di pikiran anda
d. Siapkan ringkasan FGD untuk tim anda

In Depth Interview Guideline for Facility Based Providers
MITRA Mid Term Evaluation
CARE International Indonesia

Name of the Interviewer_____
Date_____

Selamat
Introduce Self
Preamble: We are from CARE International Indonesia and have been implementing a community based TB control project called MITRA, in this district/in four districts. We are here as to understand the activities of the project from your perspective. This will enable us to make improvements in the project strategies and identify issues requiring resolution. This will be a confidential discussion and your name will not be attached to your quotes. It will also involve an assessment of your facility and review of your registers. We anticipate the discussion to take about one hour. Do we have your permission to proceed?
If response no, move to the next available facility worker.
If response yes, continue with the questions.

Location_____
Type of Facility/whether treatment/treatment + lab/only lab_____
Name of the Interviewee and designation_____
Total months of association with the Project:_____
Total months in the current facility:_____
Staff in the facility

We may keep this here or in the facility assessment checklist

Staff Position	Sanctioned	Functioning	Trained in DOTS

1. What are your main duties in this facility?
2. What proportion of your time is spent in TB related activities (diagnosis/ treatment/counseling/ community outreach/follow up/reporting)
3. Were you given any training to carry out TB control activities? If yes when, what training and who conducted this training?
4. Was this training useful? What further support did you receive? Please describe the additional support that would have helped you to perform your duties better.
5. Do the patients come to you directly or are referred by your other colleagues in the facility (or a mix of both)?
6. Now I would like to ask you some technical questions. When do you suspect TB in a patient?
7. What is done when you suspect TB in a patient?

8. Could you tell the criteria upon which TB patients are classified into various categories?
9. What additional support is required in this facility to diagnose patients?
10. What are the common side effects of the DOTS drugs?
11. When you attend to a suspected patient and after you initiate treatment, what information do you generally give to your patient?
12. What IEC material is available with you? Are they useful? Do you want to suggest some modifications to the material available?
13. Is it a norm to identify a treatment supporter for every patient who is registered for DOTS?
14. Are you required to go to the community for follow up or TB extension activities? If yes please describe your community level activities.
15. What is your role in identifying a supporter, following up on default (and without probing ascertain whether the provider is involved in counseling as well)
16. What is your role in drug management (maintaining adequate drug supply) and lab management (if a lab is attached to the facility : ensuring adequacy of lab consumables, supervision, reporting etc)
17. What reporting formats are you required to submit? Did your training have sessions on formats?
18. Who supervises your work? When did you last receive a supervisory visit? What does your supervisor check when he/she visits you? Please list. Did you receive any feedback? Was it useful?
19. If you had a choice, would you work with TB patients?
20. Do you think that a health care worker, who has TB but is not sick, should be allowed to continue to work?
21. If a member of your household became ill with TB, would you want it to remain secret?
22. Some people think that TB patients deserve the illness that they have. Do you agree with this point of view?
23. What support has this facility received from MITRA? (trainings, review meetings, linkages with treatment supporters etc)
24. Do the activities of this facility undergo any review? If yes how often and who are the participants in the review?
25. Does this facility partner with any community based groups or other NGOs
26. Please describe some key problems faced to control TB. Please tell us what can be done to overcome these problems.

Thank you indeed for your time. We would like to observe the facility now and review some of your registers.

27.

Thank you for your time! The survey is complete.

Panduan Wawancara Mendalam untuk Pemberi Layanan Berbasis Fasilitas
MITRA Mid Term Evaluation
CARE International Indonesia

Nama pewawancara_____
Tanggal_____

Selamat
Perkenalan
Pembukaan: Seperti yang telah anda ketahui, kami sedang melaksanakan evaluasi pertengahan periode untuk proyek MITRA di kabupaten ini dan kami ingin mengetahui pandangan anda mengenai kekuatan dan kelemahan dari strategi proyek ini dan program DOTS. Diskusi ini bersifat rahasia dan nama anda tidak akan dihubungkan dengan jawaban anda. Kami juga akan melihat-lihat fasilitas anda, catatan anda dan berdiskusi dengan beberapa orang staff Dinkes. Diskusi ini akan memakan waktu kurang lebih setengah jam. Bisa kami lanjutkan?
Apabila jawaban tidak, lanjut ke orang berikutnya.
Apabila jawaban ya, lanjutkan dengan pertanyaan.

Lokasi_____
Tersambung dengan fasilitas, kalau iya/ apakah fasilitas pengobatan/ pengobatan dan lab/ hanya lab _____
Name responden
Total bekerja dengan proyek :_____bulan
Total bekerja pada fasilitas ini:_____bulan
Jumlah staff pada fasilitas ini

Posisi staff	Penunjukan	Fungsi	Pelatihan DOTS

1. Apakah tugas utama anda di fasilitas ini?
2. Berapa banyak waktu yang anda habiskan untuk kegiatan yang terkait dengan TB (diagnosis/ pengobatan/ konseling/ penjangkauan masyarakat/ tindak lanjut/ pelaporan)
3. Apakah anda pernah mendapatkan pelatihan untuk menjalankan kegiatan penanggulangan TB? Apabila ya, kapan, pelatihan apa dan siapa yang memberikan pelatihan ini?
4. Apakah pelatihan ini bermanfaat? Dukungan apalagi yang anda dapatkan? Tolong sebutkan dukungan lain yang dapat membantu anda untuk melaksanakan tugas anda dengan lebih baik lagi.
5. Apakah pasien datang kepada anda secara langsung atau dirujuk oleh rekan anda di fasilitas (atau gabungan dari keduanya)?
6. Sekarang saya ingin menanyakan beberapa pertanyaan teknis. Kapan seseorang dicurigai mengidap TB?
7. Apa yang harus dilakukan pada saat seseorang dicurigai mengidap TB? Bagaimana pasien diperiksa?
8. Fasilitas apa sajakah yang tersedia di kabupaten untuk mendiagnosa pasien suspek TB?

9. Apakah anda bisa menyebutkan kriteria-kriteria yang digunakan dalam penggolongan penderita TB ke dalam berbagai kategori?
10. Obat apa yang diresepkan? Sebutkan (lihat apakah berbeda untuk kategori yang berbeda)
11. Apa sajakah efek samping yang biasa disebabkan oleh obat DOTS?
12. Materi KIE apa sajakah yang tersedia di kabupaten? Apakah materi-materi tersebut berguna? Apakah anda memiliki saran untuk perubahan materi yang ada sekarang?
13. Apakah anda diwajibkan untuk terjun ke masyarakat untuk menindaklanjuti kegiatan penyuluhan KPP? Apabila ya, tolong ceritakan mengenai kegiatan anda pada tingkat masyarakat
14. Apa peran anda dalam menunjuk PMO, menindaklanjuti kasus drop out (dan tanpa memastikan apakah responden juga terlibat dalam konseling)
15. Apa peran anda dalam manajemen obat (menjaga kecukupan pasokan obat) dan manajemen lab (apabila ada lab di fasilitas tsb: memastikan kecupukan perlengkapan lab, pengawasan, pelaporan, dll)
16. Siapa yang mensupervisi pekerjaan anda? Kapan terakhir kali anda mendapatkan kunjungan supervisi? Apa yang biasanya dia periksa pada saat berkunjung? Sebutkan. Apakah anda mendapatkan umpan balik? Apakah hal tersebut berguna?
17. Menurut anda, apakah seorang petugas kesehatan, yang menderita TB tetapi tidak sakit , diperbolehkan untuk tetap bekerja?
18. Apabila anggota keluarga anda menderita TB, apakah anda ingin merahasiakan hal tersebut?
19. Beberapa orang beranggapan bahwa penderita TB pantas untuk mendapatkan penyakit tersebut. Apakah anda setuju dengan pandangan ini?
20. Dukungan apa yang sudah didapatkan kabupaten ini dari MITRA? (pelatihan, pertemuan monitoring, penguhubungan dengan PMO dan swasta, dll)
21. Apakah kegiatan-kegiatan di tingkat kabupaten ini sudah pernah dievaluasi/ ditinjau? Apabila ya, seberapa sering dan siapa sajakah peserta peninjauan? Kapan terakhir kali diadakan peninjuan? Apa hasil dari peninjauan tersebut?
22. Apakah kabupaten memiliki hubungan kemitraan dengan Ormas atau LSM lain?
23. Apakah ada upaya untuk melibatkan swasta? Tolong ceritakan pengalaman anda (kesulitan dan ide inovatif, apabila ada)

Terima kasih atas waktu anda. Sekarang kami ingin melihat-lihat fasilitas dan catatan-catatan anda.

Thank you for your time! The survey is complete.

In Depth Interview Guideline for Wasors
MITRA Mid Term Evaluation
CARE International Indonesia

Name of the Interviewer_____
Date_____

Selamat
Introduce Self
Preamble: As you are aware we are carrying out the mid term evaluation of project MITRA in this district and would like to understand your perspective on the strengths and weakness of project strategies and the DOTS program. This will enable us to make improvements in the project strategies and identify issues requiring resolution. This will be a confidential discussion and your name will not be attached to your quotes. It will also involve an assessment of your facility and review of your registers. We anticipate the discussion to take about half hour. Do we have your permission to proceed?
If response is yes then continue with the questions.

Location_____
Attached to a Facility or Lab_____
Name of the Interviewee _____
Total months of association with the Project:_____
Total months in the current position:_____

1. Please describe your role as a Lab Officer. How many Labs do you monitor and support?
2. What proportion of your time is spent on each of the TB control activities
   - Actual lab work
   - supervision
   - reporting
   - Management
3. What is the current load of disease in your area? Is it increasing or decreasing?
4. Please describe some of the difficulties you face in implementing the program and possible solutions

   - Case notification
   - Case detection
   - Diagnosis
   - Lab functioning
   - Treatment
   - MDR TB
   - Budgets
   - Information management
5. What trainings have you received to carry out efficient lab management and networking. Who conducted these trainings?
6. Was this training useful? What further support did you receive? Please describe the additional support that would have helped you to perform your duties better.
7. Now I would like to ask you some technical questions. When does one suspect TB in a patient?
8. What is done when one suspects TB in a patient? How is the patient investigated?
9. What are the facilities available in the district to diagnose suspected TB patients?
10. Could you relate the criteria upon which TB patients are classified into various categories?
11. What additional support is required in the district to diagnose patients?
12. Please describe how you coordinate activities and what support do you get from

District health officer
Wasor
BCC officer
MO communicable diseases

13. How is the internal quality assessment done? How frequently is this done? What problems do you face in carrying out internal quality assessment?
14. How is the external quality assessment done? How frequently is this done? What problems do you face in carrying out internal quality assessment?
15. Is the availability of equipments, infrastructure and consumables adequate in the district labs? Do you face any problems in this regard?
16. What reporting formats are you required to submit? Did your training have sessions on formats?
17. Who supervises your work? When did you last receive a supervisory visit? What does your supervisor check when he/she visits you? Please list. Did you receive any feedback? Was it useful? Describe the support you receive from the NTP.
18. What support has this district received from MITRA? (trainings, review meetings, linkages with treatment supporters and private providers etc)
19. Do the activities at district level undergo any review? If yes how often and who are the participants in the review?
20. Is there an effort to involve private providers? Please describe your experiences (difficulties and innovative ideas if any)

Thank you indeed for your time.

Checklist untuk Peninjauan Laboratorium
***MITRA* (TB Project) Mid Term Evaluation**
CARE International Indonesia

I. Infrastruktur dan Kegiatan Laboratorium

Apakah ada ruang khusus untuk laboratorium	Yes/No
Apakah ada protap yang tersedia	Yes/No
Ada catatan laboratorium	Yes/No
Apakah ada miskroskop binokular yang berfungsi?	Yes/No
Apakah pemeriksaan dahak dilakukan oleh teknisi/petugas laboratorium? Kapan terakhir pelatihan	Yes/No
Apakah terdapat persediaan reagen, slide dan persediaan lainnya untuk satu bulan ke depan?	Yes/No
Apakah reagen laboratorium dipersiapkan secara fresh (segar)?	Yes/No
Apabila iya, kapan hal tersebut dipersiapkan (pada a/b/c)?	Yes/No
Apakah nama dan alamat pada catatan laboratorium TB ditulis dengan jelas	Yes/No
Apakah ada rangkuman kegiatan mikroskopis pada setiap akhir bulan?	Yes/No
Apakah teknisi laboratorium menyimpan slide untuk dilihat kembali oleh supervisor untuk protokol memastikan kualitas?	Yes/No
Adakah kunjungan supervisi terakhir dan siapa yang melakukan	
Apakah supervisor/wasor melihat juga slide yang disimpan oleh teknisi laboratorium pada saat evaluasi on-site?	Yes/No
Apakah laporan evaluasi yang dilakukan oleh supervisor tersedia di fasilitas/tempat ini (setidaknya untuk bulan lalu)?	Yes/No
Apakah ada upaya revisi/korektif yang disarankan pada laporan dilakukan oleh fasilitas? (status pada saat ini dapat digunakan sebagai ukuran apakah upaya revisi/korektif sudah dilakukan atau belum)	Yes/No
Apakah sampah biomedis dibuang sesuai aturan	Yes/No
Apakah laboratorium mengembangkan kultur mycobacterial dan tes suscepsibilitas obat	Yes/ No
Slide disimpan untuk QA internal	Yes/No
Total slide yang diperiksa	
Total slide positif	
Total slide negative	

II. Sumber Daya Manusia:

Pelatihan dan Sensitisasi yang dilakukan pada 4 triwulan terakhir:

Jenis staff	**Jenis pelatihan**	**Jumlah hari pelatihan**
1		
2		
3		
4		

In Depth Interview Guideline for Facility Based Providers
MITRA Mid Term Evaluation
CARE International Indonesia

Name of the Interviewer_____
Date_____

Selamat
Introduce Self
Preamble: We are from CARE International Indonesia and have been implementing a community based TB control project called MITRA, in this district/in four districts. We are here as to understand your association with the project and issues pertaining to TB control in the private sector. This will enable us to make improvements in the project strategies and identify gaps that require bridging. This will be a confidential discussion and your name will not be attached to your quotes. We anticipate the discussion to take about one hour. Do we have your permission to proceed?
If response in negative, move to the next available facility worker.
If response yes, continue with the questions.

Location_____
Type of Facility/whether treatment/treatment + lab/only lab_____
Name of the Interviewee and qualifications_____
Total months of association with the Project:_____
Total months in the current facility:_____
Staff in the facility (number trained in DOTS) N (n)

1. What are your main duties in this clinic? Do you also work in any government facility?
2. What proportion of your time is spent in TB related activities (diagnosis/ treatment/counseling/ community outreach/follow up/reporting)
3. On an average how many suspected TB patients do you see in a month?
4. Currently how many TB patients are undergoing treatment here?
5. Were you given any training to carry out TB control activities? If yes when, what training and who conducted this training?
6. Was this training useful? What further support did you receive? Please describe the additional support that would have helped you to perform your duties better.
7. Do the patients come to you directly or are referred by your colleagues from other clinics (or a mix of both)?
8. Now I would like to ask you some technical questions. When do you suspect TB in a patient?
9. What is done when you suspect TB in a patient? How do you investigate them?
10. Could you tell us the criteria upon which TB patients are classified into various categories?
11. What are the facilities available in this clinic to diagnose suspected TB patients? If none, then where do you refer them for investigations?
12. When you attend to a suspected patient and after you initiate treatment, what information do you generally give to your patient?
13. What IEC material is available with you? Are they useful? Do you want to suggest some modifications to the material available?
14. What drugs do you prescribe? List (note if different for different categories)
15. What are the common side effects of the drugs used for treatment?
16. Do you dispense the drugs or just prescribe them?
17. Where do the patients buy these drugs from?

18. If provider mentions referral to government facility for free drugs – ask him which facility and how does he/she follows up on the patient?
19. How often do you ask the patient to visit you? What happens when the patient does not come for his next follow up visit?
20. Do you follow a system of appointing treatment supporters fro you patients?
21. If there is labs in the facility then ask – what are the measures taken to ensure quality in the lab. Is external/internal quality monitoring done?
22. Are you required to submit any reports? If yes what reports do you submit and to whom?
23. If you had a choice, would you work with TB patients?
24. Do you think that a health care worker, who has TB but is not sick, should be allowed to continue to work?
25. If a member of your household became ill with TB, would you want it to remain secret?
26. Some people think that TB patients deserve the illness that they have. Do you agree with this point of view?
27. What support have you received from MITRA? (trainings, review meetings, linkages with treatment supporters etc)
28. Are you required to attend any meetings under this project, if yes what meetings and the purpose of these meetings.
29. Please describe some key problems faced to control TB. Please tell us what can be done to overcome these problems.

Thank you indeed for your time.

Panduan Wawancara Mendalam untuk Pemberi Layanan Berbasis Fasilitas
MITRA Mid Term Evaluation
CARE International Indonesia

Nama pewawancara_____
Tanggal_____

Selamat
Perkenalan
Pembukaan: Seperti yang telah bapak/ibu ketahui, kami sedang melaksanakan evaluasi pertengahan periode untuk proyek MITRA di kabupaten ini dan kami ingin mengetahui pandangan bapak/ibu mengenai kekuatan dan kelemahan dari strategi proyek ini dan program DOTS. Diskusi ini bersifat rahasia dan nama bapak/ibu tidak akan dihubungkan dengan jawaban bapak/ibu. Kami juga akan melihat-lihat fasilitas bapak/ibu, catatan bapak/ibu dan berdiskusi dengan beberapa orang staff . Diskusi ini akan memakan waktu kurang lebih setengah jam. Bisa kami lanjutkan?
Apabila jawaban tidak, lanjut ke orang berikutnya.
Apabila jawaban ya, lanjutkan dengan pertanyaan.

Lokasi_____
Tersambung dengan fasilitas lain? , kalau iya/ apakah fasilitas pengobatan/ pengobatan dan lab/ hanya lab saja
_____
Name responden
Total bekerja dengan proyek :_____bulan
Total bekerja pada fasilitas ini:_____bulan
Jumlah staff pada fasilitas ini (jumlah yang mendapatkan pelatihan DOTS)

1. Berapa lama bekerjasama dengan program MITRA?
2. Berapa lama bekerja di tempat ini?
3. Berapa jumlah staf yang bekerja di tempat ini? Berapa orang yang sudah dilatih DOTS dan siapa yang memberikan pelatihan?
4. Apakah tugas utama bapak/ibu di klinik/tempat ini?
5. Berapa banyak waktu yang bapak/ibu habiskan untuk kegiatan yang terkait dengan TBC (diagnosis/ pengobatan/ konseling/ penjangkauan masyarakat/ tindak lanjut/ pelaporan)
6. Berapa banyak suspek TB yang bapak/ibu periksa dalam 3 bulan terakhir?
7. Saat ini, ada berapa orang pasien TB yang masih berobat di sini?
8. Pernahkah bapak/ibu mengikuti pelatihan TB ? jika pernah, bisakah menyebutkan materinya dan siapa yang melaksanakan (mengadakannya)?
9. Apakah pelatihan TB tersebut bermanfaat? Dukungan apalagi yang bapak/ibu dapatkan? Tolong sebutkan dukungan lain yang dapat membantu bapak/ibu untuk melaksanakan tugas bapak/ibu dengan lebih baik lagi.
10. Apakah pasien/suspek TB, datang kepada bapak/ibu secara langsung ke tempat praktek bapak/ibu atau dirujuk dari tempat lain?
11. Menurut bapak/ibu, gejala apa yang menyebabkan seseorang dicurigai mengidap TBC?
12. Apa yang harus dilakukan pada saat seseorang dicurigai mengidap TBC? Bagaimana pasien diperiksa?
13. Apakah bapak/ibu bisa menyebutkan kriteria-kriteria yang digunakan dalam penggolongan penderita TBC ke dalam berbagai kategori?
14. Fasilitas apa sajakah yang tersedia di klinik ini untuk mendiagnosa pasien suspek TBC? Apabila tidak ada, kemana bapak/ibu akan merujuk mereka untuk pemeriksaan?
15. Apabila bapak/ibu merawat pasien suspek dan setelah bapak/ibu memulai pengobatan, informasi apa yang umumnya bapak/ibu berikan kepada pasien bapak/ibu?

16. Materi penyuluhan apa, yang pernah bapak/ibu terima? Apakah materi-materi tersebut berguna? Apakah bapak/ibu memiliki saran untuk perubahan materi yang ada sekarang?
17. Obat apa yang bapak/ibu resepkan? Sebutkan (lihat apakah berbeda untuk kategori yang berbeda)
18. Apa sajakah efek samping yang biasa disebabkan oleh obat yang digunakan dalam pengobatan?
19. Apakah bapak/ibu menyediakan obat atau hanya menuliskan resep saja?
20. Di mana pasien biasanya membeli obat?
21. Apabila responden menyebutkan rujukan ke puskesmas atau pelayanan kesehatan lain yang memberikan obat gratis - tanyakan fasilitas mana dan bagaimana dia menindaklanjuti pasien?
22. Berapa kali bapak/ibu meminta pasien untuk datang kembali ke tempat bapak/ibu? Apa yang terjadi apabila pasien tidak datang pada kunjungan berikutnya?
23. Apakah bapak/ibu menunjuk seorang PMO untuk pasien bapak/ibu?
24. (Apabila terdapat laboratorium pada fasilitas tersebut) tanyakan, langkah-langkah apa sajakah yang diambil untuk memastikan kualitas pengawasan yang dilakukan?
25. Apakah yang bapak/ibu melakukan pelaporan kasus TB yang bapak/ibu tangani?
26. Apabila diberi pilihan apakah bapak/ibu bersedia memberikan pelayanan kepada pasien TBC?
27. Menurut bapak/ibu, bagaimana jika seorang petugas kesehatan yang menderita TBC tetapi tidak sakit , diperbolehkan untuk tetap bekerja?
28. Apabila anggota keluarga bapak/ibu menderita TB, apakah bapak/ibu ingin merahasiakan hal tersebut?
29. Beberapa orang beranggapan bahwa penderita TB pantas untuk mendapatkan penyakit tersebut. Apakah bapak/ibu setuju dengan anggapan ini?
30. Dukungan apa yang sudah didapatkan kabupaten ini dari MITRA? (pelatihan, pertemuan “review”, penguhubungan dengan PMO dan swasta, dll)
31. Apakah bapak/ibu pernah mengikuti menghadiri pertemuan pada proyek ini, apabila ya, pertemuan apa dan apa tujuan dari pertemuan ini?
32. Sebutkan apa saja yang menjadi kendala dalam pengendalian TB? Bagaimana cara mengatasinya?

Terima kasih untuk waktu bapak/ibu.

In Depth Interview Guideline for District Health Officer
MITRA Mid Term Evaluation
CARE International Indonesia

Name of the Interviewer_____
Date_____

Selamat
Introduce Self
Preamble: As you are aware we are carrying out the mid term evaluation of project MITRA in this district and would like to understand your perspective on the strengths and weakness of project strategies and the DOTS program. This will enable us to make improvements in the project strategies and identify issues requiring resolution. This will be a confidential discussion and your name will not be attached to your quotes. It will also involve an assessment of your facility, review of your registers and discussions with some key staff members of the *Dinkes* We anticipate the discussion to take about half hour. Do we have your permission to proceed?

Location_____
Attached to a Facility if so /whether treatment/treatment + lab/only lab_____
Name of the Interviewee
Total months of association with the Project:_____
Total months in the current position:_____

1. Please describe your role as a District Health Officer. How many facilities do you monitor and support?
2. What proportion of your time is spent on each of the TB control activities
3. What are the current challenges, pertaining to TB, in your district? Is it increasing or decreasing?
4. Please describe some of the difficulties you face in implementing the program and possible solutions.
5. Have you received any orientation towards DOTS If yes when, what orientations/training and who conducted this training?
6. What further support did you receive? Please describe the additional support that would have helped you to perform your duties better.
7. What are the facilities available in the district to diagnose suspected TB patients?
8. What additional support is required in the district to diagnose patients?
9. What IEC material is available in the district? Are they useful? Do you want to suggest some modifications to the material available?
10. Please describe the role of the
    Wasor
    BCC officer
    MO communicable diseases
11. What reporting formats are you required to submit? Did your training have sessions on formats?
12. What support has this district received from MITRA? (trainings, review meetings, linkages with treatment supporters and private providers etc)
13. Do the activities at district level undergo any review? If yes how often and who are the participants in the review?
14. Does the district have partnerships with any community based groups or other NGOs? How have these contributed to the program?
15. Is there an effort to involve private providers? Please describe your experiences (difficulties and innovative ideas if any)

Thank you indeed for your time.

Panduan Wawancara Mendalam untuk Kepala Dinas Kesehatan Kabupaten
MITRA Mid -Term Evaluation
CARE International Evaluation

Nama pewawancara :……
Tanggal :……

Salam,

Perkenalan:

- Saya……beserta tim Evaluasi, diikut sertakan pada kegiatan pelaksanaan evaluasi pertengahan periode untuk Proyek MITRA diempat Kabupaten, salah satunya Kabupaten yang Bapak/Ibu pimpin ini.
- Pada wawancara ini kami ingin mengetahui *pandangan* Bapak/Ibu mengenai *kekuatan* dan *kelemahan* dari strategi proyek ini berkaitan dengan program DOTS.
- Diskusi ini bersifat *rahasia* dan *nama* Bapak/Ibu tidak akan kemi hubungkan dengan jawaban Bapak/Ibu
- Dalam proses evaluasi ini kami akan mewawancarai staf Dinas Kesehatan, pasien dan masyarakat yang terlibat Proyek MITRA, erta melihat fasilitas pelayanan, dan melihat catatan-catatan yang diperlukan.
- Diskusi dengan Bapak/Ibu akan memakan waktu kurang lebih satu jam.
- Apakah wawancara ini bisa kita mulai ?

Nama lokasi:……..
Nama responden:…….

Proyek Mitra di Kabupaten ini sudah berjalan berapa Bulan……..,
dan berapa orang yang terlibat…….

1. Tolong ceritakan *peranan* Bapak/Ibu sebagai Kepala Dinas.
2. Berapa banyak waktu yang Bapak/Ibu gunakan untuk pengendalian TB ?
3. Apa tantangan yng Bapak/Ibu hadapi di Kabupaten ini.
4. Tolong ceritakan beberapa kesulitan yang Bapak/Ibu hadapi dalam menjalankan program dan sekaligus apa pemecahan (solusi) nya.
5. Apakah Bapak pernah mendapat orientasi/pelatihan dari DOTS, …….apa bila ya kapan,……., orientasi/pelatihan apa……, dan siapa penyelenggara pelatihan?……
6. Dukungan apa yang Bapak/Ibu pernah terima ……., dan dukungan tambahan apa lagi yang bapak/Ibu perlukan untuk pelaksanaan tugas yang lebih baik ?.....
7. Fasilitas apa saja yang tersedia untuk mendiagnosa suspek TB

8. Dukungan apa yang dibutuhkan Kabupaten untuk mendiagnosa pasien TB ?
9. Materi penyuluhan (KIE) apa yang tersedia di Kabupaten ?
10. Tolong ceritakan mengenai peran dari:
    Wasor:…….
    Petugas KPP/Promkes:……
    MO (Medical officer) penyakit menular:……..
11. Dukungan apa yang sudah didapat Kabupaten dari MITRA ?
    (pelatihan, pertemuan "review", berkaitan dengan pengobatan , swasta dsb).
12. Apakah kegiatan tingkat Kabupaten pernah di "di- review" ?
13. Apakah Kabupaten memiliki hubungan kemitraan dengan ORMAS atau NGO lainnya ?
14. Bagaimana cara hubungan kerja dalam rangka memberikan kontribusi kepada Kabupaten.
15. Apakah ada usaha untuk melibatkan swasta?

    .....
    Tolong ceritakan pengalaman Bapak/ IBU
    (kesulitan dan ide-ide inovativ apabila ada).

……

In Depth Interview Guideline for Wasors
MITRA Mid Term Evaluation
CARE International Indonesia

Name of the Interviewer_____
Date_____

Selamat
Introduce Self
Preamble: As you are aware we are carrying out the mid term evaluation of project MITRA in this district and would like to understand your perspective on the strengths and weakness of project strategies and the DOTS program. This will enable us to make improvements in the project strategies and identify issues requiring resolution. This will be a confidential discussion and your name will not be attached to your quotes. It will also involve an assessment of your facility and review of your registers. We anticipate the discussion to take about one hour. Do we have your permission to proceed?
If response no, move to the next available Wasor.
If response yes, continue with the questions.

Location_____
Attached to a Facility if so /whether treatment/treatment + lab/only lab_____
Name of the Interviewee
Total months of association with the Project:_____
Total months in the current position:_____

1. Please describe your role as a Wasor. How many facilities do you monitor and support?
2. What proportion of your time is spent on each of the TB control activities
   - Diagnosis
   - Treatment
   - Counseling
   - community outreach/follow up
   - supervision
   - reporting
3. What is the current load of disease in your area? Is it increasing or decreasing?
4. Please describe some of the difficulties you face in implementing the program and possible solutions

   - Case notification
   - Case detection
   - Diagnosis
   - Lab functioning
   - Treatment
   - Drug management
   - Community outreach
   - Defaults/transfers
   - Default retrievals
   - MDR TB
   - Partnerships with private and NGO sector
   - Budgets
   - Information management

5. Were you given any training to carry out TB control activities? If yes when, what training and who conducted this training?
6. Was this training useful? What further support did you receive? Please describe the additional support that would have helped you to perform your duties better.
7. Now I would like to ask you some technical questions. When does one suspect TB in a patient?
8. What is done when one suspects TB in a patient? How is the patient investigated?
9. What are the facilities available in the district to diagnose suspected TB patients?
10. Could you tell the criteria upon which TB patients are classified into various categories?
11. What additional support is required in the district to diagnose patients?
12. What drugs are prescribed? List (note if different for different categories)
13. What are the common side effects of the DOTS drugs?
14. What IEC material is available in the district? Are they useful? Do you want to suggest some modifications to the material available?
15. Is it a norm to identify a treatment supporter for every patient who is registered for DOTS?
16. Are you required to go to the community for follow up or TB extension activities? If yes please describe your community level activities.
17. What is your role in drug management (maintaining adequate drug supply) and lab management (if a lab is attached to the facility : ensuring adequacy of lab consumables, supervision, reporting etc)
18. Please describe the role of the
    district health officer in TB control
    BCC officer
    MO communicable diseases
19. What reporting formats are you required to submit? Did your training have sessions on formats?
20. Who supervises your work? When did you last receive a supervisory visit? What does your supervisor check when he/she visits you? Please list. Did you receive any feedback? Was it useful? Describe the support you receive from the NTP.
21. What support has this district received from MITRA? (trainings, review meetings, linkages with treatment supporters and private providers etc)
22. Do the activities at district level undergo any review? If yes how often and who are the participants in the review?
23. Does the district have partnerships with any community based groups or other NGOs
24. Is there an effort to involve private providers? Please describe your experiences (difficulties and innovative ideas if any)

Thank you indeed for your time.

Thank you for your time! The survey is complete.

Panduan Wawancara Mendalam untuk Wasor
MITRA Mid Term Evaluation
CARE International Indonesia

Nama pewawancara_____
Tanggal_____

Selamat
Perkenalan
Pembukaan: Seperti yang telah anda ketahui, kami sedang melaksanakan evaluasi pertengahan periode untuk proyek MITRA di kabupaten ini dan kami ingin mengetahui pandangan anda mengenai kekuatan dan kelemahan dari strategi proyek ini dan program DOTS. Diskusi ini bersifat rahasia dan nama anda tidak akan dihubungkan dengan jawaban anda. Kami juga akan melihat-lihat fasilitas anda, catatan anda dan berdiskusi dengan beberapa orang staff Dinkes. Diskusi ini akan memakan waktu kurang lebih setengah jam. Bisa kami lanjutkan?
Apabila jawaban tidak, lanjut ke Wasor berikutnya.
Apabila jawaban ya, lanjutkan dengan pertanyaan.

Lokasi_____
Tersambung dengan fasilitas, kalau iya/ apakah pengobatan/ pengobatan+lab/ hanya lab
_____
Name responden
Total bekerja dengan proyek :_____bulan
Total bekerja pada posisi ini:_____bulan

1. Tolong ceritakan peran anda sebagai staff P2PL.
2. Apakah daerah memiliki strategi menyeluruh untuk kesehatan? Apabila iya, tolong jelaskan strategi yang menyangkut pengendalian TBC.
3. Tantangan apa yang sedang dihadapi kabupaten terkait dengan penyakit menular?
4. Peran apa yang anda mainkan dalam mengatasi permasalahan TBC dan HIV?
5. Apakah anda memiliki rencana aksi untuk menjalankan kegiatan pengendalian bencana? Apabila ya, bisa tolong anda jelaskan?
6. Apakah anda mendapatkan dukungan anggaran yang memadai?
7. Materi KIE apa sajakah yang tersedia di kabupaten? Apakah materi-materi tersebut berguna? Apakah anda memiliki saran untuk perubahan materi yang ada sekarang?
8. Apakah anda diwajibkan untuk terjun ke masyarakat untuk mensupervisi kegiatan penyuluhan? Apabila ya tolong ceritakan mengenai kegiatan anda pada tingkat masyarakat.
9. Bagaimana anda mengkoordinasikan kegiatan anda dengan dinkes, petugas promkes, koordinator labkesda dan wasor?
10. Dukungan apa yang sudah didapatkan kabupaten ini dari MITRA? (pelatihan, pertemuan, monitoring/peninjauan, penghubungan dengan PMO dan pelayanan kesehatan swasta, dll)
11. Apakah kegiatan-kegiatan di tingkat kabupaten ini sudah pernah dievaluasi/ ditinjau? Apabila ya, seberapa sering dan siapa sajakah peserta review?
12. Apakah kabupaten memiliki hubungan kemitraan dengan Ormas atau LSM lain?
13. Apakah ada upaya untuk melibatkan swasta? Tolong ceritakan pengalaman anda (kesulitan dan ide inovatif, apabila ada)

Terima kasih atas waktu anda.

In Depth Interview Guideline for Wasors
MITRA Mid Term Evaluation
CARE International Indonesia

Name of the Interviewer_____
Date_____

Selamat
Introduce Self
Preamble: As you are aware we are carrying out the mid term evaluation of project MITRA in this district and would like to understand your perspective on the strengths and weakness of project strategies and the DOTS program. This will enable us to make improvements in the project strategies and identify issues requiring resolution. This will be a confidential discussion and your name will not be attached to your quotes. We anticipate the discussion to take about half hour. Do we have your permission to proceed?

Location_____
Attached to a Facility if so /whether treatment/treatment + lab/only lab_____
Name of the Interviewee
Total months of association with the Project:_____
Total months in the current position:_____

1. Please describe your role as the BCC Officer.
2. Does the district have an overall BCC strategy for health? If yes describe the strategy for controlling and preventing TB.
3. What are the current TB BCC challenges facing the district?
4. What role do you play in addressing the issue of TB?
5. What additional support do you need to ensure patients seek treatment, adhere and complete treatment, and are not stigmatized by the society?
6. Do you have a plan of action for implementing BCC activities? If so could you please describe it?
7. Are you sufficiently supported by budgets?
8. What IEC material is available in the district? Are they useful? Do you want to suggest some modifications to the material available?
9. Were you given any training pertaining to TB control? If yes when, what training and who conducted this training?
10. Was this training useful? What further support did you receive? Please describe the additional support that would have helped you to perform your duties better.
11. Now I would like to ask you some technical questions. When does one suspect TB in a patient?
12. What is done when one suspects TB in a patient? How is the patient investigated?
13. What are the facilities available in the district to diagnose suspected TB patients?
14. Could you tell the criteria upon which TB patients are classified into various categories?
15. What drugs are prescribed? List (note if different for different categories)
16. What are the common side effects of the DOTS drugs?
17. Is it a norm to identify a treatment supporter for every patient who is registered for DOTS?
18. Are you required to go to the community for follow up BCC extension activities? If yes please describe your community level activities.
19. How do you coordinate your activities with the DHO, MO communicable diseases and the Wasor
20. What support has this district received from MITRA? (trainings, review meetings, linkages with treatment supporters and private providers etc)
21. Do the activities at district level undergo any review? If yes how often and who are the participants in the review?

22. Does the district have partnerships with any community based groups or other NGOs
23. Is there an effort to involve private providers? Please describe your experiences (difficulties and innovative ideas if any)

Thank you indeed for your time.

Thank you for your time! The survey is complete.

Panduan Wawancara Mendalam untuk Staf Promkes
MITRA Mid Term Evaluation
CARE International Indonesia

Nama pewawancara_____
Tanggal_____

Selamat
Perkenalan
Pembukaan: Seperti yang telah anda ketahui, kami sedang melaksanakan evaluasi pertengahan periode untuk proyek MITRA di kabupaten ini dan kami ingin mengetahui pandangan anda mengenai kekuatan dan kelemahan dari strategi proyek ini dan program DOTS. Diskusi ini bersifat rahasia dan nama anda tidak akan dihubungkan dengan jawaban anda. Kami juga akan melihat-lihat fasilitas anda, catatan anda dan berdiskusi dengan beberapa orang staff Dinkes. Diskusi ini akan memakan waktu kurang lebih setengah jam. Bisa kami lanjutkan?

Lokasi_____
Tersambung dengan fasilitas, kalau iya/ apakah pengobatan/ pengobatan+lab/ hanya lab

Name responden
Total bekerja dengan proyek :_____bulan
Total bekerja pada posisi ini:_____bulan

1. Tolong ceritakan “peran dan tugas” anda sebagai petugas KPP.
2. Apa sajakah tantangan yang sedang dihadapi di kabupaten ini, terkait dengan KPP TBC?
3. Bagaimana cara anda memotivasi pasien untuk berobat secara teratur ?
4. Bagaimana menghapuskan stigma tentang TB dimasyarakat?
5. Apakah anda memiliki rencana kerja untuk melaksanakan kegiatan-kegiatan KPP? Apabila ada, bisa tolong anda ceritakan?
6. Apakah anda didukung dengan anggaran yang memadai?
7. Materi KIE apa sajakah yang tersedia di kabupaten? Apakah materi-materi tersebut berguna? Apakah anda memiliki saran untuk perubahan materi yang ada sekarang?
8. Apakah anda mendapatkan pelatihan mengenai pengendalian TB? Apabila ya, kapan, pelatihan apa dan siapa yang memberikan pelatihan?
9. Apakah pelatihan tersebut bermanfaat? Dukungan apa lagi yang anda dapatkan? Tolong ceritakan mengenai dukungan tambahan yang dapat membantu anda untuk menjalankan tugas anda dengan lebih baik.
10. Menurut anda, kapan seseorang dicurigai mengidap TBC?
11. Apa yang harus dilakukan pada saat seseorang dicurigai mengidap TBC? Bagaimana pasien diperiksa?
12. Apa sajakah efek samping yang biasa disebabkan oleh obat DOTS?
13. Apakah biasanya setiap pasien yang mengikuti DOTS diberikan satu orang PMO?
14. Apakah anda diwajibkan untuk terjun ke masyarakan untuk menindaklanjuti kegiatan penyuluhan KPP? Apabila ya tolong ceritakan mengenai kegiatan anda pada tingkat masyarakat.
15. Bagaimana anda mengkoordinasikan kegiatan anda dengan dinkes, MO Penyakit Menular dan Wasor
16. Dukungan apa yang sudah didapatkan kabupaten ini dari MITRA? (pelatihan, pertemuan “review”, penguhubungan dengan PMO dan swasta, dll)
17. Apakah kegiatan-kegiatan di tingkat kabupaten ini sudah pernah dievaluasi/ ditinjau? Apabila ya, seberapa sering dan siapa sajakah peserta review?
18. Apakah kabupaten memiliki hubungan kemitraan dengan Ormas atau LSM lain?
19. Apakah ada upaya untuk melibatkan swasta? Tolong ceritakan pengalaman anda (kesulitan dan ide inovatif, apabila ada)

Terima kasih atas waktu anda.

In Depth Interview Guideline for Wasors
MITRA Mid Term Evaluation
CARE International Indonesia

Name of the Interviewer_____
Date_____

Selamat
Introduce Self
Preamble: As you are aware we are carrying out the mid term evaluation of project MITRA in this district and would like to understand your perspective on the strengths and weakness of project strategies and the DOTS program. This will enable us to make improvements in the project strategies and identify issues requiring resolution. This will be a confidential discussion and your name will not be attached to your quotes. It will also involve an assessment of your facility and review of your registers. We anticipate the discussion to take about half hour. Do we have your permission to proceed?
If response is yes then continue with the questions.

Location_____
Attached to a Facility or Lab_____
Name of the Interviewee _____
Total months of association with the Project:_____
Total months in the current position:_____

1. Please describe your role as a Lab Officer. How many Labs do you monitor and support?
2. What proportion of your time is spent on each of the TB control activities
   - Actual lab work
   - supervision
   - reporting
   - Management
3. What is the current load of disease in your area? Is it increasing or decreasing?
4. Please describe some of the difficulties you face in implementing the program and possible solutions

   - Case notification
   - Case detection
   - Diagnosis
   - Lab functioning
   - Treatment
   - MDR TB
   - Budgets
   - Information management
5. What trainings have you received to carry out efficient lab management and networking. Who conducted these trainings?
6. Was this training useful? What further support did you receive? Please describe the additional support that would have helped you to perform your duties better.
7. Now I would like to ask you some technical questions. When does one suspect TB in a patient?
8. What is done when one suspects TB in a patient? How is the patient investigated?
9. What are the facilities available in the district to diagnose suspected TB patients?
10. Could you relate the criteria upon which TB patients are classified into various categories?
11. What additional support is required in the district to diagnose patients?
12. Please describe how you coordinate activities and what support do you get from

District health officer
Wasor
BCC officer
MO communicable diseases

13. How is the internal quality assessment done? How frequently is this done? What problems do you face in carrying out internal quality assessment?
14. How is the external quality assessment done? How frequently is this done? What problems do you face in carrying out internal quality assessment?
15. Is the availability of equipments, infrastructure and consumables adequate in the district labs? Do you face any problems in this regard?
16. What reporting formats are you required to submit? Did your training have sessions on formats?
17. Who supervises your work? When did you last receive a supervisory visit? What does your supervisor check when he/she visits you? Please list. Did you receive any feedback? Was it useful? Describe the support you receive from the NTP.
18. What support has this district received from MITRA? (trainings, review meetings, linkages with treatment supporters and private providers etc)
19. Do the activities at district level undergo any review? If yes how often and who are the participants in the review?
20. Is there an effort to involve private providers? Please describe your experiences (difficulties and innovative ideas if any)

Thank you indeed for your time.

Panduan Wawancara Mendalam untuk pengelola Laboratorium
MITRA Mid Term Evaluation
CARE International Indonesia

Nama pewawancara_____
Tanggal_____

Selamat
Perkenalan
Pembukaan: Seperti yang telah anda ketahui, kami sedang melaksanakan evaluasi pertengahan periode untuk proyek MITRA di kabupaten ini dan kami ingin mengetahui pandangan anda mengenai kekuatan dan kelemahan dari strategi proyek ini dan program DOTS. Diskusi ini bersifat rahasia dan nama anda tidak akan dihubungkan dengan jawaban anda. Kami juga akan melihat-lihat fasilitas anda, catatan anda dan berdiskusi dengan beberapa orang staff Dinkes. Diskusi ini akan memakan waktu kurang lebih setengah jam. Bisa kami lanjutkan?
Apabila jawaban tidak, lanjut ke Wasor berikutnya.
Apabila jawaban ya, lanjutkan dengan pertanyaan.

Lokasi_____
Tersambung dengan fasilitas, kalau iya/ apakah pengobatan/ pengobatan+lab/ hanya lab
_____
Nama responden
Total bekerja dengan proyek :_____bulan
Total bekerja pada posisi ini:_____bulan

1. Tolong ceritakan peran bapak/ibu sebagai kepala laboratorium kesehatan. Berapa fasilitas bapak/ibu yang anda monitor dan berapa yang anda dukung?
2. Seberapa banyak dari waktu anda yang bapak/ibu gunakan untuk masing-masing kegiatan pengendalian TB
   - Pekerjaan lab
   - Supervisi
   - Pelaporan
   - Manajemen
3. Seberapa banyak kasus TBC di daerah bapak/ibu? Apakah meningkat atau menurun?
4. Tolong ceritakan kesulitan-kesulitan yang anda hadapi dalam menjalankan program dan solusi yang dimungkinkan

   - Notifikasi kasus
   - Penemuan kasus
   - Diagnosis
   - Fungsi lab
   - Pengobatan
   - MDR TB
   - Anggaran
   - Manajemen informasi

5. Pelatihan apa yang pernah anda dapatkan untuk melaksanakan manajemen lab dan jejaring yang efisien siapa yang memberikan pelatihan ini?
6. Apakah pelatihan ini bermanfaat? Dukungan apa yang anda dapatkan? Dukungan tambahan apa sajakah yang dapat membantu anda untuk melaksanakan tugas anda dengan lebih baik?

7. Sekarang saya ingin menanyakan beberapa pertanyaan teknis. Menurut anda, kapan seseorang dicurigai mengidap TB?
8. Apa yang harus dilakukan pada saat seseorang dicurigai mengidap TBC? Bagaimana pasien diperiksa?
9. Fasilitas apa sajakah yang tersedia di kabupaten untuk mendiagnosa suspek TB?
10. Apakah anda bisa menyebutkan kriteria-kriteria yang digunakan dalam penggolongan penderita TBC ke dalam berbagai kategori?
11. Dukungan tambahan apa yang dibutuhkan kabupaten untuk dapat mendiagnosa pasien?
12. Tolong ceritakan bagaimana anda berkoordinasi dengan dan dukungan apa yang anda dapatkan dari
    Kepala Dinas Kesehatan
    Wasor
    Petugas KPP
    MO penyakit menular
13. Bagaimana cross check dilaksanakan secara internal? Seberapa sering hal ini dilakukan? Permasalahan apa yang anda hadapi dalam melaksanakan penilaian kualitas internal?
14. Bagaimana cross check dilaksanakan secara eksternal? Seberapa sering hal ini dilakukan? Permasalahan apa yang anda hadapi dalam melaksanakan penilaian kualitas eksternal?
15. Apakah sudah tersedia peralatan, infrastruktur dan perlengkapan yang memadai pada laboratorium kabupaten? Apakah anda memiliki permasalah terkait dengan hal ini?
16. Format pelaporan seperti apa yang anda harus sampaikan? Apakah pada pelatihan yang anda ikuti ada sesi mengenai format?
17. Siapa yang mensupervisi pekerjaan anda? Kapan terakhir kali anda mendapatkan kunjungan supervisi? Apa yang biasanya dia periksa pada saat berkunjung? Sebutkan. Apakah anda mendapatkan umpan balik? Apakah hal tersebut berguna? Ceritakan dukungan yang anda dapatkan dari Program TB Nasional.
18. Dukungan apa yang sudah didapatkan kabupaten ini dari MITRA? (pelatihan, pertemuan “review”, penguhubungan dengan PMO dan swasta, dll)
19. Apakah kegiatan-kegiatan di tingkat kabupaten ini sudah pernah dievaluasi/ ditinjau? Apabila ya, seberapa sering dan siapa sajakah peserta evaluasi?
20. Apakah ada upaya untuk melibatkan swasta? Tolong ceritakan pengalaman anda (kesulitan dan ide inovatif, apabila ada)

Terima kasih atas waktu anda.

Checklist untuk Peninjauan Fasilitas (termasuk Lab)
***MITRA* (TB Project) Mid Term Evaluation**
CARE International Indonesia

Nama fasilitas:
Jenis a) fasilitas pengobatans saja b) lab mikroskopi c) pengobatan and mikroskopi
Nama observer:
Tanggal kunjungan :

I. Informasi Umum

Area terpisah di mana pasien TBC melapor	Y	N	
Sistem untuk merujuk pasien suspek TB ke petugas DOTS pada fasilitas	Y	N	
Materi KIE ditempelkan pada fasilitas	Y	N	
Sarana pembuangan dahak yang aman	Y	N	
Staff khusus untuk melayani pasien TBC	Y	N	
Proporsi staff yang mendapatkan pelatihan TBC	(N)	terlatih	
Proporsi staff yang tidak mendapatkan pelatihan TBC	(N)	terlatih	
Apakah ada pencatatan TBC dan kemuktahiran	Y	N	
Apakah ada format TBC yang memadai dan apakah diisi secara tepat	Y	N	
Apakah kesediaan obat mencukupi (kecukupan sebagai ukuran terhadap jumlah pasien baru yang mendaftar setiap caturwulan)	Y	N	
Suspek TB diperiksa untuk diagnosis (untuk bulan lalu)	(N)		
Suspek TB yang positik	(N)		
Suspek TB yang menjalani pemeriksaan dahak ulang	(N)		
Suspek TB yang ditemukan positif pada pemeriksaan ulang dahak	(N)		
Pasien follow up yang diperiksa	(N)		
Jumlah pasien follow up	(N)		
Jumlah pasien yang terdaftar	(N)		
Jumlah kotak obat yang tersedia	(N)		
Jumlah drop out	(N)		
Jumlah yang memiliki PMO	(N)		

II. Kegiatan Diagnosis

Proporsi suspek TB yang menjalani 3 pemeriksaan dahak untuk diagnosis? *(Dapat diperkirakan dengan mempelajari beberapa halaman dari catatan lab)*	(N)	Done	%
Proporsi suspek TB yang menjalani 2 pemeriksaan dahak untuk diagnosis? *(Dapat diperkirakan dengan mempelajari beberapa halaman dari catatan lab)entries in the Lab register)*			

Jumlah DO pada caturwulan sebelumnya:			

III. Infrastruktur dan Kegiatan Lab

Apakah ada ruang khusus untuk lab	Yes/No
Apakah ada protap yang tersedia	Yes/No
Ada catatan lab	Yes/No
Apakah ada miskroskop binokular yang berfungsi?	Yes/No
Apakah pemeriksaan dahak dilakukan oleh teknisi lab? Kapan terakhir pelatihan	Yes/No
Apakah terdapat persediaan reagen, slide dan persediaan lainnya untuk satu bulan ke depan?	Yes/No
Apakah reagen lab dipersiapkan secara fresh (segar)? optional	Yes/No
Apabila iya, kapan hal tersebut dipersiapkan (pada a/b/c)? optional	Yes/No
Apakah nama dan alamat pada catatan lab TB ditulis dengan jelas	Yes/No
Are the positive results written in red & negative in blue/black? Don't know if this is a norm in Indonesia	Yes/No
Apakah ada rangkuman kegiatan mikroskopis pada setiap akhir bulan?	Yes/No
Apakah teknisi lab menyimpan slide untuk dilihat kembali oleh supervisor untuk protokol memastikan kualitas?	Yes/No
Last supervisory visit and from whom	
Is the supervisor reviewing slides preserved by the LT during the on site evaluation?	Yes/No
Is there evidence of EQA *('x', 'o' marks in the Lab register) again please review for the norm in Indonesia*	Yes/No
Apakah laporan evaluasi on site yang dilakukan oleh supervisor tersedia di fasilitas (setidaknya untuk bulan lalu)?	Yes/No
Apakah ada upaya korektif yang disarankan pada laporan dilakukan oleh fasiltias? (status pada saat ini dapat digunakan sebagai ukuran apakah upaya korektif sudah dilakukan atau belum)	Yes/No
Apakah sampah biomedis dibuang sesuai norma	Yes/No
Apakah lab mengembangkan kultur mycobacterial dan tes suscepsibilitas obat	Yes/ No
Slide disimpan untuk QA internal (optional)	Yes/No
Total slide yang diperiksa	
Total slide positif	
Total slide negatif	

Optional : blinding, errors detected, resolved

IV. Kegiatan pengobatan:

Apakah kotak obat untuk pasien ditandai dan dijaga untuk setiap pasien berobat jalan yang mendapatkan pengobatan pada pusat DOT?
Apakah fasilitas untuk DOTS memuaskan (air bersih, gelas sekali pakai, privasi)?
Apakah ada pengaturan yang memadai untuk SM injeksi (apabila ada pasien kat 2 mendapatkan pengobatan di pusat DOTS ini)?

Apakah terdapat konsistensi antara jumlah dosis yang ada di kartu pengobatan dan kotak obat? (periksa 2 kotak) Kotak 1 (nama_____) Kotak 2 (nama_____)
Apakah ada kunjungan rumah untuk membawa pasien yang tidak teratur berobat kembali? *(Atau pasien yang tidak datang untuk dosis, bagian dari kartu pengobatan dapat diperiksa)*
Apakah ada obat di kotak obat pasien yang sudah kadaluarsa Kotak 1 (nama_____) Kotak 2 (nama_____)
Apakah alamat pasien diverivikasi sebelum memulai pengobatan? *(KArtu pengobatan dapa diperiksa untuk kunjungan rumah awal)*

V. Sumber Daya Manusia:

Pelatihan dan Sensitisasi yang dilakukan pada 4 cawu terakhir:

Jenis staff	**Pelatihan RNTCP Formal**	**Sensitisasi RNTCP**
1		
2		
3		
4		

VI. Mekanisme rujukan untuk pengobatan dan umpan balik:

- Apakah ada catatan rujukan untuk pengobatan yang dilakukan?
- Apakah formulir pengobatan digunakan untuk merujuk pasien yang didiagnosa di fasilitas ke tempat lain? Di dalam dan di luar kabupaten?
- Apakah ada kenda dalam perujukan pasien ke pusat TBC?
- Apakah ada umpan balik mengenai pasien yang berikan ke departemen perujuk oleh pusat DOTS?

VII. DOTS Indoor: *(untuk RS- termasuk observasi kunjungan ke bangsal TB- Paru/ Medicine Department)*

- Apakah obat-obatan yang dipasok oleh PTN digunakan di bangsal untuk pasien rawat inap?
- Apakah ada sumber lain untuk OAT (yang sudah tersedia melalui PTN) untuk pasien rawat inap?
- Apakah pasien rawat inap juga tercatat di tempat lain?
- Apakah mekanisme “Transfer Out” dicatat dengan baik pada saat rawat inap?

VIII. Koordinasi TB/HIV (*berdasarkan kunjungan ke pusat VCT dan ART, kalau ada*

- Apakah ada pusat VCT di fasilitas atau disekitar?
- Apakah ada standar mekanisma perujukan silang antara pusat DOTS dan VCT?
- Apakah ada mekanisme untuk membawa pasien TB dalam ART ke pusat DOTS?

IX. Supervisi dan Monitoring:

- Kapan terakhir kali pertemuan supervisi diadakan?
- Siapa yang berkunjung?

- Umpan balik apa yang diberikan pada kunjungan tersebut?
- Tindak lanjut apa yang telah dilakukan berdasarkan umpan balik?

Checklist for Facility (including Lab) Assessment
***MITRA* (TB Project) Mid Term Evaluation**
CARE International Indonesia

Name of the Facility:
Whether a) treatment only facility b) microscopy lab c) treatment and microscopy
Name of the Observer:
Date of Visit:

I. General Information

Separate area where all suspected TB patients report	Y	N	
System for referring suspected TB patients to DOTS provider within facility	Y	N	
IEC material displayed in the facility	Y	N	
Provision for safe sputum disposal	Y	N	
Dedicated staff to attend TB patients	Y	N	
Proportion of TB Staff Trained	(N)	Trained	
Proportion of non-TB staff trained in DOTS	(N)	Trained	
Whether TB register present and up to date	Y	N	
Whether adequate TB formats available and filled appropriately	Y	N	
Whether adequate drugs available (adequacy as a measure of expected number of new patients registered on a quarterly basis)	Y	N	
TB suspects examined for diagnosis (for the last month)	(N)		
TB suspects found to be positive	(N)		
TB suspects undergoing repeat sputum examination	(N)		
TB suspects found to be positive on repeat sputum examination	(N)		
Follow up patients examined	(N)		
Patients positive on follow up	(N)		
Number of patients registered	(N)		
Number of dedicated drug boxes	(N)		
Number of defaulters	(N)		
Number with treatment supporters	(N)		

II. Diagnostic Activities

Proportion of TB suspects for whom 3 sputum smears were done for diagnosis? *(Can be estimated by examining a few pages of entries in the Lab register)*	(N)	Done	%
Proportion of TB patients for whom 2 sputum smears were done during follow up examination? *(Can be similarly estimated by examining a few pages of* *entries in the Lab register)*			

No. of initial defaulters in the previous quarter:			

III. Lab Infrastructure and Activities

Is there a separate lab space	Yes/No
Is there a Standard Operating Procedure present	Yes/No
Lab register present	Yes/No
Is there a functional binocular microscope in the MC?	Yes/No
Is a trained Lab Technician (LT) doing the sputum microscopy? When last trained	Yes/No
Are there adequate supplies of reagents, slides and other consumables for the next one-month?	Yes/No
Are the lab reagents freshly prepared? optional	Yes/No
If yes, where are they prepared (at a/b/c)? optional	Yes/No
Are the names and addresses in the TB laboratory register written legibly?	Yes/No
Are the positive results written in red & negative in blue/black? Don't know if this is a norm in Indonesia	Yes/No
Is there a summary of the microscopy activities at the end of each month?	Yes/No
Is the LT preserving slides for review by the supervisor as per the quality assurance protocol?	Yes/No
Last supervisory visit and from whom	
Is the supervisor reviewing slides preserved by the LT during the on site evaluation?	Yes/No
Is there evidence of EQA *('x', 'o' marks in the Lab register) again please review for the norm in Indonesia*	Yes/No
Are the reports of On Site Evaluation done by supervisor available in the facility (at least for last month)?	Yes/No
Is corrective action as suggested in report being carried out by the facility? (current status may be used as an assessment about the corrective actions taken)	Yes/No
Is the bio-medical waste disposed as per norms	Yes/No
Does the lab engage in Mycobacterial culture and drug susceptibility testing	Yes/ No
Slides maintained for internal quality (optional)	Yes/No
Total slides examined	
Total slides positive	
Total negative slides	

Optional : blinding, errors detected, resolved

IV. Treatment Activities:

Are patient-wise drug boxes being marked and maintained for each outpatient receiving treatment at the DOT Centre?
Are the facilities (clean water, disposable cups, privacy) for DOTS satisfactory?
Is there adequate arrangement available for providing Inj SM (if Cat II patients are receiving treatment at this DOT centre)?

Is there consistency between the number of doses on treatment card and drug box? (check any 2 boxes) Box 1 (name_____) Box 2 (name_____)
Are prompt home visits made to bring irregular patients back on treatment? *(For patients who have missed doses, the relevant section on treatment card can be checked for entries)*
Have any of the drugs in the Patient Wise Boxes (PWBs) crossed the date of expiry Box 1 (name_____) Box 2 (name_____)
Is home address verification done for patients before start of treatment? *(Treatment cards can be examined for entries in the section for Initial home visit)*

V. Human Resources:

Training and sensitization held in the last four quarters:

Kind of staff	**Formally Trained in RNTCP**	**Sensitized in RNTCP**
1		
2		
3		
4		

VI. Referral for treatment and feedback mechanism:

- Is a Referral for Treatment Register maintained?
- Are Treatment Forms used to refer patients diagnosed in the facility to other centers? within and outside the district?
- Are there any constraints in the referral of TB patients to the DOT centers?
- Is any feedback regarding referred patients provided to the referring department by the DOTS centres?

VII. Indoor DOTS: *(for hospitals - includes observations based on visit to wards in TB-Chest/ Medicine Department)*

- Are the NTP supplied drugs used in the wards for indoor patients?
- Are there any other source of anti-TB drugs (which are already available under NTP) for indoor patients?
- Is the in patient registered elsewhere also?
- Is the "Transfer Out" mechanism working satisfactorily registered while on indoor treatment?

VIII. TB/HIV Coordination (*to be based on visit to VCTC and ART centre, if any*)

- Is there a VCTC in the facility or nearby?
- Is the standard cross-referral mechanism between the DOTS center and VCTC established?
- Is there a mechanism to put TB patients treated in the ART centre on DOTS?

IX. Supervision and Monitoring:

- When was the last supervisory visit made?

- Who made this visit?
- What feedback was provided during that visit?
- What follow up action was taken based on the feedback?

ENDLINE SURVEY

KNOWLEDGE, PRACTICE AND COVERAGE

IN

KANCHANPUR, DOTI, DADELDHURA AND BAJHANG.

SUBMITTED TO

CARE NEPAL

CHILD SURVIVAL PROJECT

KRISHNA GALLI, LALITPUR

JULY 2007

SUBMITTED BY

SOLUTIONS CONSULTANT P. LTD.
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ACRONYMS

AHW	:	Auxiliary Health Worker
AIDS	:	Acquired Immuno-deficiency Syndrome
ANC	:	Ante-natal Care
ANM	:	Auxiliary Nurse Midwife
ARI	:	Acute Respiratory Tract Infection
BCG	:	Bacille Calmette-Guerin
BL	:	Baseline
CB-IMCI	:	Community Based Integrated Management of Childhood Illness
CDD	:	Control of Diarrhoeal Diseases
CMA	:	Community Medical Assistant
CPR	:	Contraceptive Prevalence Rate
CSP	:	Child Survival Project
CYP	:	Couple Year of Protection
DHO	:	District Health Office/Officer
DHS	:	Demographic and Health Survey/Department of Health Services
DPT	:	Diphtheria Pertussis Tetanus
EL	:	Endline
EOP	:	Emergency Order Point
EPI	:	Expanded Program on Immunization
FCHV	:	Female Community Health Volunteer
FWDR	:	Far Western Development Region
FY	:	Fiscal Year
HA	:	Health Assistant
HDI	:	Human Development Indicators
HFOMC	:	Health Facility Operation and Management Committee
HIV	:	Human Immuno-deficiency Virus
HMG	:	His Majesty's Government
HP	:	Health Post
HW	:	Health Worker
IDD	:	Iodine Deficiency Disorders
KPC	:	Knowledge Practice and Coverage
MCHW	:	Maternal and Child Health Worker
MUAC	:	Mid-upper Arm Circumference
NGO	:	Non Governmental Organization
ORS	:	Oral Rehydration Solution
PHCC	:	Primary Health Care Centre
PNC	:	Post-natal Care
RHD	:	Regional Health Directorate

SHDK	:	Safe Home Delivery Kit
SHP	:	Sub Health Post
TBA	:	Traditional Birth Attendant
TT	:	Tetanus Toxoid
TTBA	:	Trained Traditional Birth Attendant
UTBA	:	Untrained Traditional Birth Attendant
VDC	:	Village Development Committee
VHW	:	Village Health Worker
WHO	:	World Health Organization

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EXECUTIVE SUMMARY

The endline study for CS XIX is aimed at establishing an endline and compare with the baseline information in the four project districts, Kanchanpur, Doti, Dadeldhura and Bajhang. The main objective of the endline study is to estimate the present level of maternal and child health indicators at household and community levels and to compare the progress against the baseline result carried out by the project in January 2004. The study methodology was developed based on KPC 2000+ module. By using cluster sampling method, total of 1310 mothers of children age 0-23 months; 209 health workers; 79 health facilities and 133 FCHVs were included in this study. Data was collected on the major intervention areas, namely, nutrition and breastfeeding, diarrhea, acute respiratory infection, malaria, maternal and newborn care. The data also includes mother's knowledge of HIV/AIDS.

District-wise results are presented in the main text of the report. Baseline and endline data are compared between Kanchanpur and Other districts (Bajhang, Dadeldhura and Doti) as CSP in these districts is being implemented at the same time with the same objectives and approaches. In Kanchanpur, however, the CSP project was extended.

Child Health, Nutrition and Breast Feeding

- Nearly all the children (100% in Kanchanpur and 99.6% in Other districts) of age 0-23 months were breastfed at some point during their life.
- The percentage of mothers who initiated breast milk within one hour of delivery has increased from 52.7 % to 83.0% in Kanchanpur, and from 56.0% to 59.2% in Other districts.
- Practice of mothers feeding their first milk to their child has increased from 74.7% to 83.9% in Kanchanpur, and from 36.7% to 73.2% in Other districts.
- 100% of the mothers in Kanchanpur and 99.1% of the mothers in Other districts were currently breastfeeding their children of age 0-5 months.
- Children aged between 0-5 months who were exclusively breastfed during the last 24 hours, has increased from 50% to 87.7% in Kanchanpur and 67 to 69.5% in Other districts.
- The practice of giving complementary food within four months has decreased in all the districts. This could be due to the increase knowledge and practice of mothers for exclusive breastfeeding.
- Knowledge of "Sarbottam pitho" (Super Flour) by the respondent mothers has increased in all districts compared to baseline survey. However, only 48.1% mothers of Kanchanpur and 26.4% mothers of Other districts had knowledge about the availability of Sarbottam pitho in local market, which clearly shows that there is a need to continuously educate mothers about the knowledge and availability of Sarbottam pitho in the local market.
- 35.2% of children of Kanchanpur, and 17.3% of children of Other districts had been weighed at birth. Likewise, 51.2% children of Kanchanpur and 16.3% children of Other district had

their growth monitoring card. These figures are higher than the base line survey, with room for increasing the the level of possession of the growth monitoring card in all of the four districts.

- 73.9% of the mothers of Kanchanpur had visited health care provider for ANC during pregnancy. Likewise, ANC coverage has increased from 36.9% to 56.3% in Other districts.
- 51.2% of the mothers in Kanchanpur and 16.3% of the mothers in other districts had growth monitoring card for the children. The baseline figures were 29.3% in Kanchapur and 20.5% in Other districts.
- Among the male children, 22.9% in Kanchanpur and 26.7% in the Other districts were found to be severely stunted (below -3SD), while among the the female children, 20.8% in Kanchanpur and 21.6% in the Other districts were found to be severely stunted (below -3SD). While, 42.2% male and 40.3% female children of Kanchanpur, and 48.1 male and 45.0% female children of Other districts were found to be stunted (below -2SD). During the base line survey 32.7% male and 23.8 female children of Kanchanpur were severely stunted and 59.5% male and 64.4% female children were stunted.
- 6.9% of male and 4.1% of female children of Kanchanpur, and 5.3% of male and 4.3% of female children of Other district were severely wasted (below -3SD). Likewise, 12.2% male and 16.4% female children of Kanchanpur, and 14.6% male and 11.9% female children of Other districts were wasted (below -2SD). During the baseline survey, 8.9% male and 9.3% female children of Kanchanpur were severely wasted and 12.2% male and 16.4% female children were wasted.
- 9.2% male and 8.6% female children of Kanchanpur, and 9.8% male and 6.3% female children of Other districts were severely underweight (Below -3SD). Similarly, 32.6% male and 21.9% female children of Kanchanpur, and 34.9% male and 27.9% female children of Other districts were found underweight (Below -2SD).
- Among the children of age 12-23 months, as indicated by a mid upper arm circumferences (MUAC) of less than 12.5 cm, 32.1% children of Kanchanpur were severely malnourished against 27.3% in baseline survey. Likewise 21.9% children of Other districts were severely malnourished in Other districts against 18.2% in baseline survey.
- Among the respondent mothers, 5.2% in Kanchanpur and 5.7% mothers in Other districts had MUAC less than 21 cm.

Integrated Management of Childhood Illness (IMCI)

- It was found that, 70.6% of the mothers in Kanchanpur and 67.4% in the Other districts had knowledge on at least 2 danger signs of illness requiring treatment for the children. The baseline figure of this indicator was 84% in Kanchanpur and 58.2% in Other districts.

- The practice of "Giving more or same amount of fluid to a child during illness", as mentioned by the respondents was found to have increased from around 64% in baseline study to 68% in Kanchanpur, and from 40.9% to 58.4% in the Other districts.

Diarrheal Diseases

- The prevalence of diarrhea among children, in the two weeks prior to the interview, was found to be 4.9% in Kanchanpur and 17% in the Other districts against the baseline survey of 12.7% in Kanchanpur and 50.7% in the Other districts.
- 32.7% of the mothers of Kanchanpur and 27.3% of the mothers of the Other districts mentioned that they gave more fluids than usual to their children during the diarrheal episode. This indicates that the majority of the mothers are still not aware about the need of feeding fluids during childhood disease.
- 26.4% of the mothers of Kanchanpur and 15.4%of the mothers of the Other districts were found to be feeding solid foods more than usual during childhood diarrhea.
- 72.1% of the mothers of Kanchanpur and 67.6% of the mothers of the Other Districts had correct knowledge about the symptom of Diarrhea. However, 52.7% of the mothers of Kanchanpur and 19.0% of the mothers of the Other districts did not have knowledge about signs of diarrhoeal dehydration.
- 76.4% of the mothers of Kanchanpur and 58.1% of the mothers of the Other districts claimed that they could correctly prepare Oral Rehydration Solution. However, only 58.8% mothers of Kanchanpur and 29.9% mothers of the Other districts were found to have the correct knowledge on ORS preparation.
- Households having their own toilet increased from 36% to 47% in Kanchanpur, and from 23.7% to 29.9% in Other districts, compared to the baseline study.
- Hand washing practices among the mothers - with soap or ash in four stipulated conditions (before food preparation, before feeding the child, after defecation, and after handling the child who had defecated) were found to be 7.6% in Kanchanpur and 10.2% in the Others districts against the baseline survey of 16% in Kanchanpur and 1.9% in the Other districts.

Acute Respiratory Infection (ARI)

- The prevalence of ARI among the children aged below 2 years, in the last 2 weeks prior to the interview decreased from 18.3% to 14.2% in Kanchanpur, and from 39.2% to 21.3% in Other districts compared to the base line survey.
- 46.1% of the mothers of Kanchanpur and 39.2% of the mothers of the other districts mentioned fast or difficult breathing and chest in-drawing (i.e. correct knowledge) as the sign and symptoms of pneumonia. This figure is higher than in the baseline survey.
- A vast majority of Health workers seemed to be managing dehydration with the use of ORS, followed by giving more fluids, advice for breast feeding and referrals to health facilities.

- 93.3% of the health workers of Kanchanpur and more than 95% of the health workers in the Other districts mentioned that pneumonia should be treated with antibiotics.
- 72.7% of the pneumonia cases of Kanchanpur, and more than 80% of the cases of the Other districts were cured, a significant improvement compared to baseline survey.

Malaria

- As per the mothers' reports, in the two weeks preceding the endline survey, 2.7 % and 10.3% of the children aged between 0-23 months suffered from malaria in Kanchanpur and the Other districts respectively, against the baseline data of 9.0% in Kanchanpur and 17.6% in the Other districts.
- Mothers of Kanchanpur had better knowledge about preventing malaria as compared to the mothers of the Other districts.
- In Kanchanpur, 91.5% of the households reported having bed nets while only 10.1% of households in the Others districts had bed nets against baseline figures of 93% in Kanchanpur and 6.8% in Other districts.

Maternal and Newborn Care

- About 74% of the mothers of Kanchanpur and 56.3% of the mothers of the Others districts had visited antenatal clinic at least once, against the baseline figures of 62.3% in Kanchanpur and 36.9% in the Others districts.
- Based on the card plus maternal recall, 88.4% of the mothers in Kanchanpur and 66.5% of the mothers in the Others districts had received at least two doses of TT during the last pregnancy, as against the baseline figures of 65.3% in Kanchanpur and 45.8% in the Others districts.
- Children aged between 0-23 months and whose births were attended by skilled health personnel has increased from 24% during the baseline to 34.8% in Kanchanpur, and from 10% to 15.1% in the Other districts.
- About 67% of the mothers of Kanchanpur and 59% of the mothers of the Other districts had knowledge of at least two danger sign and symptoms during pregnancy against the baseline figures of 43% in Kanchanpur and 38.6% in the Other districts.
- Practice of taking any iron/folic acid by the pregnant mothers increased from 56% to 84.8% in Kanchanpur and from 33.4% to 59.5% in the Other districts, when compared with the baseline figures.
- Majority of the deliveries took place with the assistance of the family members. The delivery being assisted by skilled health professional has slightly increased as compared to baseline survey.

- Among those deliveries conducted in home, a safe delivery kit was used by 32.4% of the mothers of Kanchanpur and 11.0% of the mothers of the Other districts against the baseline figures of 31.6% in Kanchanpur and 10.5% in the Other districts.
- 80.3% of the mothers of Kanchanpur and 47.7% of the mothers of the Other districts had received Vitamin A within 45 days after delivery against the baseline figures of 63.7% in Kanchanpur and 33.9% in other districts.

Knowledge of Mothers about HIV/AIDS

- 66.7% of the mothers of Kanchanpur and 34.7% of the mothers of the Other districts had heard of HIV/AIDS as against 56.3% mothers of Kanchanpur and 21.6% mothers of the Other districts in baseline survey.
- The percentage of the mothers who cite at least two known ways of reducing the risk of HIV infection, has increased from 38% to 52.4% in Kanchanpur and from 10% to 18.2% in the Other districts, compared to baseline survey.

Others

- Compared to the baseline survey, the stock balance update was better for many essential commodities in all districts. Availability, functioning and use of essential instrument were better in all districts.
- This endline survey clearly shows that KPC of the mothers on the maternal and child health has improved as compared to the baseline survey. However, there are many areas to improve the existing KPC level of the mothers on child health. There is still a need to strengthen the quality of health care at the health facility; fulfill the vacant posts; and improve the professional competency of the health workers at various levels and issues.
- The earlier period of civil unrest and insurgency in the project districts, the hardship caused to the ordinary people and the project staff are not discussed in this report due to the quantitative and KPC focused nature of the survey. Problems faced by the project staff and difficulties to implement various program as per the schedule might have to be included in other qualitative reports. Although the civil unrest and insurgency did not specifically target the health services and the health workers, but the project staffs did have to encounter problems for monitoring and supervising the programs due to the regular strikes and unfavourable security environment. Similarly, the endline survey was done almost nine months earlier than the stipulated end of the program to maintain seasonal consistency with the baseline survey. After April 2006, the political situation in Nepal has changed dramatically, and the project staffs of CARE/CSP program are working at the field level with close cooperation with various stakeholders. In this situation one could easily expect more achievement within forthcoming nine months and the progress indicator would be better by the end of the project.

RAPID CATCH PRIORITY INDICATORS

Indicators	Kanchanpur	Bajhang	Dadeldhura	Doti
1. Percentage of children age 0-23 months who are underweight (-2SD from the median weight-for-age, according to the WHO/NCHS reference population).	**27.5%** (74/269)	**42.1%** (125/297)	**23.4%** (66/282)	**28.2%** (85/301)
2. Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**63.4%** (71/112)	**77.0%** (134/174)	**72.9%** (135/185)	**74.4%** (128/172)
3. Percentage of children age 0-23 months whose births were attended by skilled health personnel *(Note: Includes doctor, nurse, ANM, MCHW)*	**34.8%** (115/330)	**8.5%** (28/328)	**26.9%** (89/330)	**9.6%** (31/322)
4. Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child (by card)	**79.4%** (262/330)	**50.3%** (165/328)	**60.1%** (199/330)	**46.3%** (149/322)
5. Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours.	**87.7%** (79/90)	**91.3%** (43/58)	**63.9%** (55/86)	**72.6%** (53/79)
6. Percentage of children age 6-9 months who received breastmilk and complementary foods during the last 24 hours.	**82.2%** (60/73)	**86.0%** (68/79)	**82.5%** (52/63)	**74.1%** (43/58)
7. Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday.	**53.3%** (40/75)	**54.1%** (13/24)	**74.5%** (35/47)	**54.2%** (19/35)
8. Percentage of children age 12-23 months who received a measles vaccine.	**79.3%** (115/145)	**81.2%** (126/155)	**79.6%** (121/152)	**73.0%** (122/167)
9. Percentage of children age 0-23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night.	**2.4%** (8/330)	**0%** (0/328)	**0.3%** (1/330)	**0%** (0/322)
10. Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection.	**52.4%** (173/330)	**14.0%** (46/328)	**18.5%** (61/330)	**22.0%** (71/322)
11. Percentage of mothers with children age 0-23 months who report that they wash their hands with	**7.5%** (25/330)	**19.5%** (64/328))	**4.2%** (14/330)	**6.8%** (22/322)

soap/ash before food preparation, before feeding children, after defecation, and a after attending to a child who has defecated (washed hands in all four conditions).				
12. Percentage of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment.	**86.3%** (285/330)	**88.4%** (290/328)	**84.5%** (279/330)	**84.7%** (273/322)
13. Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	**33.3%** (22/66)	**19.6%** (20/102)	**16.1%** (24/149)	**16.4%** (21/128)

Consolidated Information of four Districts on Rapid Catch Indicators

Indicator	Kanchanpur		Other districts (Doti, Dadeldhura, Bajhang)	
	Baseline Aug 03	**Endline** Jan 07	**Baseline** Jan 04	**Endline** Jan 07
1. Percentage of children age 0-23 months who are underweight (-2SD from the median weight-for-age, according to the WHO/NCHS reference population).	**38%**	**28%**	**38%**	**32%**
2. Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**68%**	**63.4%**	**75%**	**74.7%**
3. Percentage of children age 0-23 months whose births were attended by skilled health personnel *(Note: Includes doctor, nurse, ANM, MCHW)*	**24%**	**34.8%**	**10%**	**15.1%**
4. Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child (by card or reported verbally by mother)	**65%**	**79.4%**	**46%**	**52.3%**
5. Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours.	**50%**	**87.7%**	**67%**	**69.5%**
6. Percentage of children age 6-9 months who received breastmilk and complementary foods during the last 24 hours.	**83%**	**82.2%**	**71%**	**81.5%**

Indicator	Kanchanpur		Other districts (Doti, Dadeldhura, Bajhang)	
	Baseline Aug 03	**Endline** Jan 07	**Baseline** Jan 04	**Endline** Jan 07
7. Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday.	**74%**	**53.3%**	**45%**	**63.2%**
8. Percentage of children age 12-23 months who received a measles vaccine.	**87%**	**79.3%**	**60%**	**77.8%**
9. Percentage of children age 0-23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night.	**2%**	**2.4%**	**0%**	**0.1%**
10. Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection.	**38%**	**52.4%**	**10%**	**18.2%**
11. Percentage of mothers with children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated (washed hands in all four conditions).	**16%**	**7.5%**	**2%**	**10.2%**
12. Percentage of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment.	**84%**	**86.3**	**58%**	**85.9**
13. Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	NA	**33.3%**	NA	**17.2%**

Note: All consolidated information are unweighted, at CI 95% and error margin of 10%.

CHAPTER ONE

INTRODUCTION

In this chapter:

CHAPTER ONE
INTRODUCTION

1.1 Background

Nepal's economic development has been severely constrained by geographic, topological and socio-cultural factors. Mortality and morbidity rates especially among and children are alarmingly high. Acute preventable childhood disease, complication of child birth, nutritional disorders and endemic disease such as malaria, tuberculosis, STDs and vector borne disease continue to prevail at a high rate. Determinants of such conditions are associated with pervasive poverty, low literacy rates, poor mass education, rough terrain and difficult communications, low levels of hygiene and sanitation facilities, and limited availability of safe drinking water. These problems are further exacerbated by underutilization of resources; shortage of adequately trained personnel; underdeveloped infrastructure; poor public sector management; and weak intra and inter-sectoral coordination.

As a result of planned development, health sector has improved substantially. However, from the point of view of health indicators, satisfactory progress has not been made yet as compared with other developing countries. Especially remote and rural communities and the people there who are devoid of health services have not been benefited from the essential health services.

Healthy human resource, low mortality rates of infant and children, development of safe motherhood improves the various aspects of human development indicators (HDI) and hence contribute to reduction of poverty. The health indicators are comparatively weaker in the Mid-western and Far-western development regions (Tenth Plan 2002).

CARE began working in Nepal in 1978. The early focus was on improving infrastructure and implementing agriculture extension activities with investment in natural resource management. A strategic programmatic shift occurred in the early 1990s with the introduction of more diversified portfolio. CARE Nepal, Ministry of Health and population and Social Welfare Council are jointly implementing Child Survival Project-XIX, a four year program to support health system in Bajhang, Dadeldhura, Doti and Kanchanpur Districts of Far-western Development Region. The project aims at contributing to improve the health of the children (under age five) and pregnant and lactating mothers in the four districts. The project has identified key interventions – Community Based Integrated Management of Childhood Illness (CB-IMCI), Health Facility Operation and Management Committee (HFOMC) strengthening of Far-western Region of Nepal.

1.2 CARE/CSP Efforts to Combat of Child Health Issues

Child Survival Project, CS XIX (Oct 2003 – Sept 2007) is one of the CARE Health project, being implemented in four districts (Bajhang, Doti, Dadeldhura and Kanchanpur) of Far Western Development Region after the successful completion of Child Survival Project XV (Oct 1999 – Sept 2003) in Kanchanpur district. The project goal is to reduce child and maternal mortality and morbidity through strengthened community, local NGO and MOH capacities in Far Western Region of Nepal. The project targets to benefit 146,514 under-five children and 47,484 pregnant and lactating women among total population of 932,054 from the four project districts. The project focuses on key interventions at the health facility and community level.

Working Approach

The working framework of CSP project is CB-IMCI, one of the most prioritized areas of Government of Nepal, Ministry of Health and Population; to increase the access to health services, the quality of care and behavioral change towards healthy practices. The key strategic approaches are:

- To demonstrate successful and sustainable implementation of CB-IMCI (especially for management of pneumonia and diarrheal disease) through improved quality of care strategies.
- To strengthen linkages between local government and civil society participants in health care management at the Health Post (HP), Sub Health Post (SHP) and district Health level.
- Develop a sustainable program implementation model in Kanchanpur through strengthening community support and linkages with line agencies of Government of Nepal.
- Strengthening of project staff and other stakeholders capacity (especially marginalized communities and women) to operate in existing environment of insurgency in Nepal;
- Evidence-based advocacy to increase support for CB-IMCI by regional and national MOH Child Health Division.

1.3 Objectives of CARE/Child Survival Project (CSP)

The objectives of CARE/Child survival project are:

- *Access to Services Supplies*: Families have increased sustainable access to health education, quality health services, and essential medicine at the community level.
- *Quality of Care*: Community level MOH personnel, Female Community Health Volunteers (FCHV), and other service providers practice appropriate care management of pneumonia and diarrhea, and other key IMCI intervention areas.
- *Behavioral Change*: Caregivers of children below five years of agepractice healthy behaviors and seek medical care from trained sources when needed.

- *Building Local Capacities*: Local and community-based institutions and local NGOs are strengthened to support child survivals activities on a sustainable basis.

1.4 A Brief Overview of Project Area

Nepal has made progress in a number of health indicators in recent years including some with direct bearing on maternal and child health. Yet women and children are still at a risk and largely neglected population in the country. Nepal has the world's highest maternal mortality rate. Similarly, infant mortality is 64/1000 live births and the risk of neonatal deaths (39/1000 live births) is one and half times higher than the risk of post-neonatal deaths (26/1000 live births). (Annual Report - DoHS, 2003).

Under 5 mortality rate in Far-western Development Region of Nepal have averaged 149.20 over the past 10 years compared to 91.2 currently at national level. Remoteness due to the lack of roadneworks and infrastructures, low level of female literacy are the major obstacles to effective delivery of health care services as well as the utilization of available health services (DHS, 2001).

Bajhang district is bordered with Bajura and Humla at East, Baitadi and Darchula at the West, Humla and Tibet at the North and Doti and Accham at the South. Total area of the district is 3,422 square KM and fertile land is 268.83 square-km. Total population of the district is 167,026. The district is divided in to 47 VDC with no municipality at all. The total numbers of health facilities are 52 with one district hospital. The literacy rate is 38%, of which only 16% are female. There weren't any non governmental organizations working for the children and maternal health (CARE/CSP Baseline Survey 2004).

Dadeldhura, one of the project districts is occupying an area of 1,538 sq. km. It is bordered with Doti in the east, India in West, Baitadi in north and Kailali and Kanchanpur in south. The altitude ranges from 432m to 2,639 meter from sea level. Around 76% of the district is covered with deep green forest. According to 2001 census, total population of the district is 126,162 (female- 65,197 and male- 60,965) with population density of 83-person/sq km. The literacy rate of district is 53.07% with female literacy rate of 35.45%. Administratively, the district is divided into one municipality and twenty Village Development Committees (CARE/CSP Baseline Survey 2004).

Doti is bordered with Achham and Surkhet in East, Dadeldhura and Baitadi in West, Bajhang in north and Kailali in South. The total area of the district is 2025 sq. Km. For the administrative purpose; the district is divided in 50 VDCs and one municipality. Total population of the district according to Census data 2001 is 207,066 (male- 103,521, female- 103,545) with population density 102 persons per sq km.

Kanchanpur is one of the most densely populated districts in the Far-western Development Region of Nepal. According to the 2001 Census, the district has a total population of 377,899. The migration from the hills and mountain to Kanchanpur is a common phenomena resulting in a high population growth (annual growth rate of 3.9%) for the period of 1991-2001. The literacy rate of the district is 59.6%, with a female literacy rate of 46.9%. Agriculture remains the major occupation in the district. Although there is an access to a motor road for most of the flatlands of the district, some highlands of the district are still deprived of such access, electricity and telecommunication facilities. Kanchanpur remains one the districts with the lowest health service facility - population ratio in the country. There are 21 primary health care units in the district including 2 Primary Health Care Centers (PHCC) to serve the entire population. This ratio is much lower compared to one of the similar tarai districts in the Central region; in Saptari, for example, 116 such units serve a population less than half the size of that in Kanchanpur.

1.5 Objectives of the Endline Study

The endline study for CS XIX is aimed at establishing an endline data and compare with baseline data in the four project districts. Thus the main objective of the endline study is to estimate the present level of maternal and child indicators at household and community levels and to compare the progress against the baseline result carried out by the project in January 2004. The specific objectives of this study were to assess:

At household level:

- Knowledge, coverage and practices of women regarding breastfeeding and nutrition
- Knowledge and practice of women regarding maternal and newborn case
- Knowledge, coverage and practices of women regarding management of childhood illness
- Knowledge and practice of mothers about micronutrients (Vitamin A, Iron and Iodine)
- Knowledge and practice of mothers about malaria and HIV/AIDS
- Growth monitoring of children

At health facility level:

- Assess the health staff situation (sanctioned and filled) at the PHCC, HP and SHP
- Assess the existing child health service delivery pattern of PHCC, HP and SHP
- Assess the stock situation of essential commodities in PHCC, HP and SHP

At health worker (and Volunteer) level

- Assess the technical competency of health workers and volunteers in providing child and maternal health services in the project districts
- Assess the training types and outcome of the health workers at PHCC, HP, SHP and FCHVs.

CHAPTER TWO

METHODOLOGY

In this chapter:

CHAPTER-II
METHODOLOGY

The study methodology was developed based on KPC 2000+ module.

The evaluation team reviewed the project documents, including the project proposal, baseline survey report and detailed implementation plan. Key indicators to be measured were identified from the log-frame of the DIP, Rapid CATCH, KPC 2000+ modules and the baseline report. An evaluation plan was designed. The KPC guidelines were reviewed and discussed for finalizing the methodological approach to the survey.

2.1 Study Area

The endline survey was conducted in the following four districts of Far-western development region.

- Bajhang
- Doti
- Dadeldhura
- Kanchanpur

2.2 Study Design

District based cross sectional design was selected for this study to explore the overall effectiveness of the program. A 30-cluster sampling design was adopted to select the mothers of children 0-23 months. Key indicators to be measured were identified from the log-frame of the DIP, Rapid CATCH, KPC 2000+ modules and the baseline report. An evaluation plan was designed. The KPC guidelines were reviewed and discussed for finalizing the methodological approach to the survey.

2.3 Study Population

- Household mothers having children below two years of age
- District level governmental health facilities
- Child health services providers

2.4 Development of Questionnaire

An initial draft questionnaire was prepared in English and Nepali languages by CARE/CSP and shared among the team. The questionnaire was finalized after incorporating feedback from various stakeholders in Silgadi Doti, CARE/CSP Regional Office. The questionnaire was pre-tested in each district. Based on the results of field-testing, the translation was reviewed and corrected. The final questionnaire is part of the Annex to this report.

The questionnaire covered the following modules:

- General characteristics of respondent mothers
- Nutrition and breastfeeding
- Growth monitoring and immunization
- Maternal and new born care
- Integrated management of childhood illness
- Pneumonia case management
- Diarrhea
- Malaria
- HIV/AIDS

In addition, the survey also included anthropometric measurement and mid upper arm circumference (MUAC) for children and mothers. Accuracy of the measuring instrument was periodically checked.

2.5 Sampling Design, Size and Process

In a simple random sampling design, the sample size is derived using the formula $n = z^2 (p\ q)/d$, With p=0.5, (q=l-p), a precision of 10% (d=0.1), assuming 95% confidence interval (z=1.96) the required sample size (n) is 96.

In 30-cluster design with the same values of p, d and z, minimum sample size is 210, where design effect is considered 2, that is 7 per cluster. To maintain an approximate ± 10% level of precision for most variables, since design effect is variable-specific, the minimum sample size for the KPC survey was set at 300 (30 clusters of 10 respondents) instead of 210. Taking this into consideration, as well as to provide for 10% non-response, a sample size of 330 was selected. Therefore, to obtain 330 samples, 11 households from each cluster were covered for the interview.

Ward of VDCs and municipality were used as cluster in the present endline study. The total population of the district and population of each ward were used according to 2001 Census conducted by Central Bureau of Statistics. All the wards with in the districts were eligible for selection and clusters were not limited to project areas only. The sampling interval was derived from the formula given in the guideline, that is, total population divided by 30. The first cluster, the ward with equal or less than population of sampling interval, was randomly chosen using a computer program. All the process was done together with Consultants, CARE/CSP team and enumerators during the training sessions following the process given in the guidelines.

A public place within the cluster was chosen as the centre of the cluster. Direction of households from the centre to be surveyed was randomly selected by spinning a bottle. Following the direction of bottle, 11 subsequent households and mothers with children under 24 months were selected for interviews. The household was defined as a unit or people living together and sharing the same kitchen. In case where there were two families in the household with the children aged less than 24 months, the responding mother was selected by flipping a coin. If the mother had more than one child of less than 24 months, the youngest on was chosen as the reference or index child, (A list of the selected clusters is presented in Annex). During the regional level meeting in Doti, it was mentioned by the CARE/CSP team that at least proposed sample size would be available in each cluster. During the field visit, however, required sample size was not available in few clusters. For example, in Jijidamandu -4 of Doti district, there were only 3 mothers; in Mashdev -3 of Bajhang there were only 9 mothers. Therefore, the total number of surveyed mother is slightly less in the two districts. This number, however, is not less than the minimum sample size in each cluster.

In case of health facility and health workers, twenty five percent of the health facility of each district was selected purposively and one child health service provider was interviewed from each of the selected health facilities. Thirty FCHVs were selected ensuring one from each cluster in each district as well. Health facilities were selected (PHC/HP/SHP) proportionately to represent the whole district.

Sample distribution

District	KPC Questionnaire	HW Questionnaire	HF Questionnaire	FCHV Questionnaire
Bajhang	328	48	18	30
Dadeldhura	330	47	18	31
Doti	322	66	28	40
Kanchanpur	330	48	15	32
Total	**1310**	**209**	**79**	**133**

2.6 Regional and District Level Orientation and Training

A total of three days regional level orientation and training was conducted in Doti starting from the 31st of January 2007 for the consistency of the endline survey. CARE/CSP team from the Kathmandu Office and respective districts, and consultants from Kathmandu had a detail discussion on working modality. The training consisted of field procedures for the survey, detailed review of the questionnaires, sampling design, practicing weighing and measuring children and role play interviews among the participants. Furthermore, discussion was focused on roles and responsibility of consultants; CARE/CSP team at the Central, Regional and District levels and supervisors; questionnaire guidelines; interview tips; supervision; editing and maintaining the data quality in the field.

Enumerators' training was conducted in the individual districts. For this purpose, 32 local people with health background (CMA, ANM) and/or with previous exposure in similar studies were selected as enumerators for the endline survey. Interviewers were locally recruited; of which half of them were female. CSP senior staff, DHO staff and partner NGOs supervised the quality of data at the field level.

Three days training schedule for the emumerators and supervisors in each district included objective of the evaluation, sampling process of 30 cluster sampling design, selection of actual clusters, objective of each questionnaire mentioned for the interview, interview technique and data collection process and other practical issues during the fieldwork.

2.7 Data Collection Procedure

After the data collectors were trained each pair (one male and one female in a team) was sent to collect data to cover all the 30 clusters. Daily schedule of the survey for all the groups was finalized before the survey started. This allowed supervisors to monitor the interviews in various clusters. Based on this schedule, a separate schedule was prepared for the supervisors.

In each district, 4 pairs of enumerators visited different clusters under the close supervision of Survey Coordinator of Solutions Consultants, DHO staff and CARE/CSP senior staff. A total number of 4-6 supervisors have supervised the team that consisted of 8-9 local enumerators (two in each group) from each study district resulting in a total of 4-5 teams of field researchers. The supervisor checked at least two questionnaires from each cluster on the spot and corrected immediately any missing or incorrectly recorded information, discussed with the interviewers about their problems and constraints in data collection and tried to fix them.

The information was collected from the 11 households (KPC questionnaire) and 1 questionnaire of Female Community Health Volunteer in each cluster. Each household survey was conducted

to gather information about all members of the household. For this purpose a mother with a child of age below 2 years was identified and administered KPC questionnaire. Mid-upper Arm Circumference of the mother and Height, weight and Mid-upper Arm Circumference of her child (the target one) was measured. It took approximately 1-1.5 hours to administer the KPC questionnaire and half an hour to health worker questionnaire.

After completing data collection, each team returned to the district headquarters for final debriefing meeting. At that time, they reviewed profiles of the respondents and addressed some issues that arose during data collection. Data collection process started and ended within the month of February 2007 in each district.

2.8 Validity and Consistency of Interviews

All measurements were made for the field workers whose training included both inter and intra-observer standardization. Each enumerator was trained in preparation for the work and had been regularly supervised including random controls of their recording procedures. For the indirect validity testing, supervisors had focused on:

- Interviewers' rapport building process and probing during the interview
- Cross verification of the data. For example, present age of youngest child vs. date of birth.
- Re-interview of about 10% mothers to check the consistency of reporting.

2.9 Data Coding, Processing and Management

Data processing involved:

(a) Coding to allow classification and tabulation

(b) Editing to minimize the errors and to ensure clean data.

Similarly, the data management system was developed that incorporated a system of editing and documentation at all level of the study. The data entry was done using EPI Data, Version 3.1. The confidentiality was maintained. Multiple back checks were carried out on computerized records in Solutions Consultants, Kathmandu.

2.10 Data Analysis

To facilitate the process of data processing, a standardized data entry / management software package had been developed with a number of quality control devices, including validity checks, duplicate detection and verification procedures. The cleaned data set were analyzed using SPSS

14. The anthropometric analysis was also done in SPSS using the macros developed by WHO. (Available in WHO website - http://www.who.int/childgrowth/software/macros_special_spss/en/index.html).

2.11 Results and Discussion

Results are organized in different sub sections. Each section provides information on different study indicators. In the beginning of this section, summary of rapid CATCH indicators are given in separate tables. The details of the results are given in subsequent sub sections. For the convenience of reader, results and discussions are integrated in the same section. In the executive summary section and some other revevant sections, the results are catagorized into Kanchanpur and other districts (Bajhang, Dadeldhura, Doti), and are compared with the baseline data and project goals where the indicators are revevant. Thus, other district, in this report refers the combined data of Bajhang, Dadeldhura and Doti. The CSP project started in these districts is being implemented at the same time with the same objectives and approaches. In Kanchanpur, the CSP project was extended.

2.12 Limitation of the Survey

Maoist insurgency and counter-insurgency operations in the project districts, hardship caused to the ordinary people and the project staff are not discussed in this report due to the quantative and KPC focused nature of the survey. Problems faced by the project staff and difficulties to implement various program as per the schedule might be included in various qualitative reports. Although Maoist did specifically target the health services and the health workers, but the project staffs did have problems on the aspects of monitoring and supervising the programs due to regular strike and unfavourable security environment. Similarly, the endline survey was done almost nine months earlier to maintain seasonal consistency of the baseline and endline survey. After April 2006, political situation in Nepal has changed dramatically, and the project staffs of CARE/CSP program are working at the field level with close cooperation with various stakeholders. In this situation one could easily expect more achievement within forthcoming nine months and the progress indicator would be better by the end of the project.

CHAPTER THREE

PRESENTATIONS OF THE FINDINGS: HOUSEHOLD SURVEY

In this chapter:

CHAPTER –III
HOUSEHOLD SURVEY

3.1 Demographic Characteristics, Birth Spacing and Child Care

This subsection presents selected background characteristics of the respondents included in both the baseline (BL) and the endlne (EL) surveys. A total of 1,320 mothers having children less than 24 months of age were included in the baseline survey and 1,310 in the endline survey were included in the study. Other districts, in this report, refer to Bajhang, Dadeldhura and Doti districts.

3.1.1 Age, Educational Status and Ethnicity

Age, educational status and ethnicity are important demographic and socio-cultural variable and are primary basis of demographic classification. Among the respondent mothers, the majority of them were of the age group 20-30 years (77.6% in Kanchanpur and 68.2% in the Other districts). In case of the baseline (BL) survey, the corresponding figures were 60% and 70% respectively. In the endline survey, 7.9% of the mothers were between the age of 30-40 years in Kanchanpur, whereas 30.7% of the responding mothers were of the same age group in the baseline survey. The age composition of the respondents between baseline and endline surveys for the Other districts was similar (see Table 1.).

Data indicates that there is high proportion of household mothers who have no education. 38.5 % of mothers were found to be illiterate in Kanchanpur, followed by 70% in other districts. In the case of the baseline survey, the corresponding figure was 48% and 72.5% respectively. The secondary and higher level education attainment was very low both in the baseline and endline surveys. The literacy rate seems to have slightly improved in the districts over the last 3 years.

The endline survey categorized caste and ethnic groups into three major headings: ethnic group, Dalits and others. The baseline survey, however, categorized it into different way. Therefore, the caste/ethnic data are not clearly comparable between endline and baseline survey. However, the large proportion was represented by 'high caste hills' (e.g. Brahmin and Chhetri) and 'hill dalits' (i.e. Kamai, Damai, Sarki and other occupational groups) in the baseline and endline surveys (see Table 1.).

Table 1. Age, Educational and Ethnicity status of the interviewed mothers

District	Kanchanpur		Doti		Dadeldhura		Bajhang		Other Districts	
	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL
n	330	330	330	322	330	330	330	328	990	980
	%	%	%	%	%	%	%	%	%	%
Age										
< than 20 years	9.3	13.3	4.9	5.9	9.1	6.4	6.0	7.3	7.0	6.5
20 - 30 years	60.0	77.6	70.9	63.0	69.0	73.0	70.0	68.3	70.0	68.2
30 - 40 years	30.7	7.9	20.9	27.0	19.0	18.2	20.0	22.6	20.0	22.6
> than 40 years	-	1.2	3.3	4.0	3.0	2.4	4.0	1.8	3.0	2.8
Literacy										
Illiterate	48.0	38.5	81.2	76.1	63.0	63.0	73.0	71.0	72.5	70.0
Not been to school but read and write	14.0	11.2	10.6	15.2	15.0	9.4	20.0	18.0	15.2	14.2
Primary (Class 1-5)	12.0	13.9	3.3	5.6	10.0	10.3	2.1	3.0	5.2	6.3
Middle (Class 5-7)	11.0	18.5	1.2	1.9	6.1	10.6	2.4	2.1	3.2	4.9
Secondary (Class 9-10)	7.7	9.4	2.4	0.6	3.6	4.2	1.8	1.5	2.6	2.1
Above Class 10 (SLC and Above)	7.3	8.5	1.2	0.6	2.1	2.4	0.6	4.3	1.3	2.4
Ethnicity										
High Caste Hills	47	51.8	78.2	66.8	72.1	72.1	70.9	72.9	73.7	70.6
Hill Dalits	29.7	8.2	21.5	26.7	26.1	22.7	26.7	27.1	24.7	25.5
Ethnic Groups	9.3	39.1	-	5.9	1.2	4.5	2.4	-	1.2	3.5
High Caste Terai	-	0.6	-	0.3	-	0.3	-	-	-	0.2
Terai Dalits	-	0.3	-	0.3	-	0.3	-	-	-	0.2
Others	14.0	-	0.3	-	0.6	-	-	-	0.3	-

3.1.2 Number of Children below 5 Years and 24 Months

The number of children in the household affects the maternal and child health. In the endline survey, 55.2% of the respondents in Kanchanpur, 37.3 % in Doti, 37.9% in Dadeldhura and 39.0% in Bajhang had one child whereas during in the baseline survey; 55% in Kanchanpur, 37.9% in Doti, 40.9 % in Dadeldhura and 33.6 % in Bajhang had one child (see Table 2.). The figures in the Table 2. shows that the findings of endline survey indicate that there has been increase in households with 3 or more children (15.5% in endline) in the Other districts compared to baseline survey (10.0%)

Table 2. No. of children below 5 years of age in the household

District	Kanchanpur		Doti		Dadeldhura		Bajhang		Other Districts	
	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL
n	330	330	330	322	330	330	330	328	990	980
	%	%	%	%	%	%	%	%	%	%
No. of Children in household										
1 Child	55.0	55.2	37.9	37.3	40.9	37.9	33.6	39.0	40.0	38.1

2 Children	45.0[1]	32.4	47.0	42.5	44.6	50.3	43.9	46.0	50.0	46.3
3 Children		7.0	8.5	12.1	11.8	9.1	13.3	9.1	5.0	10.1
4 and more		5.5	6.6	8.1	2.7	2.7	9.1	5.8	5.0	5.5

[1] During the baseline survey in Kanchanpur, the number of children in the household was categorized into two main groups: one child and two or more children.

The youngest children in the household under the age of 24 months was chosen as the targeted children for the purpose of the endline survey. During the baseline survey in Kanchanpur 47.7% of these targeted children were male, while 54.5% of the sampled children under the age of 24 months were male in endline study. The composition of male and female children under the age of 24 months in the sample was similar in both baseline and endline surveys in the Other districts (see Table 3.). Representation of male child of age less than six months sampled in Kanchanpur was 30.6% in endline survey, while it was 23.1% in baseline survey. The representation of male child of age less than six months in the sample in the Other districts was similar for both endline and baseline surveys.

Table 3. Age and Sex of the targeted children below 24 months

District	Kanchanpur				Doti				Dadeldhura				Bajhang				Other Districts			
	Baseline		Endline		Baseline		Endline		Baseline		Endline		Baseline		Endline		Baseline		Endline	
sex	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
n	143	157	180	150	174	156	161	161	176	154	186	144	169	161	171	157	519	471	518	462
%	47.7	52.3	54.5	45.5	52.7	47.3	50.0	50.0	53.3	46.7	56.4	43.6	51.2	48.8	52.1	47.9	52.4	41.6	52.9	41.1
Age	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
< 6 month	23.1	22.3	30.6	23.3	20.1	26.9	19.3	29.8	21	27.9	26.9	25	21.8	21.7	17	18.5	21	25.5	21.2	24.5
6 - 11 months	42	43.3	25	33.3	27	26.2	27.3	19.9	25	21.4	26.9	29.2	30.7	31	31.6	38.9	27.6	26.3	28.6	29.2
12 - 23 months	35	34.4	44.4	43.3	52.8	46.7	53.4	50.3	53.9	50.6	46.2	45.8	47.3	47.2	51.5	42.7	51.4	48.2	50.2	46.3

3.1.3 Birth Spacing

Birth intervals or spacing is associated with maternal and child health status. Short birth intervals are associated with an increased risk of death for the mothers and the children. This is particularly true for the babies born less than 24 months after a previous birth. It was found that 36.6% of the births in Kanchanpur, 25.6% and 27.0% births of Doti & Dadeldhura, and 23.0% births of Bajhang occurred within 24 months. This finding indicates that there has not been much changes from the baseline assessment.

Malaria Control Program

Program overview, Achievement and Lessons Learned

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Executive summary

Malaria Control Program is one of the programs of CARE Nepal, implemented in Kanchanpur district through Child Survival Project and funded by Nepal Family Health Program (NFHP) with an aim to support/assist District Public Health Office Kanchanpur to increase the availability, accessibility and quality of the services provided to control malaria at the household and community levels. The ultimate objective of the program was to prevent mortality and reduce morbidity due to malaria by providing support/assistance to DPHO Kanchanpur to increase the availability, accessibility and quality of the services provided to control malaria at the household and community levels.

The major activities of the program has been to establish malaria laboratory facilities and its strengthening for early diagnosis and proper management of cases at health facility and community level, training of institution as well as peripheral and grass-root-level health workers in malaria case identification and its proper management and to improve the quality of service provided; promotion of health education, awareness and advocacy programs both at the community and health facility level to prevent vector transmission of disease; and strengthen monitoring mechanism of district health system on malaria control.

Altogether there are 12 labs with malaria microscopy facility in Kanchanpur, of which 9 were established through the project by mobilizing Health Facility Operation and Management Committee (HFOMC) and 3 initially operating labs at primary health care centers (PHC) through national health system. Further, there has been a momentum of establishment of malaria microscopy labs in other VDC of the district. Through this program, CARE Nepal has provided support for the recruitment of one local laboratory technician for seven malaria microscopy centers on cost sharing basis with agreement between the HFOMC, DPHO Kanchanpur and CARE Nepal. From the existing 12 malaria microscopy centers in the district communities are benefiting from a wide range of services, in addition to the malaria microscopy services provided from these centers. The service delivery statistics showed that a total of 18,294 beneficiaries have benefited from the malaria microscopy centers in the project period.

To deliver better quality and sustainable malaria control activities through institutional and individual capacity building: institutional development trainings, orientation and supervisory visits have been continuously provided from CARE Nepal and DPHO Kanchanpur. Individual capacity building has been promoted through training and orientation programs for lab assistants, health facility staffs, schoolteachers and FCHV. Seven-days malarial microscopy training was conducted for five newly recruited laboratory technicians (three from the initially proposed malaria microscopy centers and two additional newly established malaria microscopy centers) in coordination with NFHP Infectious Disease Coordinator. Monitoring, supervision and trainings to health facilities' staffs, lab assistants and community level health workers have continuously been provided to ensure the provision of quality services provided by the health facilities. Lab accreditation has been one activity that is planned in the district to ensuring the quality of malarial microscopy services provided from the private sector for which orientation has been provided to 14 private labs in the district. Two-days orientation program was conducted for FCHVs on Malaria Prevention and Control in the district was conducted in all the 19 VDC and Mahendranagar Municipality through 32 events. A total of 748 out of 833 FCHVs were oriented through the program where other grass-root and peripheral level health workers, viz. AHW (2), ANM (7), VHW (20), MCHW

(11) and 4 Lab Assistants (4) were oriented totaling to 793 health workers and volunteers receiving orientation. Altogether 218 treatment FCHV for malaria control activities in the district have been selected for taking blood slides from clinical malaria cases, providing Chloroquine, maintaining records, reporting and referral of complicated case. Awareness raising for behavioral change has been by far the most crucial and effective intervention of the program which has resulted in a significant change in the behaviour of the communities, particularly the school children.

Community-based communication strategies, particularly through FCHV to mothers' groups and health education to school children has been the major strategy adopted for behavioural communication. With the ultimate goal of enhancement of the participation of schoolteachers and school children in contributing towards malaria control activity school health education program was conducted in the district through the two activities, viz., orientation to school-teachers and health facility staffs and health education sessions with school children. A two-days orientation program was conducted through 4 events, for 50 schoolteachers from 49 schools both from secondary and lower secondary level schools and 15 health-facility staffs (health facility in-charge) with the objective to support the district's malaria control program by conducting health education programs and monitoring the malaria control program at their respective schools and communities. A 5-sessioned school health education program each for grades VII, VIII and IX was conducted in 49 schools with the joint efforts from the oriented schoolteachers and health-facility staffs as per the plans developed by them at the orientation program. Altogether 8,819 school students both from the secondary and lower secondary levels benefited from the program.

Free distribution of insecticide treated nets (LLIN) and social marketing approach has been promoted in the district as a method of vector control and transmission risk-reduction. 17,000 LLIN were distributed by the D(P)HO/Kanchanpur in the year 2005 in the high-risk areas for malaria while in this year 2006, 17,498 LLIN has been distributed by PSI/Nepal has distributed nets through social marketing approach to make the ITN available to communities that were not reached by the free distribution scheme at a subsidized. An estimated 103,494 people are thought to be having benefiting from the free-distributed nets. The LLIN have reached the population of low socio-economic status, particularly, the low-income and the poorest segment, illiterate and socially deprived groups like the Dalits, the Janajatis and the marginalized. IRS as a major vector control activity in malaria control has been a regular intervention activity of D(P)HO Kanchanpur in malaria prone areas of the district every year. 86,629 people of the district have been covered this year by the regular IRS program.

The changes brought about by the program so far has not yet been reflected through the indicators. However, significant changes have been observed in the health behaviour of the communities that suggests for an unexpectedly better outcome. Effective coordination with D(P)HO and partners realization of the program as their own program by D(P)HO and communities has been a major reason for success.

Community participation, particularly the one who are most at the risk in planning interventions appropriate to address their needs and social mobilization for awareness raising; strategic shift to make prevention and control activities gain a civil concern rather than the responsibility of certain organizations; and harnessing local initiatives, local resources, community mobilization and a sense of ownership among the people who are most affected by the problem has been the have been the approach looked forward for future malaria control program.

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INTRODUCTION 1

Background

Malaria is a parasitic infection of the blood transmitted by night biting female *Anopheline* mosquitoes. It is one of the most serious diseases in the developing countries. Once the first symptoms appear, malaria can kill very rapidly – and often does. Malaria, particularly, *Plasmodium falciparum* is potentially a fatal disease, if not recognized and treated in time. Clinical conditions of patients suffering from *Pl. falciparum* may suddenly deteriorate within 24 hours of the presentation of febrile illness. Malaria can affect all segments of the population, but children, pregnant women, people living in emergency situations and people living with HIV/AIDS are particularly vulnerable to this devastating disease. In pregnant women and children malaria has a profound effect due to lower immunity in these groups making them vulnerable to developing severe complications. Malaria in pregnancy induces abortion, stillbirth, premature births, underweight babies and complications of delivery. Cerebral and other complications particularly severe anemia, hypoglycemia and pulmonary edema are more common in pregnant women than non-pregnant women. The children who survive a severe bout of malaria may develop chronic anemia and neurological impairment.

Malaria has been a major public health problem in Nepal since a long time. It is transmitted in all areas of Nepal except the eleven Himalayan districts and the three districts that make up the Kathmandu valley. The majority of malaria transmission in Nepal occurs in **only 12 districts** and these have been labeled "priority" districts. *Pl. vivax* is the predominant malarial parasite (approximately ten times more common than *Pl. falciparum*) in Nepal for past several years. However, about 10 per cent of *Pl. falciparum* cases are seen at the times of outbreak in the country.

Western Terai of Nepal has been identified as highest malarious region. Kanchanpur is a malaria endemic Terai district of Far West Nepal that constituted the highest proportion of malaria cases, i.e. 52 per cent, in 2003 (HMG/N, 2003). The entire population of Kanchanpur 377899 (CBS, 2001) is regarded as risk population for malaria. The District has been classified under "Stratum I and II" having low receptivity and seasonal transmission from March through October and constitutes the highest proportion of malaria cases. The sub-tropical climate here is favorable for mosquitoes to breed and transmit malaria through out the year. Furthermore, the district is surrounded by Dadeldhura and Kailali, in the north and east, respectively and India (Uttar Pradesh and Uttaranchal) in the south and west, respectively. Out of the 19 VDCs and 1 Municipality in the district, 11 VDCs and 1 Municipality (it constitute more than 60 percent of its part) are adjoining with Indian Territory. This suggests for the high population mobility due to free open border that accounts for the inestimable inter-country transmission of malaria in this region. The national data shows that in districts bordering with India, 85 per cent of the total cases were collected out of which 89 per cent were positive for malaria (DoHS, 2004).

The first attempt to control malaria in Nepal was initiated in 1954 through the Insect Borne Disease Control Program, supported by United States Agency for International Development (USAID). In 1958, the malaria eradication program was launched, the first national public health program in the country, with an objective of eradicating malaria from the country within a limited time period. Due to various constraints, this objective could not be achieved

and consequently the program reverted to malaria control in 1978. Prevailing ecological, epidemiological and socio-economic factors suggested changes in the malaria control strategy, and as a result the current strategy was revised in accordance with the Global Malaria Control Strategy 1992 of World Health Organization (WHO). Nepal has also been signatory to the United Nation's Declaration of Millennium Development Goals (MDG) accepting the commitment to fulfill the eight goals set, combating malaria being MDG 6th out of the eight goals.

The Government of Nepal's National Health Policy for Malaria Control in Nepal is to provide anti-malarial services at the doorsteps of the community, free of cost, through existing network of Primary Health Care (PHC) Centers, Health Posts (HP) and Sub Health Posts (SHP) by adopting PHC approach. It has been providing malaria control services to the people in Kanchanpur district in accordance with the revised Global Malaria Control Strategy (GMCS) 1992 of WHO and transmission risk-reduction through increased access to early detection and prompt treatment of malaria for the people living in high risk areas has been a principal to reach the goal of 'Roll Back Malaria' (RBM). Indoor residual spraying (IRS); information, education and communication (IEC); and disease surveillance are the other major strategies within the RBM approach. The goal of National Malaria Control Program (NMCP) is to sustain the prevention of mortality and reduce the morbidity of malaria by 50 per cent in Nepal by the year 2010; prevention and control of epidemics with particular reference to *Pl. falciparum*; and containment of *Pl. falciparum* and drug resistant malaria.

Malaria Control Program, Kanchanpur

Malaria Control Program is one of the programs of CARE Nepal in Kanchanpur district, funded by Nepal Family Health Program (NFHP) and implemented by Child Survival Project to support/assist District Public Health Office Kanchanpur to increase the availability, accessibility and quality of the services provided to control malaria at the household and community levels. NFHP is a USAID project to support the Government of Nepal in its long-term goal of reducing fertility and under-five mortality. CARE Nepal, as a collaborating partner of NFHP, with its objective to support /assist D(P)HO to increase the availability, accessibility and quality of the basic package of Family Planning/Maternal and Child Health (FP/MCH) services at household and community level. NFHP is also supporting D(P)HOs for vector borne disease control program in selected Core Program Districts (CPD) viz., Dhanusa, Mahottari and Kanchanpur.

Objectives

The ultimate aim of the program is to prevent mortality and reduce morbidity due to malaria with the aim of contributing for better health of children (under age five) and pregnant and lactating women as a direct contribution on improving household livelihood security and health status of rural people in Kanchanpur district through different health interventions.

General objective

The major objective of the program is to support/assist D(P)HO/Kanchanpur to increase the availability, accessibility and quality of the services provided to control malaria at the household and community levels.

Specific objectives

1. To support the Health Facility Operation Management Committees (HFOMC) for sustainable running of malaria microscopy centers on cost-sharing basis;

2. To strengthen the capacity of grass-root level health workers in malaria case identification and case management;
3. To conduct health education, awareness and advocacy activities to improve the community access to malaria microscopy services, early diagnosis and proper treatment, and promote personal protection measures;
4. To conduct operational research to assess and monitor communities' KAP on malaria prevention and control, and impact of malaria control program;
5. To monitor the quality of private malaria microscopy clinics on regular basis and to provide necessary recommendations and feedbacks based on the findings; and
6. To support D(P)HO/Kanchanpur in coordinating, implementing, monitoring and supervising the malaria control activities in the district.

Expected outcome

The expected outcomes of the program were:

- Increased malaria case identification and better management of malaria cases through FCHV and health facilities in Kanchanpur district;
- Reduced incidence of malaria related illness among the population of Kanchanpur district;
- Increased awareness among community people on ways of malaria prevention and control in Kanchanpur district leading to EDPT;
- Strengthened capacity of D(P)HO/Kanchanpur to have effective management of vector borne diseases, especially malaria in the district; and
- Effective management system of malaria and other vector borne diseases control program in D(P)HO/Kanchanpur.

Box 1
Strategies: Malaria Control Program

- Establishment of laboratory facilities and its strengthening for early diagnosis and proper management of cases at health facility and community level;
- Training of institution as well as peripheral/grass-root-level health workers in malaria case identification and its proper management and to improve the quality of service provided;
- Passive Case Detection 'Volunteers' (PCD'V') strengthening in malaria prone areas;
- EDPT of uncomplicated cases and strengthening prompt referral mechanism for complicated and severe cases;
- Promotion of health education, awareness and advocacy programs both at the community and health facility level thereby contributing to RBM campaign in its attempt to prevent vector transmission of disease;
- Promotion of operational field research on malaria;
- Monitoring and supervision of malaria control activities; and
- Strengthen monitoring mechanism of district health system on malaria control.

PROGRAM OVERVIEW 2

General preview

Following the baseline survey on malaria that was carried to assess the situation on different aspects of malaria in the district and incorporating recommendations from the survey, malaria control activities were initiated in the district in coordination with D(P)HO/Kanchanpur to reduce child and maternal mortality and morbidity, particularly due to malaria in the district. With the basic theme, those at risk must have access to the most effective preventive measures, and those suffering from malaria must have access to prompt and effective treatment, the malaria control activities were planned and carried out in the district under following sectoral interventions:

1. Establishment of new malaria microscopy centers

In many areas of the district, the public health system was unable to reach a significant proportion of the population at risk. Therefore, a new mechanism was put in place to provide access to health services for these people. In order to work in partnership with the local communities and strengthen the capacity of the local bodies through the approach of community involvement; allow rapid expansion of malarial services; provide employment opportunities to local people; and enhance access to quality prevention and treatment services at reasonable cost closer to the homes of the most affected establishment of malaria microscopy centers was planned for further three new sites viz. Krishnapur, Pipladi, and Suda VDC, in addition to already operating four sites Jimuwa, Daijai, Jhalari and Tribhuvanbasti VDC of Kanchanpur, in close coordination with D(P)HO/Kanchanpur. Malaria microscopy centers has been established in those health facilities, which do not have provision of lab facilities, i.e. health posts (HP) and sub-health posts (SHP), through the National health Policy (1991). CSP/NFHP CARE has supported the D(P)HO and HFOMC through technical, logistics and financial assistance for the establishment.

Box 2
Health Facility Operation Management Committee managed malaria microscopy centers

An approach of managing health through local health management committee is the outcome of the implementation of decentralization policy and local self-governance act of government of Nepal. Health Facility Operation and Management Committees (HFOMC) have been established as a result in the entire VDC of Kanchanpur district.

With technical support from CSP/NFHP CARE and D(P)HO Kanchanpur the HFOMC have recruited local lab assistant and established malaria microscopy centers at seven sites (additional two on their own initiation). For this, D(P)HO Kanchanpur have provided microscopes. It has been providing slides, prickling needles, chemicals and reagents for the microscopy of malaria and tuberculosis. HFOMC and CSP/NFHP CARE have provided salaries of the lab assistants on cost sharing basis. **t** is planned that it would be to be provided fully by the HFOMC from January 2007. The training for the lab assistants on malaria microscopy are managed by the D(P)HO.

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Currently, there has been a momentum of establishment of malaria microscopy labs in other VDC of the district. Labs have been established in additional VDC, viz. Rampur bilashpur and Dekhatbhuli VDC. Altogether there are 12 labs, 9 established through HFOMC and 3 initially operating labs at primary health care centers (PHC) through national health system.

Summary of CARE (NFHP) Specific malaria control activities for the year 2006

S.N.	Activity	Target group	Unit	Indicator	Data needed		Target	Achievement
1	Establishment of new malaria microscopy centers	Three sites at Suda, Pipaladi and Krishnapur VDC	Site	% Of HFOMC conducting malaria microscopy centers	N	No. of HFOMC conducting MMC	3	5 (166.67%)
					D	Target MMC		
2	Lab facility support	Three newly established labs	Site	% Of MMC provided glassware and furniture support	N	No. of MMC provided glassware and furniture	3	3 (100%)
					D	Target MMC		
3	Orientation of FCHV on malaria prevention and control	All FCHV (833)	Person	% Of FCHV covered in the orientation	N	No. of FCHV oriented	833	748 (89.79%)
					D	Target no. of FCHV		
4	Malaria microscopy training	Newly recruited Lab Assistants	Person	% Of newly recruited laboratory technicians taking malarial microscopy training	N	No of LA trained	3	5 (166.67%)
					D	Target no. of LA to be trained		
5	Orientation of schoolteachers on malaria prevention and control	School-teachers and health facility staffs	Person	% Of orientation conducted for school teachers	N	No. of schoolteachers oriented	60	49 (81.67%)
					D	Target no. of schoolteachers to be oriented		
6	School health education program on malaria prevention and control	Secondary-Level school students from 60 school of Kanchanpur district	School	% Of schools conducting SHEP on malaria prevention and control	N	No. of schools conducting SHEP	60	49 (81.67%)
					D	Target no. of schools		
7	LQAS survey	Mothers of 0-23 months children	Event	Successful conduction of LQAS Survey			1	
8	Follow-up study on LLIN distributed by Global Fund	Household distributed LLIN in FY 2006	Event	Successful conduction of follow-up study				
9	Private lab accreditation scheme	Interested private labs in Kanchanpur	Number	% of private labs accredited	N	No. of Pvt. Labs accredited	14	Process on-going
					D	Target no. of Pvt. Labs		
10	Monitoring and documentation	All health facilities					On-going	

Features of HFOMC managed malaria microscopy centers

Accessibility Access of the communities to malaria microscopy services has been ensured by the establishment of the lab services in the areas most affected by malaria. The services have been available to the community people at their doorstep.

Affordability Utilization of services is usually deterred from the payment of high prices for the lab services. The malaria microscopy has been providing low-cost services to the community. The poor could even benefit from the exemption schemes that are available at some centers.

Quality Provision of quality services through adequately trained lab assistants with quality microscopes is one of the features of malaria microscopy centers. Quality service is further ensured through the periodic monitoring and supervision from the district.

Community participation Community participation in the operation and management of the lab service through representatives from all possible groups of the community in health facility operation and management committee (HFOMC) is the most important aspect that is addressed by the labs. Committee members equitably participate in the identification of local issues in malaria control, need assessment, prioritization and identifying best possible solutions, communities' resources and resource mobilization.

Equity The services are established in those are where there is actual need. Further, the needs of the poor and the most vulnerable are addressed in while providing lab services.

Financial and logistics support

The project has provided support for the recruitment of one local laboratory technician for seven malaria microscopy centers (i.e. Jimuwa, Daijai, Jhalari, Tribhuvanbasti, Krishnapur, Pipladi, and Suda VDC) on cost sharing basis with agreement between the HFOMC, D(P)HO/Kanchanpur and CARE Nepal. The project covered the full cost of the lab technician in all seven malaria microscopy centers until June 2006. From July to December 2006, the project contributed 50 per cent of the cost, and the HFOMC covered 50 per cent of the cost. From January 2007, it is expected that the HFOMC would take up all the responsibility of covering the entire cost of lab operation.

In order to support the establishment of malaria microscopy centers and in the sustainability in their operation logistics support, viz. furniture, glassware and centrifugal machines were provided in three new sites, viz. Suda, Pipaladi and Krishnapur VDC, as per the need. Support has also been provided to the newly established site at Rampur bilashpur VDC through centrifugal machine. As per the demand and need, fifty per cent contribution has been provided to the Suda HFOMC in the purchase of refrigerator with a view to support not only the lab services but the regular immunization and safe-motherhood program, too.

Box 3
Summary of lessons learned from established malaria microscopy centers

- Community has been empowered to identify their own problems and is capable of identifying the ways and resources to solve the problems at their own efforts. In this regards the communities have now been realizing malaria as a major public health problem. Lessons learned from other VDCs' health intervention and replicating the successful intervention has been the wide spread practice in the district. A momentum has, thus, been established in the district to establishing the labs at other VDC^{s}. So, there has been an increasing demand for the establishment of HFOMC-managed labs.
- Sustainability of lab services has been by far the most important issue raised after its establishm ent. Assistance from external donors have short-term implication over the operation of labs while, health facilities own services charge are the most reliable source of income for its sustainable lab operation. So, approach to promote labs to provide wider range of quality services and encourage community to utilize the lab services provided would add a benefit to lab operation.
- The active members of HFOMC and their active participation to seek ways for sustaining lab service is a key to its sustainability. Selection of active members in HFOMC and strengthening the HFOMC and the HFOMC members for mobilization for identifying ways of sustaining labs and coordinating with district line agencies and development partners for support would be an important approach.
- Communities' perception about the quality of services provided through governmental lab facilities have been the most important factor in the low utilization of the services provided through these labs. Changing communities' perception would contribute to increased utilization of the services. External agencies, particularly CARE Nepal in Kanchanpur has a lasting impression upon the communities since it has been working with the communities since long as a development partner and communities are convinced by what it spells. A propagandist approach to make such organization advocate about the quality of lab services provided through governmental lab facilities as a better one, for mass utilization, would be an appropriate approach.

Box 4
Increased services and increased service utilization, key to sustainable lab operation

Malaria microscopy centers have not only provided the employment opportunities for the lab assistants in the district, but are also providing a wide range of low-cost and quality lab services, in addition to malaria microscopy services to the people of the communities. Health facilities have also been equally benefiting from the support provided to various other services there. Poor people who cannot afford high costs of laboratory services in the district can also benefit through free lab services provided through the exemption schemes for the poor. Talking about the quality of services provided through the labs, the slides sent for the crosscheck have also been proved to be cent percent accurate.

On one hand there is a problem for providing salary to lab assistants, while on the other hand the labs have not been able to meet the increasing demands of the communities that is necessary and can be provided through labs. There is a big question raised that if the HFOMC would be able to pay the salaries of lab assistants after the agreement between CSP/NFHP CARE, the D(P)HO/Kanchanpur and the HFOMC would be over in December 2006. If this situation would come then not only the lab assistants would devoid of employment opportunity but also the health institutions as well as the community people would also devoid the affordable and quality lab services. This would also affect the other health services provided through the health facilities.

It has been therefore necessary to critically think about the continuity and sustainability of the services provided through labs. The support provided through the external agencies can only sustain for a short time. So, lab services charge is the only reliable source of income for the sustainable lab operation. Therefore, increasing the number of services provided through the lab would be the only approach to ensure lab sustainability.

Further there is a wide spread perception among the community people that the private clinics/labs provide better quality services than the government ones. In one hand, the communities devoid of quality services that are provided from government labs by highly qualified and trained lab assistants and quality equipment while on the other hand they are compelled to pay high costs. So, it has been necessary that the community be informed and advocated to utilize the government labs for increased utilization. These messages if conveyed by external agencies would add a benefit since community largely has a faith on them and would accept what they would be easily convinced.

Apart from these donors' assistance, district development committee (DDC) and village development committee's (VDC) contribution and contribution from OPD and CDP income would add value to it.

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2. Capacity building of community level health workers

To deliver better quality and sustainable malaria control activities through individual capacity building and institutional development trainings, orientation and supervisory visits have been continuously provided from CARE Nepal and D(P)HO. Institutional capacity building has been promoted through CARE Nepal specific activities like workshops and trainings on HFOMC management and partners' defined quality (PDQ). Planned technical support visits (TSV) have also been organized in order to develop institutional capacity on health service management and quality assurance.

Individual capacity building has been promoted through training and orientation programs for lab assistants, health facility staffs, schoolteachers and FCHV.

a. Malaria microscopy training

Seven-days malarial microscopy training was conducted for five newly recruited laboratory technicians (three from the initially proposed malaria microscopy centers in Krishnapur, Pipladi, and Suda VDC and two additional newly established malaria microscopy centers at Dekhatbhuli and Rampur bilashpur VDC of Kanchanpur district) in coordination with NFHP ID Coordinator. The training is effective to impart knowledge on both the theory and practical

portion to the trainees. Since the academic training courses of lab assistant in the institutions are not sufficient to give the proper knowledge to the lab assistants on malaria the training is very effective for the lab assistants who intend to provide malaria microscopy services.

Box 5
Summary of lessons learned from malaria microscopy training

- It is well understood that the academic training course of lab assistant in the institutions are not sufficient to give the proper knowledge to the lab assistants on malaria. Such training is found to have positive impact on the trainees to increase their competency to identify parasites and provide quality microscopy services.
- An estimated 60 per cent of the service has been provided by the private sector in Nepal where the services are provided through the lab assistants that do not have any reinforcing training apart from the academic training course. Similar trainings if provided to the private lab service providers would ensure the quality services provided through the private labs to a significant portion of the population.
- Since, there has been an increasing demand for the establishment of community-managed (HFOMC) labs, there would be an increased demand for malaria microscopy trainings
- Training, especially for malaria microscopy, would be effective if they are organized to have practical implication on the participants. Longer duration trainings with sufficient time for the trainees to examine the slides and training given in participatory environment set in real lab situation would be effective.
- Refresher training in malaria microscopy to update their knowledge and skills, particularly to cope with the changing nature of malarial parasite, vector and latest change in the malaria microscopy techniques would be beneficial
- Follow up of the training and supervision from the district from time to time to provide guidance to the lab assistants at their workplace and cross-checking the slides examined would ensure improved competency and quality of services provide through them
- Training often become an important incentive for such health workers who are continually based on the health facilities

b. Orientation of FCHV on malaria microscopy

Two-days orientation program was conducted for FCHV on Malaria Prevention and Control in the district was conducted in all the 19 VDC and Mahendranagar Municipality through 32 events. 748 out of 833 FCHV were oriented through the program where other grass-root and peripheral level health workers, viz. 2 AHW (2), 7 ANM (7), VHW (20), MCHW (11) and 4 Lab Assistants (4) were oriented totaling to 793 health workers receiving orientation. Altogether 218 treatment FCHV for malaria control activities in the district have been selected (one treatment FCHV per ward in every VDC: 18 x 9, except 3 treatment FCHV in Rauteli bichawa VDC and 2 to 3 treatment FCHV per ward in Mahendranagar municipality).

The major objective of the orientation was to update FCHV with national malaria control strategy and to strengthen their capacity in malaria case identification, case management and to mobilize them in health education, awareness and advocacy activities in order to improve the community access to malaria microscopy services, EDPT, and promote personal protection measures against malaria. The FCHV were oriented to clearly identify the clinical malaria cases in the community with the basic theme that any fever can be malaria and provide appropriate *treatment only after taking blood slides*. The treatment FCHV selected have been oriented to prepare blood slides before the suspected case has not taken any chemotherapy. They have also been oriented to properly maintain record for the clinical malarial cases they have identified and treated or referred and to realize their role in the advocacy for the utilization of these lab services for the quality malarial microscopy services in the community.

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Box 6
Summary of lessons learned from FCHV orientation on malaria prevention and control

- Continuous and sustained training is most effective. Initial training continued by refresher training, follow-up and support are effective to enhance greater confidence and competency to work field situation. So, training needs to be an on-going process. Refresher training needs to be offered periodically in order to sustain the impact of the interventions with the changing environment
- For health volunteers like FCHV trainings are often seen as incentives and a means of motivation to promote their continued participation. Further, training like this, which are directed at mobilizing them for better health outcomes in the community if able to show the necessity of their role in this regard are successful in developing feeling more positive about their contribution
- Follow-up and supervisory visits from the district and higher concerned authority made from time to time to provide motivation and guidance to FCHV at their workplace and monitor the quality of the slides prepared and records maintained and the practice of timely reporting are effective

3. Quality assurance of health services provided for malaria control program

Quality assurance of the malaria control services provided by health facilities (both government and private) and community health workers has been one of the most important aspect of the malaria control program. Monitoring, supervision and trainings to health facilities' staffs, lab assistants and community level health workers have continuously been provided to ensure the provision of quality services provided by the health facilities. Necessary supervision and on the spot guidance has been provided as necessary. Monitoring of the activities of the health workers has been another aspect covered by the malaria control program to ensure quality of malarial services. Half yearly review meetings have been carried out in the district to ensure the qualitative recording and timely reporting.

Lab accreditation has been one activity that is planned in the district to ensuring the quality of malarial microscopy services provided from the private sector. Orientation has

Box 7
HFOMC-managed malaria microscopy – a boon for child survival

Kale Chaudhary, two and a half years old, has been one of the several beneficiaries of the malarial microscopy center in Krishnapur VDC of Kanchanpur district. Manamati Chaudhary, mother of the child, used to think that lab service provided by the private sectors is far better than the governmental labs. So, she did not hesitate to pay even a larger sum of money for the service provided by the private lab in the community when her child was hit by fever.

She was reluctant to take her child to the governmental health facility when the private lab's diagnosis found *Plasmodium falciparum* in the blood of the child and was advised that if she would delay any further her child would die out of malaria and also, that she would get the treatment against malaria for free there. But the lab diagnosis there in the HFOMC managed lab at Krishnapur health facility, Kanchanpur found no Plasmodium falciparum and even the RDT could not prove the presence of the parasite in the blood of the child. The child soon got well when treated for clinical malaria by Chloroquine.

Manamati now realizes that her lab service in the Krsihnapur health facility was better than the private lab and was cheaper. The free treatment provided there for malaria has been a boon for her child survival.

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been provided to 14 private labs in the district and consent has been taken from them in this regards. It is planned that the assessment of the quality of the services would be carried out and on the spot training; guidance and support would be provided to them as necessary in this scheme. Certification of the labs in malaria microscopy in the district has been one of the important aspects of the program.

4. Promoting behavior change

Awareness raising for behavioural change has been by far the most crucial and effective intervention of the program which has resulted in a significant change in the behaviour of the communities, particularly the school children. Community-based communication strategies, particularly through FCHV to mothers' groups and health education to school children has been the major strategy adopted for behavioural communication. Since women, particularly pregnant and children under five years of age are the most vulnerable to malaria infection, the behavioural change has been targeted to these groups to improve health seeking behaviour of caregivers so that they can recognize signs of severe illness and seek appropriate care quickly. Behavioural change regarding the adoption of personal protection measures, particularly, on use of insecticide nets and environmental management has been targeted through school children.

School health education program

CSP/NFHP CARE justified the role of school children to act as an important link between the community and the health facility and a medium to spread message on malaria prevention and control. With the ultimate goal of enhancement of the participation of schoolteachers and school children in contributing towards malaria control activity school health education program was conducted in the district through the two activities, viz., orientation to school-teachers and health facility staffs and health education sessions with school children.

A two-days orientation program was conducted through 4 events, for 50 schoolteachers from 49 schools both from secondary and lower secondary level schools and 15 health-facility staffs (health facility in-charge) with the objective to support the district's malaria control program by conducting health education programs and monitoring the malaria control program at their respective schools and communities. A 5-sessioned school health education

Box 8
Summary of lessons learned from school health education program

- Community mobilization through the involvement of schoolteachers and students on awareness raising activities has ensured the intensification of the flow of information to large audience through less effort within short time frame.
- The program has been successful to attract the attention of the students and the teachers that malaria is a major public health problem that has led to an increased interest among them to combat malaria at their own efforts. For this they have been demanding similar programs in the future. Thus, community empowerment through advocacy and awareness raising activities would be the most crucial step towards gaining the problem a public concern and consequently, to take responsibility on their own.
- The urgency to completing all the planned activities within less time due to time constraints and seasonal association of the disease for its transmission has been one of the major challenges for malaria control program in the district.
- Overlapping of various activities both in CARE and D(P)HO as well as other partner organizations in the district has created difficulty in the implementation of activities due to divided manpower and, proper monitoring and supervision cannot be carried out as well.
- Mothers are the primary care takers of families, particularly of small children under five years of age. Behavioural change interventions aimed directly at this group would be a beneficial approach. Similarly, private sector, which is the major provider of first-contact malaria treatment in most communities, has not been included in the program. Activities aimed at linking the private sector with the behavioural change strategy should be initiated to ensure comprehensiveness in the program.

program each for grades VII, VIII and IX was conducted in 49 schools with the joint efforts from the oriented schoolteachers and health-facility staffs as per the plans developed by them at the orientation program. Altogether 8,819 school students both from the secondary and lower secondary levels benefited from the program. Monitoring, supervision, evaluation and follow-up of the program was carried out jointly by the health facility staffs, CSP/NFHP CARE and D(P)HO Kanchanpur.

Summary of malaria control activities conducted by D(P)HO/Kanchanpur and other organizations in the year 2006

General malaria-related services delivered

Services delivered in the district for malaria control include numbers of nets, numbers of households (HH)/units sprayed during IRS campaigns and number of population served by the locally established malaria microscopy labs. These services and services-related commodities mostly reflect core malaria control activities of national malaria control program.

1. Insecticide-treated nets

Insecticide-treated nets are one of the key interventions promoted by the national health system. Insecticide-treated nets, if used properly, are one of the best ways to prevent mosquitoes from biting people and infecting them with malaria. They are simple, safe and cost-effective: It has been shown that high levels of insecticide-treated nets coverage can reduce deaths in children by as much as 20 % from all causes, not just from malaria.

a. Free distribution

Free distribution of insecticide treated nets (LLIN) has been promoted in the district as a method of vector control and transmission risk-reduction. 17,000 LLIN were distributed by the D(P)HO/Kanchanpur in the year 2005 in the high-risk areas for malaria while in this year 2006, 17,498 LLIN has been distributed by PSI/Nepal, , an international organization working in Nepal to deliver health commodities through social marketing in the district with support from GFATM.

Box 9
Poor are likely to be deceived

Mugi Lala Chaudhary (*name changed*), Krishnapur-1, Kanchanpur, from a family of Janajatis ethnic origin, is illiterate. He lives with a four-member-family. 'Life has not always been easy for the poor', he says with eyes soaked with tears, 'and we are those that are deceived further.'

How happy he was when he was informed that his name was in the list of the person to get the LLIN that was to be distributed by the D(P)HO Kanchanpur. He took a breath of relief and was happy that his wife and his daughters would not have to face mosquito nuisance and they could take a cozy sleep even it was only in the night, after a laborious day in the farm. He had heard that the net was different than other nets in the market; more interesting was that mosquitoes would not come even around the house where it was used. How enthusiastic he was seeing the net.

Though it was not affordable for him to pay even NRs. 50 for the net, he was stunned when for the first time he was notified that the price for the net was increased to NRs. 100. But the hope for his family members' pleasure enlightened him to search for the money further; he did not hesitate to pay the amount. He borrowed the money from his relative and hurried to purchase the net. But his hope, enthusiasm and wishes shattered into pieces when he found that somebody else has purchased the net in his name. "Poor are likely to be deceived".

Though LLIN was supposed to be distributed free of cost, an uncertain price was imposed for it by the committee formed for its distribution in the district of which D(P)HO Kanchanpur is one of them. The price was not fixed but was to be decided by the respective VDC in which they were to be distributed. This money was supposed to be used for other malaria control activities in the district, particularly, if the treatment and re-treatment of the nets were to be carried out. However, the collected money has not been used for any activities yet in the district. Provision was also made for exemption for the poor who could not afford to pay the cost allocated; they would have to pay the amount they could afford. But, most of them do not know about it. It could have been better if these households are identified and informed earlier such practices could be avoided.

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b. Distribution through public-private partnership

In order to make the insecticide-treated nets available to communities that were not reached by the free distribution scheme, through non-governmental channels such as social marketing, LLIN were distributed in the district at a subsidized price through public-private partnership approach, so that those who deterred from purchasing ITNs by high prices might benefit. PSI/Nepal was involved in the distribution. About 150 private medical stores were first identified and were oriented about the importance and use of LLIN in malaria prevention in order to build awareness and influence attitudes and behaviours to promote demand creation for the LLIN. These stores were then provided with about 20 LLIN each to be distributed in low-subsidized price.

Estimates of LLIN coverage

Coverage of ITN is best assessed through household (HH) surveys which asks questions on possession and use of nets, as well as insecticide treatment status, among the target populations of children under five years of age (U5) and pregnant women. A follow-up study carried out on the effective use of LLIN gives a glimpse of household possession and use of nets, particularly, distributed through free-distribution in the district.

About 3 persons in a household with both the mother and the children along with the father are benefiting from the LLIN distributed with minimum of one person to maximum of six persons in a household while an indirect protection has also been provided to others in the household with an average of 7.2 members and the community as a whole by reducing the overall population of disease-carrying mosquitoes due to its excito repellant property, which drives away mosquito even away from the house. An estimated 103,494 people are thought to be having benefiting from the free-distributed nets. The LLIN have reached the population of low socio-economic status, particularly, the low-income and the poorest segment, illiterate and socially deprived groups like the Dalits, the Janajatis and the marginalized.

Box 10
Social barrier in use of LLIN

"Whom should I give the LLIN to?" Ram Singh Saud, an old man of 56 years of Tribhuvanbasti VDC, Kanchanpur, exclaimed when he was asked why had he not provided the LLIN, that he was provided, to one of his pregnant daughters-in-law, "All the three daughters-in law are equal to me and all are pregnant." He is not the only person in the district who is faced with such a problem. In many a household there is only one LLIN, but there are more than one pregnant woman or they have many small children less than five years of age in the same house. Sometimes, the issues like this have been a cause of quarrel in some households. So, in such cases the head of the households are compelled to preserve the LLIN in a safe place rather than to bring them in use.

The practice of living in a joint family is common in many households of Kanchanpur district where there might be more than one pregnant woman or small children of age less than five years at a time. Though the LLIN has been distributed to reach these groups of people in households, it is a difficult situation to decide to them by whom the LLIN be used.

So, the distribution programs, if able to address such social issues while planning for the distribution, the universal availability and effective utilization of the LLIN would be significant. As far as possible, if the number of the LLIN to be distributed are planned on the basis of the intended target, i.e. pregnant women and children (< 5 years) in a household rather than the taking a household as one unit for distribution, the LLIN would reach all the targets and there effective use can be ensured.

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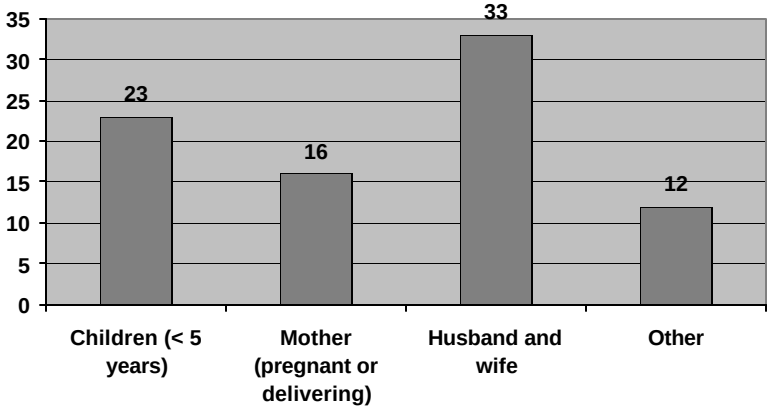
The LLIN was available in 91.03 per cent of households that were distributed LLIN and among these households that had LLIN, 91.03 per cent were in use. Some households are compelled to preserve the LLIN due to social factors. About 73.48 per cent of the households were easily able to pay for the LLIN while remaining 26.52 per cent of the respondents had to burrow it from some other sources to pay for it.

Use of LLIN (*n=78; multiple response*)



Source: CSP/NFHP CARE 2006

Among the 78 households that had LLIN, in most of them (33 households) husband and wife, along with children (if any), used to sleep under it followed by children (<5 years) in 23 households, mother/-to-be in 16 households and in the remaining households either grand parents, the elder siblings or the male members alone used to sleep under the LLIN.

2. Indoor residual spraying

Indoor residual spraying (IRS) as a major vector control activity in malaria control has been a regular intervention activity of national health system in malaria endemic-prone areas of the country. D(P)HO Kanchanpur has been carrying out IRS in malaria prone areas of the district every year. 86,629 people of the district have been covered this year by the regular IRS program.

Box 11
Summary of lessons learned from the distribution of insecticide-treated nets

- Effective distribution of insecticide-treated nets as a practical efficient tool in the management of malaria on a large scale to reach the targeted population has been ensured through such program. However, disputes are likely to arise during its distribution due to inadequate numbers of insecticide-treated nets available for distribution than the actual number of target groups. Equally, active involvement of community health volunteers, particularly, FCHV has been the most appropriate step not only in the dispute management but also to ensure the nets reach the most in need. So, mobilization of FCHV in such future programs is highly recommended.
- The nets are usually inadequate to reach the entire target group in a specified time and costs, even subsidized through social marketing schemes, are high for the community to afford. Ordinary nets are available at almost all the households. The intervention activities related to the treatment and re-treatment of the nets would, therefore, assure that the households not distributed the insecticide-treated nets also benefit from the treated nets.
- As far as possible the number of the insecticide-treated nets to be distributed should be planned on the basis of the intended target, i.e. pregnant women and children (< 5 years) in a household rather than the taking a household as one unit for distribution. To ensure this, integration of the distribution with antenatal check-ups can ensured that all the pregnant women and children <5 years receive and use the insecticide-treated nets at their first clinic visit
- Social issues are likely to affect the use of insecticide-treated nets and distribution programs, particularly, free-distribution should address this issues appropriately while planning for the distribution
- Exemption schemes have been available for the poor in the distribution but they have not been properly informed about it. Hence, they are likely to be deprived from such schemes and also very often deceive. As far as possible the insecticide-treated nets should be distributed free of cost, but if some charge is to be imposed upon it then the ability of the poorest families should be considered. If exemption scheme are available for them then the households that would be covered under such schemes should be identified and notified earlier so that none of them would have to deceive from getting it.
- The households that were provided the insecticide-treated nets when not oriented properly about it have impact on its effective use. Orienting properly on insecticide-treated nets promotes positive attitude towards its use. The distribution program should, therefore, properly orient all the households provided the insecticide-treated nets on it for its universal and effective use. Further mobilization of the health workers and the health volunteers, particularly, FCHV would be the most effective approach.

3. Lab facility services

From the existing 12 malaria microscopy centers in the district communities are benefiting from a wide range of services, in addition to the malaria microscopy services provided from these centers. 18,294 beneficiaries have benefited from the malaria microscopy centers at six sites, (except Suda).

From the eight-months data (Poush 2062 – Shrawan 2063) compiled from six sites, it has been estimated that about 138.5 persons are benefiting from a malaria microscopy center per in a month where 24.21 per cent of the beneficiaries are of malarial cases only. The average number of lab services provided is 11 ranging from minimum of 5 to maximum of 16 services at a site. In addition to this, anti-malarial drugs like Chloroquine and sulfadoxine-pyremethamine (SP) for pregnant women are also provided from the malaria microscopy centers free of cost. RDT is also provided for the *Pl. falciparum* cases from the sites while, in

the health facilities where malaria microscopy services are not available RDT is the only malarial service provided with appropriate treatment free of cost and referral service as necessary.

FCHV of Dekhatbhuli VDC, Kanchanpur: *FCHV can be the best resource to provide malaria control services in the communities. They have been involved in providing health education on malaria; identifying clinical malaria cases in the communities, taking blood slides and providing Chloroquine (treatment FCHV at the time of epidemic), recording and reporting of malaria cases, providing referral services. Their involvement in distributing nets have been very much effective in the communities since it is ensured that the nets reach the target groups and the disputes associated with the distribution are very often appropriately dealt. Also, in some VDC the FCHV have imposed some charge on the nets and have collected a significant amount of money that they have planned to use in community health activities and strengthening their activities. FCHV can be the best source to disseminate key messages on malaria to the mothers and caretakers through mothers' groups' meetings.*

Table 2
Summary of malaria control activities conducted by D(P)HO/Kanchanpur and other organizations in the year 2006

S.N.	Activity	Target group	Unit	Indicator	Data needed		Target	Achievement
1	Review meeting of malaria program at community level	Health facility	Time	% Of review meeting conducted at community level	N	No. Of review meeting conducted at community level	1	1 (100 %)
					D	Targeted review meeting to be conducted at community level		
2	Review meeting of malaria program at district level	Health facility	Time	% Of review meeting conducted at district level	N	No. Of review meeting conducted at district level	1	1 (100%)
					D	Targeted review meeting to be conducted at district level		
3	Distribution of insecticide treated nets (LLIN)	Household	Number	% Of household distributed LLIN	N	No. of household distributed LLIN	17498	17498 (100%)
					D	Target no. of household		
4	Indoor Residual Spray	General population	Number	% Of people covered by the IRS	N	No of people covered by IRS	66582	86629 (130.1%)
					D	Target no. of people to be covered		
5	Surveillance	Blood slide	Number	% Of blood slides collected	N	No. of blood slides collected for examination	60	49 (81.67%)
					D	Target no. of blood slides to be collected		
Research and Training Institute (RTI)/USAID								
1	Malaria prevalence survey	General population	Event	Successful conduction of survey			1	1 100 %

Changes

Malaria has been a major threat to entire population of the district since long. With a major aim to reducing the burden of malaria associated with its morbidity and mortality the malaria control activities have been carried out. Though there are cases of malaria throughout the year in the district, due to seasonal association of disease transmission the cases are mostly concentrated from July through October. Hence, the impact of the program activities is yet to be awaited.

Box 12
Indicators of malaria control program

Basic indicators

ABER : Annual Blood Examination Rate
API : Annual Parasite Incidence
SPR : Slide Positivity Rate
PF% : Percentage of *Plasmodium falciparum*
SFR : Slide Fatality Rate
CMI : Clinical Malaria Incidence

Additional indicators

- Insecticide-treated nets (LLIN) coverage percentage
- Percentage of received anti-malarial drugs (amD^s) within 24 hours of fever onset
- Percentage of malaria in < 5 years children
- Malaria in pregnancy
- Death record
- Referral record
- Indoor residual spray (IRS) coverage

A set of indicators are already in use to measure and monitor the progress of the regular malaria control activities of the district health system, while an additional set of indicators have further been developed to assess and monitor the impacts of the intervention activities carried out in the district. It is well pronounced that this additional set of indicators would be in practice from 2007.

The changes brought about by the program so far has not yet been reflected through the indicators. However, significant changes have been observed in the health behaviour of the communities that suggests for an unexpectedly better outcome. The section below has tried to reflect the changes seen so far.

Epidemiological data

The data presented reflects the trend of aggregated malaria cases in the district since 1995. The data shows that there have been an increased proportion of Pl. falciparum cases every four to five years, which has been the major cause of outbreaks suggesting for a probable outbreak in 2006/2007. The latest data obtained through the HMIS at 15 July 2006 suggests that there is an increasing trend of blood slides collection in the district. However, the data regarding the impact of malaria control program is yet to come since the transmission of the

Table 3: Reported malaria cases by type (probable or clinically diagnosed and laboratory confirmed)

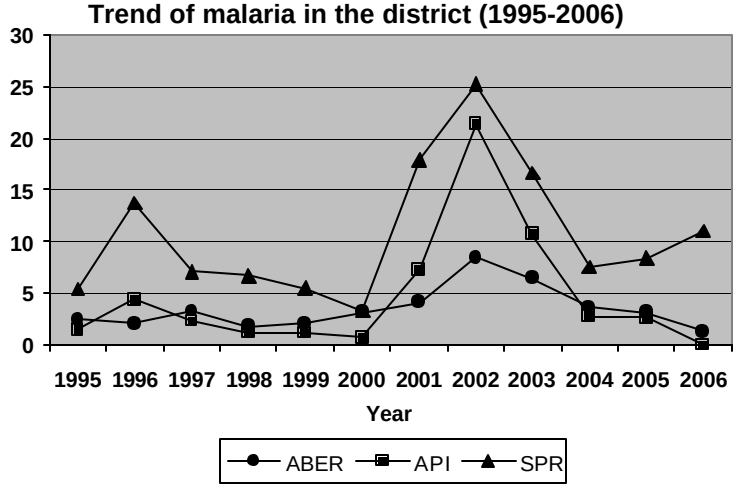
Year	Risk Population	CMI	PV cases	PF cases	No of deaths due to malaria
1995	230671	-	343	1	0
1996	262282	-	510	642	15
1997	299764	-	473	132	0
1998	330304	-	382	13	0
1999	342185	-	356	43	0
2000	354495	-	242	18	1
2001	367247	-	2619	76	0
2002	380459	24.17	6621	1472	3
2003	405449	10.31	4118	208	1
2004	417731	8.75	1084	82	1
2005	429070	9.18	1113	28	0
2006	257085[1]	0.43	373	3	0

Source: HMIS/D(P)HO Kanchanpur, 062/063 (Date of last report: 15 July 2006)

[1] ***The risk population has been computed for seven months***

infection is concentrated from July through October.

Figure 2
Trend of malaria in the district (1995-2006)



Source: HMIS/D(P)HO Kanchanpur, 062/063 (Date of last report: 15 July 2006)

Annual blood examination rate (ABER) target for the district has been 3 - 5 per cent. The district has not been able to achieve this target for past few years and the achievement till the last date of reporting (15 July 2006) has been 1.32 per cent while it was 3.17 per cent for 2005. However this year it is expected that the target would be met, since it has been well spelled by most health institutions that there is an increasing trend of blood slide collection at the health facilities which is suppose to strike a peak during September – October. The morbidity of malaria in the district till the last date of reporting 0.001 per cent while it was 2.66 in 2005. This figure would increase slightly till the end of this year, however, this indicator is also supposed to fall sharply as there has been very few cases of malaria in the communities. The distribution of insecticide treated nets and IRS done has been stated to be the contributing factor to this fall. The given figure shows that there has been a sharp increase in slide positivity rate (SPR) this year (11.04 compared to 8.39 in 2005).

The findings from the follow up study of LLIN suggests that the episode of fever with malaria had been seen among the 1.51 per cent of households distributed LLIN and the fever cases were entirely from the adult group. This means that the LLIN have proved to be effective for the pregnant and children (< 5 years). It has been evident that malaria has been the primary cause of maternal mortality and mortality in children under five in the malaria-prone regions. From a series of

Box 13
Outcomes of malaria control activities in the district

There have been an increased number of people, particularly the school children, undergoing blood test in the labs when hit by a fever, before taking any medicine. It is proved by the fact that the students have been complaining about the absence of health staffs when the health staffs were in training programs in the district. In the earlier days, the people used to take *Cetamol* as soon they had fever, but they are now aware that blood should be taken for examination before taking any medicines. The community used to think that there were no blood test facility in the sub/health posts, but now they are aware about its establishment.

Similarly, behavioural changes have been seen among the school children. They have been seen involved in filling the water-collected ditches around their houses. The children have started to give health education at their home about malaria. Their guardians have been continually been asking the school about the school health education program on malaria conducted at the schools.

A change in attitude towards insecticide treated nets have been seen among the community people who had planned not to purchase the LLIN distributed by the D(P)HO due to lack of money, were convinced by their children to buy it. Also, they have realized that the insecticide in the nets would last for long even washing for several times and would not have effect on individuals health.

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studies it has been found that ITN have been shown to decrease severe malaria, anemia in the mothers, premature births, stillbirths, incidence of underweight among newborns, morbidity of childhood malaria (< 5 years of age) and cut all-cause child mortality since malaria in pregnancy is associated with adverse consequences for mother and children. So, it can be assumed that the LLIN have had an impact upon these indicators in the district. However, the study has not been able to collect any data regarding this.

Box 14
Summary of significant changes seen: findings from the follow-up of school health education program

- School children have been established as a linkage between the community and the newly established malaria microscopy centers and health facilities for their proper utilization
- There has been increment in the number of persons undergoing blood test
- There has been changes in the behaviour of children regarding the preventive measures and drug taking practice against malaria
- The community have been informed about the existence of malaria microscopy centers in their community
- There have been an increased realization among the community about the importance of insecticide treated nets
- Before we used to think that the insecticide in the LLIN would go away through washing but we were wrong
- There a keen eye to watch over the malaria epidemic has been established in school teachers

Challenges

- The urgency to completing all the planned activities within less time due to time constraints and seasonal association of the disease for its transmission had been one of the major challenges for malaria control program in the district
- Overlapping of various activities both in CARE and D(P)HO as well as other partner organizations in the district had created difficulty in the implementation of activities due to divided manpower and, proper monitoring and supervision cannot be carried out as well
- Absence of data regarding the prevalence of malaria among pregnant mothers and children had been one of the major handicap in assessing the situation and impact of the interventions
- There were no other district-stationed partner organizations working in the field of malaria prevention and control in the district except for the D(P)HO itself for which future activities cannot be ensured
- Data from the private sectors regarding the malaria control activities were not reported which has influenced the evaluation of the program's effectiveness
- An effective monitoring mechanism suitable for monitoring the program activities has not yet been developed in the district except for the monitoring of the national regular activities of D(P)HO
- Duplication of the planned activities between CARE NFHP and GFATM had created confusion in implementing the activities

Summary of lessons learned from the overall malaria control program

External agencies that is external to the local community trying to do everything to prevent and control malaria in the community will always face a uphill struggle until the community at large internalizes the issues and acts against it. However, experiences show that involvement of community through HFOMC have been one of the best approach that ensures communities' responsibility and accountability for the malarial prevention and control in the respective communities.

Coordination has been done with the D(P)HO Kanchanpur in all phases of planning through implementation, monitoring and evaluation of the malaria control activities in the district. This has been one of the major reasons for the success of the accomplishment of activities in the district. Further realization of the program as their own program by the D(P)HO and community itself has been another reason for success.

The program has made a considerable contribution in the establishment of malarial microscopy centers through lab facility support and provision of salary for lab technicians on cost sharing basis with the active involvement of the HFOMC which has identified local human resources and other income generating services that ensures the ownership, sustainability and effective operation and management of the centers. Sustainability of labs has been the most important issue raised. Providing wide range of services as an increased source of income and encouraging communities to utilize the services are the key to sustainability.

Community empowerment through advocacy and awareness raising activities has been by far the most crucial and effective intervention of the program which has resulted in an increased attention that malaria is a major public health problem, in most parts of the district, is receiving as an issue of public concern. Consequently, community has started to identify possible resources and solutions to combating malaria.

Community mobilization through the involvement of school teachers, FCHV and students on awareness raising activities has ensured the intensification of the flow of information to large audience through less efforts within less time frame.

Community health volunteers such as FCHV and private health workers such as retail drug seller can provide first line anti-malarial treatment to patients suffering from suspected/clinical malaria provided that these workers are adequately trained to do so. Community-based interventions, particularly, education and trainings to these groups would enhance early diagnosis and prompt treatment.

A conducive atmosphere through appropriate encouragement is must for stimulating partners to initiate support in the intended activities. For health facility-stationed health workers like lab assistants and community health volunteers like FCHV, trainings are often seen as incentives and a means of motivation. Further, continuous and sustained training are effective to enhance greater competency among the trainers. Trainings complemented by follow up and supervision at frequent intervals are key to quality services.

Insecticide-treated nets have proved to be the most effective tool to reduce the malarial incidence in the district. However, there has been a significant proportion of population, particularly pregnant women, who have not yet access to insecticide-treated nets. Integration of distribution of nets with antenatal check up clinics can ensure that all the

pregnant women and children < 5 years receive and use insecticide-treated nets at their first clinic.

A large proportion of population has been served by the private sector in the district. Quality assurance of the services provided by private labs and an approach to bring them under the district health system would have an impact upon the malaria control in the district.

LOOKING FORWARD 3

Malaria control program in Kanchanpur has been one of the successful programs of CSP/NFHP CARE. Since the initiation of the program effective coordination has been done with D(P)HO Kanchanpur in all phases of planning through implementation, monitoring and evaluation of all malaria control activities. Further, realization that malaria is a major public health problem has received an issue of public concern and realization of the program as their own program by D(P)HO and communities has been a major reason for success. However, communities' participation particularly in planning of new interventions has not yet been incorporated well in the program design.

Though involvement of community through HFOMC has been one step adopted that has ensured communities' responsibility and accountability for the malaria control in respective communities, but communities, particularly the one at risk, have not been involved to take active part in planning interventions appropriate to address their needs. Emphasis has been given to assisting communities rather than seeking their active participation which is very often seen as a factor for failure to achieving what have been set out to do, by many programs.

Future actions, therefore, should try to acknowledge the community in all phases of planning and program design and support them implement the programs that directly deals with those who are most affected. There should be a strategic shift to make prevention and control activities gain a civil concern rather than the responsibility of certain organizations. To combat a long-standing disease like malaria one has to harness local initiatives, local resources, community mobilization and a sense of ownership among the people who are most affected by the problem.

New interventions should identify the success of previous activities and programs and build on them. There is no need to reinvent the wheel. The steps to prevent and combat malaria have been well recorded in previous programs and activities. It is necessary to augment those areas of the strategy that may have reduced its success in the past and to build upon the experiences and lessons learned from the past activities.

Effective interventions against malaria are available, yet the burden persists, largely for three reasons—most people at risk of malaria are unaware of interventions; they are unable to afford them; or the interventions are inaccessible. A lack of education, information and failure to achieve adequate coverage with effective interventions like drugs and insecticide-treated nets restricts the success of program, especially among the poor and the most vulnerable.

The basic steps that future program to prevent and combat the menace of malaria should be built upon are:

Step I: Setting stage

A foundation upon which the individual activities can be built with each activity having broad level of implication that goes beyond any individual theme.

a. Ensuring community participation

Every community has its own realities, its strengths and its limitations. Communities often have the knowledge and the will to combat a public health problem like malaria but lack the resources and the organizational capacity to sustain the effort. Encouraging communities to come up with meaningful ways to be involved with malaria control program should be adopted. We should be sensitive to folk health traditions and beliefs about malaria while we engage the community leaders in the planning process. It would be important to involve women's groups, youth, village development committees and local community organizations from the start. Women and children are the ones who are most susceptible and they need to be involved in the planning from the beginning. The interventions to address the community needs and the resources needed to fulfill them needs to be identified and prioritized and options for developing effective interventions, their delivery and implementation needs to be done with the communities using participatory methods such as PLA or PRA.

Objective: To ensure communities attempt to move away from the unsustainable position of being mere recipients of services, resources and development interventions towards being active partners, or owners, of the interventions

In order to help communities develop control, partners, particularly I/NGO^s should contribute their knowledge and experience to improving local skills and abilities so that the community itself can make decisions and take the actions that they believe are essential for their own development.

The development of plan should ensure: -

- Identification of possible partners, particularly the one that are most affected and the local institutions (mothers' groups, women's groups, youth groups/clubs and other community based organizations)
- Communities participate at the inception and planning of new interventions whenever possible
- Leadership and planning that ensure the relationship is a cooperative one to minimize tension between the community's role and those of other partners
- Interaction with other partners that build towards sustainable systems
- Decentralized authority and resources
- Continuous monitoring and evaluation of community activities

b. Broadening partnership

Partnership is a forum for participants to exchange resources, combine competencies and coordinate activities in a productive manner. Partnership includes the sharing of information, and the identification of common objectives and goals. Participatory approaches must therefore build partnerships into the decision-making process at the earliest stages to bring about effective and sustainable change.

Objective: To assist communities establish partnership as a collaborative relationship between entities to work toward shared objectives through a mutually agreed division of labour.

In order to develop communities identify and support their own community health interventions, our role would be to providing technical expertise and financial support in training, educating and supervising activities to maintain optimum quality of service.

The development of plan should ensure: -

- Identification of partners (private-clinics; NGO[s] and other organizations; government organizations; schools and civil societies)
- Fully involve partners from the very beginning of the program development
- Mobilize partners in the implementation of activities through a mutually agreed division of labour
- Ensure a proper mechanism to monitor and evaluate partners' activities

Key issues

- A large proportion of population (an estimated 60 per cent) has been served by the private sector in the district. Private service providers as partners in health service delivery should be brought under the district health system to have an impact upon the malaria control in the district.
- Overlapping of various activities both in CARE and D(P)HO as well as other partner organizations in the district has created difficulty in the implementation of activities due to divided manpower and, proper monitoring and supervision cannot be carried out as well.

c. Integrating malaria programs with existing community – based interventions (IMCI, immunization programs, CDP, Safe motherhood, antenatal services)

Integrated approach that combine malaria control with other health and/or development activities that can increase the reach and impact of interventions while optimizing the use of human, material and financial resources. Therefore, it is necessary to collaborate with other existing programs.

The development of plan should ensure that the malaria control activities are integrated appropriately with:

- Safe motherhood antenatal services to ensure the provision and effective use of anti-malarial drugs and nets, and intermittent preventive treatments (IPT)
- Community drug program (CDP), immunization programs, integrate management of childhood illnesses (IMCI) programs and child health services to ensure the provision of drugs to children

Step II: Developing community level intervention channels

The initial phase in community health intervention involves identifying community leaders and other key persons in communities as a influential group of people in order to establish a community development committee. But if there is an existing health committee (health facility management committee, school health management committee, etc.) or other community groups for it may be possible to strengthen them.

In order to develop effective channels for the intervention activities, our responsibilities would be to decide responsibilities for such committees in cooperation with partners.

The development of plans should ensure that the committee: -

- Represents all the existing social groups in a community
- Acts as a link between the district and communities
- Equitably resolve issues such as recruitment, remuneration and accountability
- Participate in needs assessment and analysis, as well as in prioritizing interventions.
- Contribute to identification and mobilization of resources, which may include the training of recruited health workers and community leaders, as well as the preparation of health education materials relevant to their community

Step III: Interventions into action

The weapons to fight malaria exist: medications, insecticide-treated mosquito nets and other materials, safe and effective insecticides, spraying equipment, tests to diagnose the disease. But these weapons are useless if they do not reach those who need them. Affordable and accessible prevention and treatment measures are a key requirement for malaria control. Therefore, it is necessary to combine both prevention and cure strategies.

The objectives of the intervention at community level should include:

- To improve recognition of malarial illness and provision of appropriate treatment by caregivers within 24 hours of onset of illness;
- To strengthen the capacity of health systems, particularly at the periphery, so as to support community level actions, including access to anti-malarial drugs and referral mechanisms;
- To improve health-seeking behaviour of caregivers, family and community so they can recognize signs of severe illness and seek appropriate care quickly when referral is indicated;
- To improve access to insecticide-treated nets, and to promote their regular and proper use and re-treatment;
- To promote intermittent preventive treatment for pregnant women, particularly in areas of intense malaria transmission; and
- To promote vector control, including environmental management wherever appropriate.

a. Conducting health education

Raising awareness, in the communities, of the disease first and then its cause, the communities will be able to incorporate preventive measures into local action. Knowledge also allows community to be aware of the presence of malaria, access early and effective treatment and effective. For this a number of trained health personnel would be required to lead the initiative. They need to be trained in the comprehensive community based malaria control strategy and they in turn would train the community health volunteers. The volunteers would disseminate the information through community meetings, home visits and school health education.

The behavioural change intervention through health education should ensure:

- Social mobilization as key tool for awareness raising activities to mobilize civil society, communities and partners
- Mobilization of trained volunteers, particularly, school teachers, FCHV and students
- Community-based interventions, particularly, education and trainings to private health workers such as retail drug seller as a first line anti-malarial treatment providers and Mothers are the primary care takers of families, particularly of small children under five years of age

Key issues

- Mothers are the primary care takers of families, particularly of small children under five years of age. Behavioural change interventions aimed directly at this group would be a beneficial approach. Behavioural change strategy to mobilize FCHV through mothers' groups to reach this group would ensure the achievement.
- Communities' perception about the quality of services provided through governmental lab facilities have been the most important factor in the low utilization of the services provided through these labs. An approach to changing communities' perception for increasing the utilization of these services is essential.

b. Capacity building

Capacity building initiatives to improve clinical care in health facilities should be increased for both the providers and consumers. It is necessary to train health service providers as well as communities, particularly the primary caregivers and first line of contact for treatment to recognize the symptoms of malaria and to treat it with the appropriate medication, especially if they live far away from the nearest health institutions.

Key issues

- Initial and reinforcing training should be continued by follow-up, supervision and support.
- A significant proportion of the population is served by the private sector. So quality assurance of the services provided by the private sectors through appropriate trainings and necessary supervision and guidance is essential. For this, it is necessary to bring them into district health system.

c. Strengthening the management and coordination of community based malaria control activities

By empowering local health committees to identify and address issues related to malaria prevention and control and incorporate them into the plan, manage and evaluate malaria prevention and control activities issues are at the health facility level. For this necessary interaction and technical supervisory visits should be provided by the district health system and I/NGO[s].

Key issues

- Sustainability of lab services has been by far the most important issue raised after its establishment. The active members of HFOMC and their active participation to seek ways for sustaining lab service is a key to its sustainability. Therefore, strengthening

HFOMC for identifying ways of sustaining labs and coordinating with district line agencies and development partners for support would be an important approach.

- Follow up of the training and supervision from the district and higher concerned authority from time to time to provide guidance to ensure improved competency and quality of services provided and motivation of the staffs should be strengthened.

d. Delivering malaria control services

Net culture: Mosquito nets, if used properly, are one of the best ways to prevent mosquitoes from biting people and infecting. They are simple, safe and cost-effective. It has been shown that high levels of insecticide-treated net coverage can reduce deaths in children and pregnant women. Therefore, a net culture should be established to promote the vigorous use of insecticide-treated nets especially among the young children and pregnant women. Wide publicity and promotion are first steps. Another way to ensure that insecticide-treated nets are used and retained by the population at risk is to subsidize the price so the nets are affordable.

Key issues

- The nets are usually inadequate to reach the entire target group in a specified time and costs, even subsidized through social marketing schemes, are high for the community to afford. As far as possible the insecticide-treated nets should be distributed free of cost, but if some charge is to be imposed upon it then the ability of the poorest families should be considered.
- Ordinary nets are available at almost all the households. By treating the nets with an insecticide (pyrethroid) enhances the protection as the chemical produces a barrier even beyond the net and protects the persons in the vicinity. A new treatment every six months keeps the chemical working. The intervention activities related to the treatment and re-treatment of the nets would, therefore, assure that the households not distributed the insecticide-treated nets also benefit from the treated nets.
- Social issues are likely to affect the use of insecticide-treated nets and distribution programs, particularly, free-distribution should address this issues appropriately while planning for the distribution
- The households that were provided the insecticide-treated nets when not oriented properly about it have impact on its effective use. Orienting properly on insecticide-treated nets promotes positive attitude towards its use. The distribution program should, therefore, properly orient all the households provided the insecticide-treated nets on it for its universal and effective use. Further mobilization of the health workers and the health volunteers, particularly, FCHV would be the most effective approach.

Indoor residual spraying as a major vector control strategy: Vector control is a cornerstone in preventing malaria. Indoor residual spraying – to spray the inside of people's houses with insecticide to kill mosquitoes, is one of the most effective interventions of vector control. Indoor residual spraying in specific situations (epidemic-prone areas) should be a promoted.

Case-management: Ensuring that the community has good access to prompt diagnosis and effective treatment of malaria is key to success. For this health facilities will require improvement of their laboratory services and a regular supply of the best anti-malarial drugs. Chloroquine is now an effective drug against malaria, particularly for the vulnerable

population groups such as children with acute fevers. Even better are the artemesinin-based combination therapies (ACT). Pregnant women another vulnerable group, intermittent preventive treatment (IPT) using sulfadoxine-pyrimethamine (SP) at pre-defined intervals during pregnancy has proved efficacious in reducing the incidence of malaria, anemia and low birth weigh. An effective mechanism to administer these services should be ensured.

Key issues

Lab services and supply of appropriate anti-malarial drugs are all too often not widely known by local communities and not widely available or used.

- Lab services are not provided at all the health facilities. In order to ensure the malaria control services are provided to the entire community the alternate to these services should be sought. Rapid tests are now available that can quickly diagnose malaria. These services should be provided at these facilities devoid of lab services.
- The regular supply of Chloroquine is very often interrupted. So, integration of the malaria control activities with community drug program (CDP) would ensure the availability of the drugs.
- Intermittent preventive treatment for pregnant women's is not very much given attention which should be integrated very much with the safe-motherhood and ante-natal services.

e. Strengthening the district capacity

As a responsible autonomous body of national health system, the district health system can play an essential role in guiding inexperienced communities, at the beginning of a program.

In order to ensure that community-based activities are supervised, guided and assured of quality our role would be to provide technical expertise, information and financial resources to the district health system.

The development of plan should ensure the district health system: -

- Facilitate cooperation between the partnerships working in the district
- Provide correct technical guidance in the use of tools and services for malaria prevention and treatment at community level; correct messages are being given to communities in a consistent manner; adequate personnel and resources for such duties are available
- Begin district planning activities by reviewing:
  - The availability and quality of health care in public and private sectors
  - Information provided by previous studies on key family health practices from district health service data, including demographic health surveys, knowledge, attitude and practice studies, ethnographic studies, etc.
  - Any existing community-oriented communication materials from IEC units, NGOs, etc.
  - The support systems for supervision, transport, distribution of drugs and insecticide-treated nets.
  - Community-level resources such as village health committees, women's groups, religious groups, community financing schemes, etc.
  - The sources of funding, costs and budget implications.

Step IV: Monitoring and evaluation

Monitoring and evaluation of the impact of malaria control activities and strategies, and continuous assessment and modification of strategies to achieve maximum impact, should be integral components of disease control operation. As communities take more responsibility for malaria control it is necessary that they are able to measure the success of their actions. By regularly monitoring key indicators in the community they will obtain evidence-based information upon which to make decisions. This will also allow the community to evaluate the effectiveness of their programs and improve their capacity.

The key indicators include:

- Number of households with insecticide-treated nets
- Number of malaria cases treated within 24 hours of symptoms
- Overall reduction of incidence and mortality of malaria
- Cooperation with district management and other partners, personnel and the use of funds

Objective: To ensure communities monitor their own resources, including materials and finance, and the performance of the health workers in the community.

In order to ensure strengthened community self-monitoring and decision-making, our role would be to provide continuous monitoring and appropriate feedback as necessary.

Recommendation for further studies

- A study to assess the impact of the LLIN on data concerning anemia in the mothers, premature births, stillbirths, incidence of underweight among newborns, morbidity of childhood malaria (< 5 years of age) and cut all-cause child mortality is recommended
- Absence of data regarding the prevalence of malaria among pregnant mothers and children has been one of the major handicap in assessing the situation and impact of the interventions. So, a prevalence study to determine prevalence of malaria among pregnant women and children (under age five) should be carried out.

For this, the data can be obtained from the current malaria register of the district which if properly maintained could give an exact situation of the malaria prevalence among pregnant mothers and children (< 5 years) in the district. So, the proper maintenance of the register is crucial for the assessment and it must be ensured. The monthly monitoring review of data for malaria at the district with the health facility staffs responsible for recording and reporting would ensure the timely and quality data.

Money alone cannot solve the problem – fighting malaria requires commitment from affected communities, stakeholders and country as well as coordination among all stakeholders. Therefore, it is essential to continue advocacy campaigns to raise awareness of malaria at all levels so that malaria control is incorporated into all health and development policies, strategies and programs, thus keeping malaria high on development agenda, mobilizing resources for malaria control and for research into new and more effective tools, and ensuring that the vulnerable individuals are the key participants in malaria control activities.

Terms and concepts

Advocacy — A continuous and adaptive process of gathering, organizing and formulating information into argument, with a view to raising resources or gaining the acceptance and commitment of political and social leadership to a development program, thereby preparing a society for its acceptance.

Clinical malaria — A person from malaria endemic area with fever or history of fever during last three days is considered as a cause of clinical or suspected malaria after the exclusion of other causes of fever.

Community — A group of people with common interests and fellowship living in the same local area (i.e. more intimately involved than at either district or regional areas).

Community participation — The active involvement of people living together in some form of social organization and cohesion in the planning, operations and evaluation of a program using local, national and other resources. It is a process through which communities ultimately influence and share control over the development, local initiatives, decisions and resources of projects (e.g. malaria control) that directly affect them.

Community ownership—Community participation that has been developed to increase people's sense of control over issues that affect their lives.

Community-based organizations—Local organizations functioning at grassroots level.

Participatory learning and action (PLA)—A community development approach whereby facilitators work with communities to help them analyze their needs, identify solutions to fill those needs, and develop and implement a plan of action. PLA is based on many different participatory approaches, including participatory rural appraisal (PRA), rapid rural appraisal (RRA), and applied anthropology.

Participatory rural appraisal (PRA)—A way of learning from and with community members while investigating, analyzing and evaluating locally based development projects. It is a method by which a trained team can quickly and systematically collect information for the general analysis of a specific
development intervention (e.g. needs assessments, feasibility studies) in non-literate rural communities.

Social marketing—An approach using marketing techniques to promote and distribute socially beneficial interventions rather than commercial products.

Social mobilization—A process of bringing together all interested inter-sectoral partners and allies to determine felt needs and raise awareness of and demand for a particular development objective. It involves enlisting the support of all stakeholders, including institutions, groups and communities, in identifying, raising and managing human and material resources, thereby increasing and strengthening participation for self-reliance and sustainability of achievements.

References/Bibliography

CSP/NFHP CARE, *Malaria microscopy training*, Kanchanpur, May 16 – 22, 2006

CSP/NFHP CARE, *Orientation program for FCHV on malaria*, Kanchanpur, June 2006

CSP/NFHP CARE, *School health education program*, Kanchanpur, May-June 2006

CSP/NFHP CARE, *Use of long lasting insecticide-treated nets (LLIN): a follow-up study of LLIN in Kanchanpur district of Nepal*, Kanchanpur, April 2006

International Labour Organization, *Lessons learned for the Time Bound Program*, Kathmandu, June 2001

Roll Back Malaria Partnership Secretariat, *Looking forward: Roll Back Malaria*

Roll Back Malaria Monitoring and Evaluation: Afghanistan country profile, April 2005

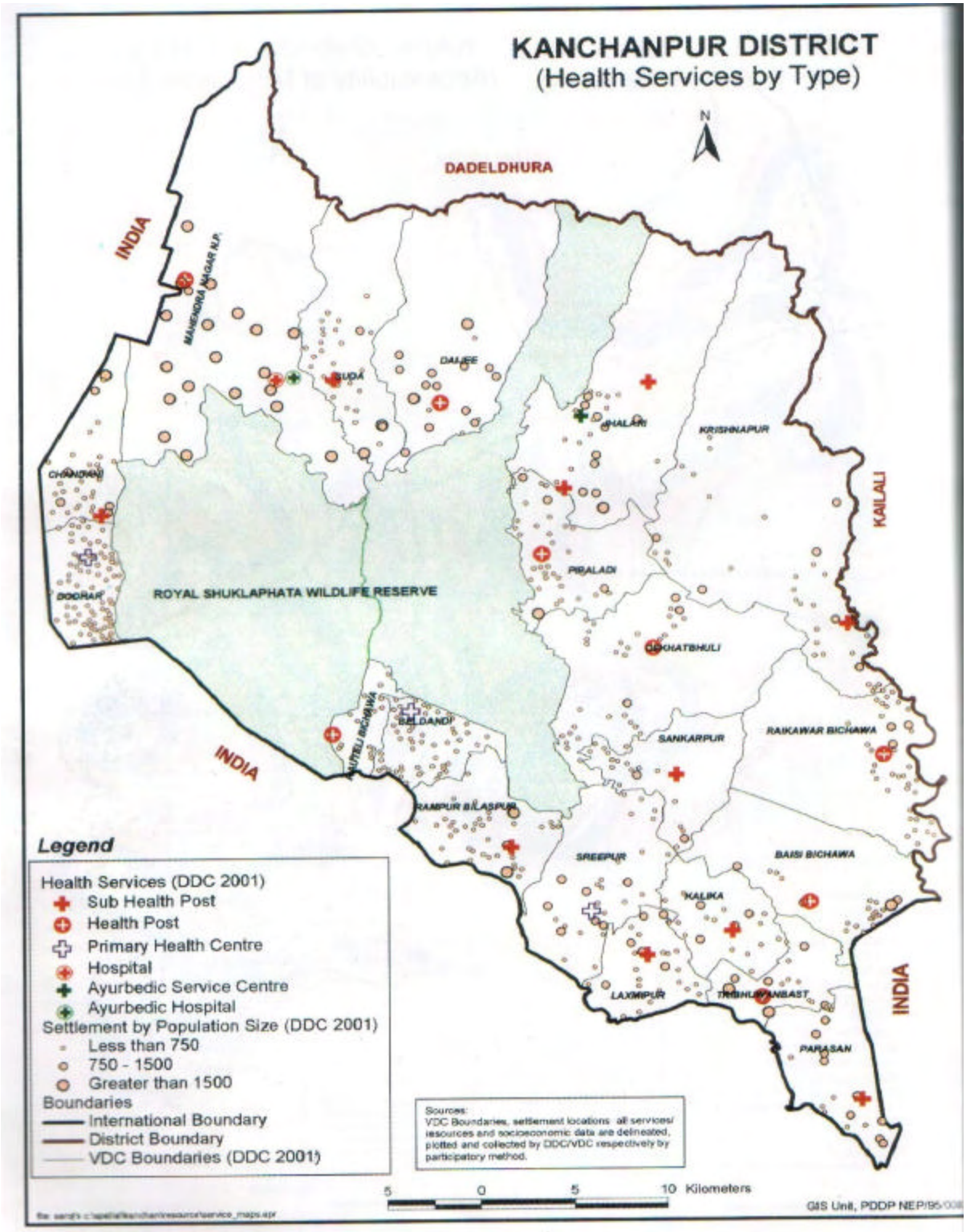
UMCOR Health Ministries, *A proposal on community based malaria control*

United Nations Development Program/World Bank/World Health Organization, *TDR strategic direction: Malaria*, February 2002

Annex I: List of acronyms

ACT	:	Artemesinin–based Combination Therapies
AHW	:	Auxiliary Health Worker
ANM	:	Auxiliary Nurse Midwife
CBS	:	Central Bureau of Statistics
CDP	:	Community Drug Program
CPD	:	Core Program District
CSP	:	Child Survival Project
DDC	:	District Development Committee
DoHS	:	Department of Health Service
D(P)HO	:	District Public Health Office
EDPT	:	Early Diagnosis and Prompt Treatment
FCHV	:	Female Community Health Volunteer
FP/MCH	:	Family Planning/Maternal and Child Health
GFATM	:	Global Fund For AIDS, Tuberculosis and Malaria
GMCS	:	Global Malaria Control Strategy
HFOMC	:	Health Facility Operation Management Committee
HMG/N	:	His Majesty's Government of Nepal
HMIS	:	Health Management Information Service
ID	:	Infectious Disease
IEC	:	Information, Education and Communication
IMCI	:	Integrated Management of Childhood Illness
I/NGO	:	International/Non-Governmental Organization
IPT	:	Intermittent Preventive Treatment
IRS	:	Indoor Residual Spraying
ITN	:	Insecticide Treated Net
LLIN	:	Long Lasting Insecticide Treated Net
MCHW	:	Maternal and Child Health Worker
NFHP	:	Nepal Family Health Program
NMCP	:	National Malaria Control Program
OPD	:	Out Patient Department
PCD'V'	:	Passive Case Detection 'Volunteer'
PDQ	:	Partners' Defined Quality
PHC	:	Primary Health Care
PLA	:	Participatory Learning and Action
PRA	:	Participatory Rural Appraisal
PSI/Nepal	:	Population Services International/Nepal
RBM	:	Roll Back Malaria
RRA	:	Rapid Rural Appraisal
RTI	:	Research and Training Institute
S/HP	:	Sub/Health Post
SP	:	Sulfadoxine-Pyrimethamine
TSV	:	Technical Support Visit
USAID	:	United States Agency for International Development
VDC	:	Village Development Committee
VHW	:	Village Health Worker
WHO	:	World Health Organization

Annex II: District map



Annex III: Scope of Work for Malaria Control Program in Kanchanpur

Background:
Nepal Family Health Program is a USAID project to support His Majesty's Government of Nepal in its long-term goal of reducing fertility and under five mortality. CARE Nepal, as a collaborating partner of NFHP, is implementing the activities in seven of seventeen Core Program Districts (CPDs) in close coordination with District (Public) Health Offices (D(P)HO). The major objective of the program is to support/assist D(P)HOs toto increase the availability, accessibility and quality of the basic package of FP/MCH services at household and community level. Nepal Family Health Program is also supporting D(P)HOs for vector borne disease control program in selected CPDs (Dhanusa, Mahottari and Kanchanpur).

Rationale:
Kanchanpur is the malaria endemic Terai district of Far West Nepal. Despite different efforts from governmental and non-governmental sectors, Kanchanpur covers about half of the total malaria cases in the country, though the annual incidence of malaria has decreased over the last two years. Due to the high prevalence of malaria cases in the district, the government system is not being able to provide adequate services to the community through its existing infrastructure and facilities. Thus, CARE-NFHP has decided to support the Kanchanpur District Public Health Office to deliver better quality health services and to improve community access to malaria microscopy, prevention and control facilities through health facilities, and female community health volunteers. This component will also be a complementary to efforts of child survival in addressing the felt need of communities to protect the mothers and young children from the malaria related problems
To respond to the burden of malaria in Kanchanpur, CARE Nepal has supported to establish three malaria microscopy centers in addition to three centers functioning under the government infrastructure. In addition, CARE Nepal is also supporting the Health Facility Operation and Management Committees to run and strengthen these centers through human resource support since its establishment to date and planning to handover the roles to the HFOMCs on cost sharing basis from June 2006 and completely from Dec 2006. The component will help give continuity to the above efforts and also to expand the provisions to few more health facilities so that the District Health office can work for the possible prevention and control of malaria related issues in a systematic manner.

Activities:

CARE/NFHP, in close coordination with District Public Health Office, Kanchanpur will provide support for following activities:

1. Provide support to establish three new malaria microscopy sites (Krishnapur, Pipladi, and Suda VDCs), in addition to currently operating three sites (Jimuwa, Daijai, Jhalari and Tribhuvanbasti) in of Kanchanpur

   Provide support for one laboratory technician for seven malaria microscopy centers established by CARE-NFHP (i.e. Jimuwa, Daijai, Jhalari, Tribhuvanbasti, Krishnapur, Pipladi, and Suda) on cost sharing basis.

   The project will cover the full cost of the lab technician in all seven Malaria microscopy centers until June 2006. From July to Decemebr 2006, the project will contribute 50% of

the cost, and the HFOMCs will cover 50% of the cost. From January 2007, it is expected that the HFOMC will take up all the responsibility of covering the entire cost of lab operation. NFHP will reimburse the cost of salary provided to laboratory technicians in currently operating four malaria microscopy clinics for the period of January 2005 to Nov 2005.

This support will help to improve the community access to malaria microscopy services; early diagnosis and proper treatment, and thus help to control the malaria problem in the district.

2. Conduct malarial microscopy training (about a week long) for three newly recruited laboratory technicians in coordination with NFHP ID Coordinator. This will enable the technicians to provide quality check-ups of malarial slides.

3. Carryout two days orientation for all FCHVs of Kanchanpur on community initiatives for malaria prevention and control. This will help update their knowledge on malaria and to motivate them to mobilize communities for malaria control.

4. Carryout two days orientation for sixty school teachers and thirty five health staffs from health facilities and District Public Health Office to improve their knowledge on malaria prevention and control.

5. Carryout school health program in sixty schools of Kanchanpur district for secondary level students to improve their knowledge on malaria prevention and control.

6. Carryout LQAS Survey (38 clusters X 19 sample) to assess community knowledge on malaria causation, prevention and treatment. This survey result will provide in-depth knowledge on the level of awareness among the people of Kanchanpur and will help to take appropriate strategies to overcome the existing barriers for malaria control.

7. Conduct follow-up study on use of Insecticide Treated Nets (ITNs) distributed by Global Fund to monitor the practice of using ITNs and its impact on malaria control.

8. Support NFHP in developing and implementing an accreditation system of private malaria microscopy clinics based on their accuracy on microscopy results of malaria slides, which will help to monitor the quality of malaria microscopy services from private clinics and to encourage/recognize those providing quality services.

9. Support District Public Health Office Kanchanpur in coordinating, implementing and monitoring malaria control program

10. Prepare a final lessons learned document on malaria control initiatives in Kanchanpur.

Program management:
One Malaria Control Officer will be locally hired to oversee overall vector borne disease control program of District Public Health Office Kanchanpur but will also support in other family health activities ongoing in the district. The Malaria Control Officer will be based at District Public Health Office and will report to District Public Health Administrator and District Health Coordinator, Child Survival Project, Kanchanpur. He/She will work closely with Malaria Inspector, other district supervisors as well as Asst M&E Officer and NFHP Field Officer.

The Child Survival Project will provide technical and backstopping support to the Malaria Control Officer, as and when required basis and the CARE-NFHP Project Manager will provide managerial support to the Malaria Control Officer. CARE Nepal Country Office, in coordination with NFHP Central Office will provide technical, monitoring and supervisory support to the team to carryout malaria control activities.
Regular progress updates will be shared with NFHP Field Coordination Unit and reported on the Semi Annual Report of CARE NFHP.

Expected Result:

- Increased malaria case identification and better management of malaria cases through FCHVs and health facilities in Kanchanpur
- Increased awareness among community people on ways of malaria prevention and control in Kanchanpur leading to early diagnosis and proper treatment.
- Strengthened capacity of District Public Health Office to have effective management of vector borne diseases, especially malaria in the district.
- Effective management system of malaria and other vector borne diseases control program in District Public Health Office in Kanchanpur
- Reduced incidence of malaria related illness among the population of Kanchanpur.

Budget Summary:
The total budget for malaria control program will be US$ 27,400.00 (NRs 1917972.00). The detail breakdown of the budget has been shown in the annex.

Annex: Budget

Activity	Unit	Quantity	Rate	Total NRS	Remarks
Establishment of lab facility					
Furniture	site	3	13000	39,000	
Glassware	site	3	15000	45,000	
Strengthening lab facility					
Salary (Jan 05 - Jun 06) - 100%	person month	4 X 18	5000	360,000	
Salary (Dec 05 - Jun 06) - 100%	person month	3 X 7	5000	105,000	
Salary (Jul 06 - Dec 06) - 50%	person month	7 X 6	2500	105,000	
Malaria Microscopy Training					
Participants Allowance	person	3 X 7days	300	6,300	
Facilitator Allowance	person	2 X 7 days	500	7,000	
Travel cost	LS	--	10,000	10,000	
Stationary and Refreshment	LS	--	5,000	5,000	
FCHV Orientation on Malaria					
Participant Allowance	person	833 X 2 days	150	249,900	
Facilitator Allowance	person	80 X 2 days	500	80,000	
Stationary and Refreshment	events	40	3500	1,40,000	
Misc (hall rent, helper)	events	40	1500	60,000	
School Health Program on malaria prevention and control					
Facilitator Allowance	person	5 X 60	300	90,000	
IEC Materials	events	60	1000	60,000	
Travel	events	60	3000	180,000	
Misc (hall rent, helper)	events	60	500	30,000	
Orientation Program					
Facilitator Allowance	person	2 X 5X 2	800	16,000	
Participant Allowance	persons	95 X 2 days	400	76,000	
IEC Materials	events	5	10000	50,000	
Travel	events	5	3000	15,000	
Misc (hall rent, helper)	events	5	1000	5,000	
LQAS Survey on community					
Enumerators allowance	person days	120	400	48,000	
Supervisor allowance	person	20	500	10,000	
Questionnaire printing	LS	--	10000	10,000	
Travel	LS	--	10000	10,000	
Analysis and report writing	LS	--	10000	10,000	
Follow-up study on use of ITN					
Enumerators allowance	person days	40	400	16,000	
Supervisor allowance	person	10	500	5,000	
Questionnaire printing	LS	--	5000	5,000	
Travel	LS	--	3000	3,000	
Analysis and report writing	LS	--	5000	5,000	
Private lab accreditation scheme					
Allowance for supervisor	person	5	500	2,500	
Travel	LS	--	5000	5,000	
Format development & printing	LS	--	5000	5,000	
Compilation of lesson learned document on malaria control initiatives on KPur	LS	--	50000	50,000	
Indirect cost @ 7.83%				139, 272	
Total				**1,917,972**	

Concept

Sustainability is an intangible concept and a term without common definition. Different people define sustainability in different ways. The Oxford dictionary defined sustainability as 'cause to continue or be prolonged for an extended period or without interruption'.

In simpler term, in context of child survival project, sustainability can be defined as positive health outcomes in maternal and child health situation, even after project input cease or decrease. Positive health outcomes can have no real impact on children's health, development and well being unless they are maintained over time; even if and when external assistance is reduced. In summary, sustainability can be understood as:

- institutionalization of project efforts
- population level impact through project efforts
- community ownership on project efforts
- multi-sectoral system level impact of project efforts

These other definitions have included—

- *Institutionalization* of strategies and practices in local organizations, often MOH structures or local NGOs;
- *Financial support* for the continuation of activities, through cost-recovery and business development strategies;
- *Empowering communities*, for instance to implement essential health activities or manage and oversee health committees;
- *Improving the supply and demand cycle* for care services, by combining quality improvement efforts with cost-recovery schemes;
- *Development* that meets the needs of the present without compromising the ability of future generations to meet their needs (i.e., *"ecologically sustainable development*").[1]

The concept of Sustainability covers following issues in context of Child Survival Project

[1] World Commission on Environment and Development ("Brundtland Commission"), United Nations, 1987.

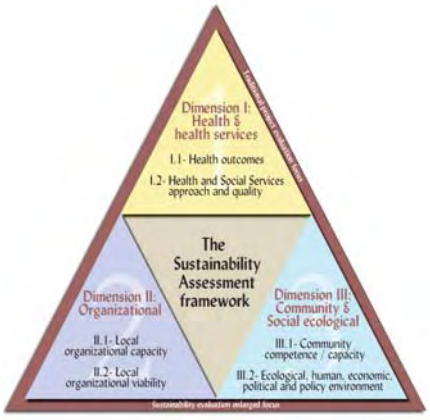
- Improved health outcomes is what we seek to sustain (programs, activities, and institutions are merely means to accomplish that goal in a changing and complex environment).
- Who owns tomorrow? Think *in* the local system, and work with others to complement, not compete.
- Plan for sustainability *now* (ideally at the beginning of a project)!
- Be accountable. Define contextually realistic objectives with your partners.
- Assess in order to know where you start, and evaluate to show how far you have gone. Monitor progress along the way.
- Find synergies between areas of intervention.
- Balance process and results.

Project Overview

CARE Nepal implemented Child Survival project in Kanchanpur district since October 1999. The first phase of the project (CS XV, Oct 99 - Sept 03) was focused on intensive implementation of the project activities based on the framework of community based integrated management of childhood illness. The progress of the first phase of the project was remarkable and thus the second phase of the project (CS XIX, Oct 03 – Sept 07) was awarded to CARE Nepal for extending program impact to additional three districts of far west Nepal. Currently, CARE Nepal in close collaboration and coordination with District Public Health Office, Kanchanpur is implementing activities with an aim of sustained health impact in health, development and wellbeing of children in Kanchanpur, that was gained during the first phase of the Child Survival project.

Dimensions of sustainability

Sustainability in Child Survival projects is a contribution to the development of conditions enabling individuals, communities, and local organizations to express their potential, improve local functionality, develop mutual relationships of support and accountability, decrease dependency on insecure resources (financial, human, technical, informational), in order for local stakeholders to negotiate their respective roles in the pursuit of health, development and wellbeing, even beyond a project intervention.



Every project operates in the local system comprising the individuals, groups, communities, local organizations and the environment on which they operate. These elements of local system are coordinated and linked through social actions and interactions and affecting the health of individual and community at large, either positively or negatively. Thus, there are three distinct dimensions of sustainability in context of Child Survival Project,

namely i) health outcomes, ii) organizational capacity, and iii) enabling environment.

Measurement of sustainability remained a big question in the development arena since a long time. In fact, measurement of sustainability is problematic, as this is an intangible concept. Sustainability is not only difficult to measure, but is quite unpredictable most of the times. The complexity of models, the multi-factoral nature of sustainability, and the practical difficulty of measuring post-intervention outcomes on various dimensions have constrained measurement of sustainability of development efforts.

Though sustainability is difficult to measure, the Child Survival Collaboration and Resource (CORE) Group, Child Survival Health and Grants Program (CSHGP) and Child Survival Technical Support project (CSTS) have worked collaboratively to develop a system to measure sustainability of child survival project being implemented through various Private Voluntary Organizations (PVO). The framework, named as Child Survival Sustainability Assessment (CSSA) framework, has been used in various Child Survival projects being implemented through different PVOs and found fruitful in monitoring progress towards sustainability and to take appropriate actions on timely manner to drive the project towards sustainability.

Methodology

With the support of CSTS, encouragement from the local USAID mission and technical assistance of New Era, CARE Nepal decided to apply the CSSA framework in Kanchanpur district. Thus a list of possible indicators were selected in consultation with the project team and shared with CSTS and other PVOs during the CSSA orientation workshop in Kathmandu. Based on the feedback and suggestion from them, a final list of indicators was prepared.

During the month of May 2006, CARE Nepal, Child Survival Project Organized two days workshop at Mahendranagar, Kancahnpur in presence of local stakeholders (CS project, District Public Health Office, District Development Committee, Mahendranagar Municipality, Female Community Health Volunteers, local NGO partners, and media).

The Objectives of the CSSA Workshop in Kanchanpur was:

- To orient district level Child Survival stakeholders on the concept of program sustainability in context of Child Survival Projects
- To review project progress in context of program sustainability based on Child Survival Sustainability Framework
- To build common understanding on improving program sustainability in context of Child Survival Project in Kanchanpur

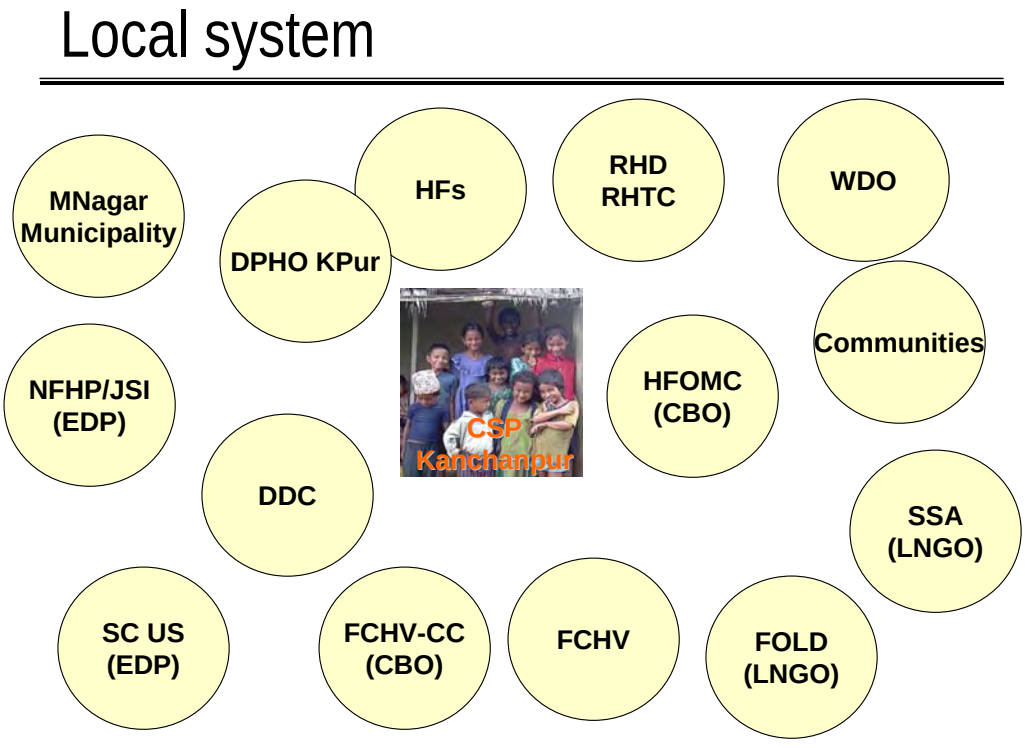
The workshop participants had interactive discussion on the short listed indicators and indicator value. The some of the indicators were modified, added and discarded as suggested by the workshop participants. Then, based on the final list of indicators, indicator value was score value was calculated in presence of all stakeholders. Data for such indicator value was obtained from different data source already available (e.g. LQAS, HMIS, LMIS etc). For some of the qualitative indicators, data value and score value was calculated through interactive discussions with participants. Finally, the score was plotted on the sustainability dashboard and presented in the plenary. The plenary analyzed the dashboard and conclusion was drawn.

At the end, role of different stakeholder for sustaining the project impact was discussed. All participants expressed their commitment to support and act in line with sustainability based on the exercise.

How the Child Survival project, Kanchanpur is moving towards sustainability?

Local system:

Participatory exercise was carried out to identify local context in context of Child Survival Project. The stakeholders were identified in relation to their role and influence in the overall goal of the project.



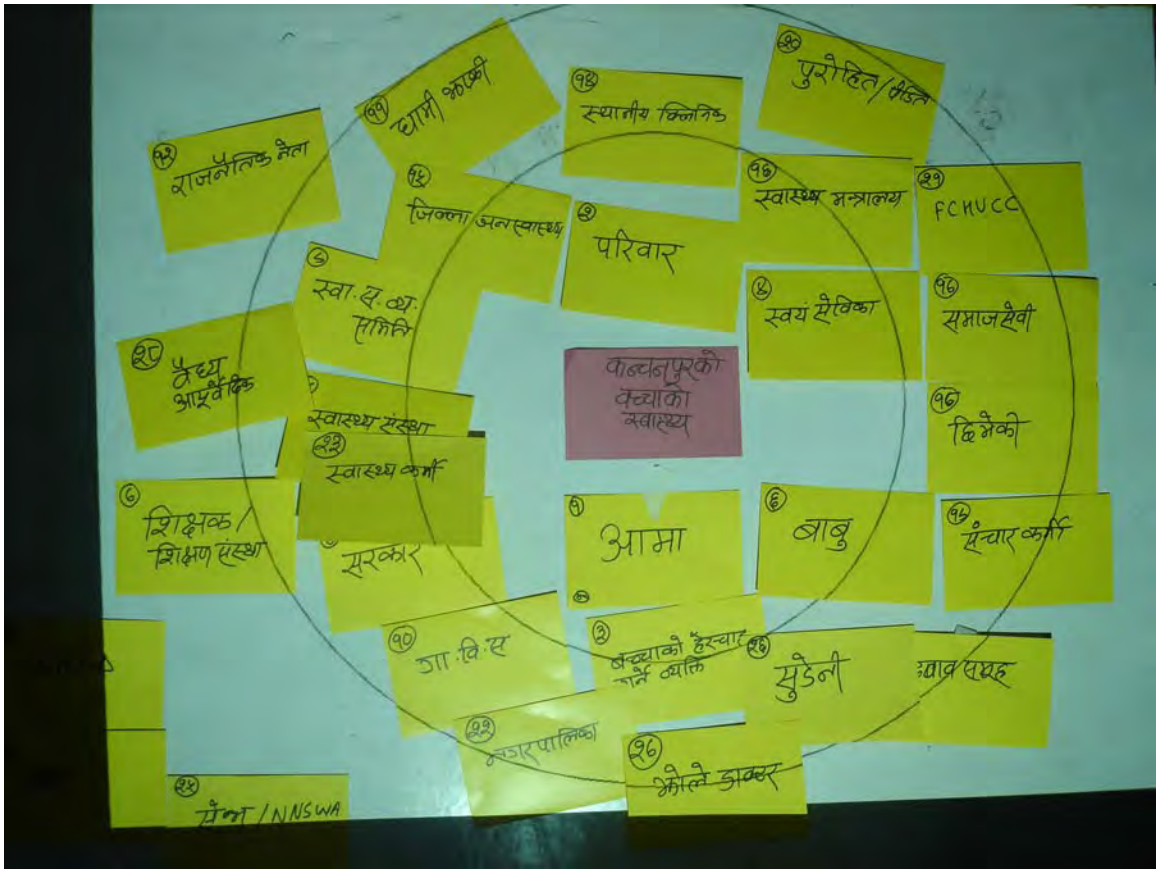


Fig: Mapping the local system of Child Survival Project, Kanchanpur

Vision:

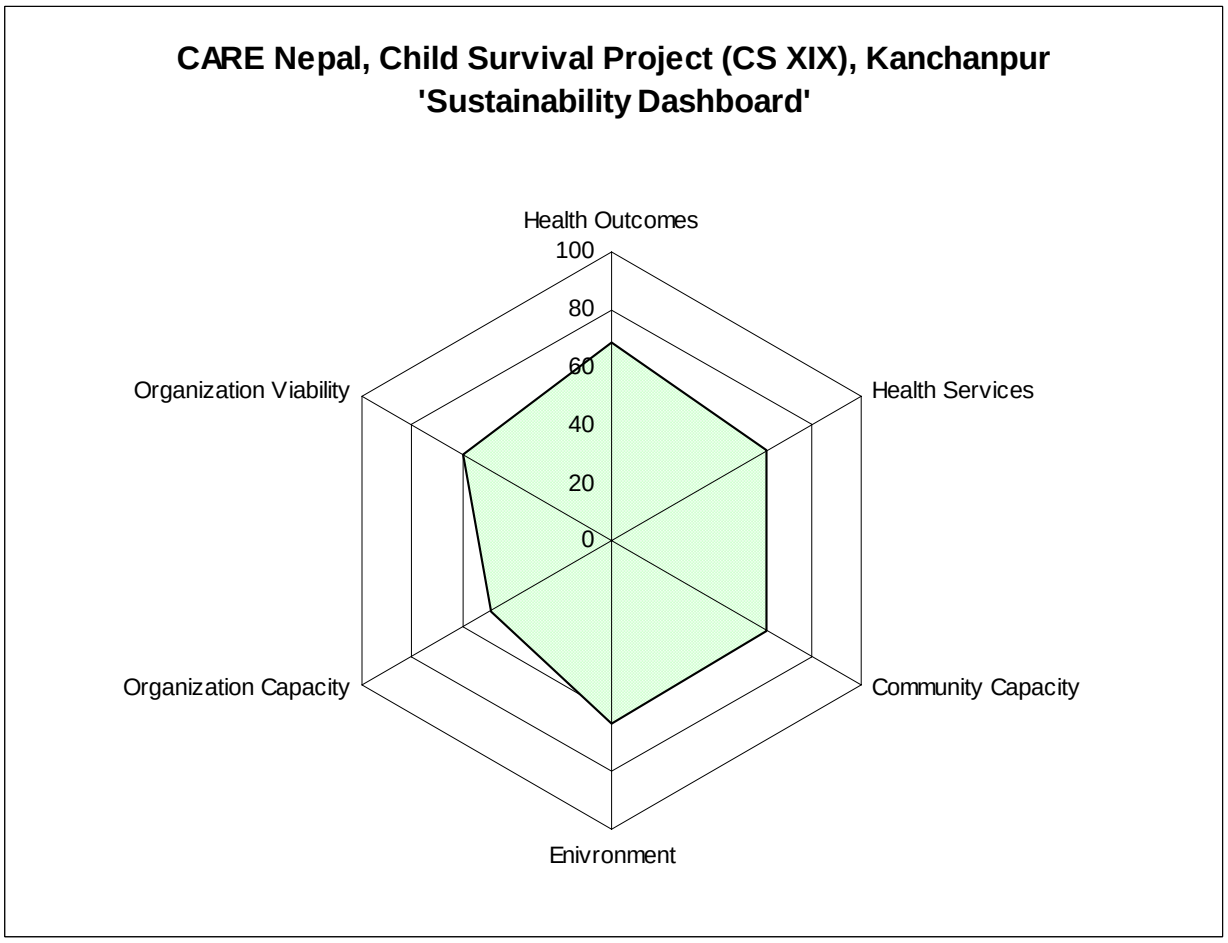
"All women and children in Kanchapur will be healthy and prosper and will survive with wellbeing and dignity"

Indicators:

Components	Dimension/Elements	Source	Measured value	Score value	Remarks
Health and Health Services	Health Outcomes				
	Percentage of births attended by skilled personnel	LQAS	31	41	
	Percentage of under six months children exclusively breastfed	LQAS	70	73.3	
	Percentage of sick children receiving increased fluid and continued feeding during illness	LQAS	89	89	
	Percentage of underweight children (based on weight for age)	Nutrition survey	20	70	
	Health Services				
	Health facilities with separate place for ANC and PNC maintaining privacy	Discussion	60	60	
	Health facilities having adequate stock of Cotrim	NFHP TSV Data	98	98	
	Percentage of health workers treating pneumonia with Cotrim	HWS	56	56	
	Percentage of health workers able to correctly diagnose pneumonia case based on respiratory rate	HWS	33.8	34	
	Percentage of FCHVs having four key commodities (ORS, Cotrim, Condom, Pills) available	NFHP TSV Data	63	63	
Organizational	Organizational capacity				
	Percentage of health workers received CB-IMCI training	Training	90	80	
	Health facilities having functional community drug program (updated register, income-expenditure, transparency, decision making etc)	Discussion	4	80	
	Percentage of health facilities having Supervision and Monitoring Plan	Discussion	30	20	
	Percentage of health facilities having annual plan of action	Discussion	20	13.3	
	Organizational viability				
	Extent to which HFOMC meetings are regular and decisions are implemented	Discussion	3	40	
	HFOMCs receiving cash or in-kind support from external agencies	Qualitative survey	4	80	
	Health facilities having own plan of action and implemented activities with their own initiation	Qualitative survey	2	40	
	FCHVs facilitating regular meeting of mother groups to discuss on maternal and child health issues	Qualitative survey	4	80	
Community and Environment	Community Capacity				
	Percentage of mothers group meeting regularly to discuss on health issues	Qualitative survey	4	80	
	Capacity of HFOMC to analyze local context, issues, need and capacity	Discussion	1.5	30	
	Capacity of FCHV Coordination committee to implement local level health awareness activities	Discussion	2.5	50	
	Capacity of local groups to discuss, analyze local issues on equity and social justice	Discussion	4	80	
	Extent of cooperation, cohesiveness and social harmony in community groups	Discussion	3.5	70	
	Enabling Environment				
	Percentage of health staff positions filled	AR, FWRHD	100	80	
	Extent to which project activities has been disturbed by conflict	Discussion	2.5	50	
	Capacity of local NGO partners to carryout child survival activities	Discussion	3	60	

Dash Board:

Fig 1: Sustainability Dashboard of CARE Nepal, Child Survival Project, Kanchanpur



Conclusion

Based on the analysis of the dashboard, following actions are recommended for moving Child Survival project, Kanchanpur more towards sustainability.

- The progress of the project towards health outcomes, health services and community capacity was found encouraging.
- Efforts should be made to ensure that the progress made on health outcome, health services and community capacity be sustained over the period of time.
- For the remaining period, project should focus on strengthening systems to improve organizational capacity, organizational viability and enabling environment. For this, project should identify actors that have roles on creating enabling environment and to strengthen organizational viability and mobilize them for sustainable health outcomes.

- Project should regularly monitor its progress based on the CSSA framework and take appropriate actions. This system should be institutionalized within district public health system.

References

Sarriot, E. Sustaining Child Survival: Many roads to choose, but do we have a map?, CSTS/CORE, Sept 2002.

CARE Nepal, Child Survival in Kanchanpur district Nepal, Final Evaluation Report, December 2003.

Sarriot, E. et. al. Qualitative research to make practical sense of sustainability in primary health care projects implemented by non-governmental organization. Int J Health Plann Mgmt 2004; 19: 3-22.

CSTS. Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven Maternal and Child Health Projects. Sept 2004.

CARE Nepal and District Public Health Office Kanchanpur
Child Survival Sustainability Assessment Workshop
28-29 May 2006
Mahendranagar, Kanchanpur

Objectives:

- To orient district level Child Survival stakeholders on the concept of program sustainability in context of Child Survival Projects
- To review project progress in context of program sustainability based on Child Survival Sustainability Framework
- To build common understanding on improving program sustainability in context of Child Survival Project in Kanchanpur

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Agenda:
Day I, Sunday 28 May 2006

Time	Agenda	Responsible
10.00 – 10.15	Introduction, Objectives and Agenda sharing	KPur
10.15 – 11.00	What is Sustainability and Program Sustainability?	R Sharan
11.00 – 1.00	Child Survival Sustainability Assessment Framework • Framework sharing • Indicator transformation (concept and process) • Experience of other PVOs and other countries • CSSA Frame: "What it is?" and "What it is not?" • Usefulness of applying CSSA Framework • Challenges and constrains	Jagat
1.00 – 2.00	LUNCH BREAK	
2.00 – 2.30	Brief review of Child Survival Project • Goal and Objectives • Strategic approach	CSP RO
2.00 – 4.30	Applying CSSA in context of CSP Kanchanpur • Identifying and defining local context • Visioning Exercise for Child Survival in Kanchanpur	Deepak
4.30 – 5.00	Wrap up and Summarization	

Agenda:
Day II, Monday 29 May 2006

Time	Agenda	Responsible
10.00 – 10.15	Review of Day I	Notetaker
10.15 – 11.00	Indicators for measurements • Indicator sharing and discussion • Group Exercise to finalize indicators • Sharing indicators by groups • Finalization of indicators	R Sharan
11.00 – 1.00	Finalizing indicator values • Group Exercise to finalize indicator value • Sharing indicator value by groups • Discussion and drawing conclusion	Deepak
1.00 – 2.00	LUNCH BREAK	
2.00 – 3.00	Preparing Sustainability DashBoard • Dashboard sharing • Discussion, Interpretation and Conclusion drawing	Jagat
3.00 – 4.30	Drawing conclusion and Common Understanding • Drawing conclusion, based on application of CSSA • Suggestions and Recommendations • Next actions for sustained child survival in Kanchanpur	R Sharan
4.30 – 5.00	Wrap up and Summarization and Closing	

CARE Nepal and District Public Health Office Kanchanpur
Child Survival Sustainability Assessment Workshop
28-29 May 2006
Mahendranagar, Kanchanpur

List of Participants

SN	Name of Participants	Position	Organization
1.	Bhagat Sing BK	Coordinator	Samajik Samanta Abhiyan
2.	Bhanmati Khadayat	FCHV Coordination Committee	FCHV, Daijee VDC
3.	Bhanu Dev Bhatt	Program officer	District Development Committee
4.	Bharati Singh	FCHV Coordination Committee	FCHV, Mahendranagar Municipality
5.	Bijay Bharati	Research Monitoring and Documentation Specialist	CARE, Child Survival Project, Regional Office
6.	Deepak Paudel	Community Health Specialist	CARE Kathmandu
7.	Dharani Bhatt	Reporter	Chhure Times (media)
8.	Ganesh Datt Joshi	Focal person	District Public Health Office, Kanchanpur
9.	Gomati Chandh	FCHV Coordination Committee	Suda
10.	Indra Adhikari	Partnership and Advocacy Specialist	CARE, Child Survival Project, Regional Office
11.	Induka Karki	Health Supervisor	CARE, Child Survival Project, Kanchanpur
12.	Jagat Basnet	Resource Person	New Era
13.	Karan Datta Aawasthi	Secretary	NFPA
14.	Keshav Datt Bhatt	CDPA	Pipladi
15.	Kusum Shahi	Health Supervisor	CARE, Child Survival Project, Kanchanpur
16.	Nandha Raj Bhatt	AHW	Laxmipur SHP
17.	Nava Raj Joshi	AHW	Jimmuwa HP
18.	Ram Sharan Pyakurel	Project Manager	CARE, Child Survival Project, Regional Office
19.	Ratan Singh Bist	AHW	Pitamber HP
20.	Shanti Raut	Health Supervisor	CARE, Child Survival Project, Kanchanpur
21.	Upendra Dhungel	Asst Institutional Capacity Building Officer	CARE, Child Survival Project, Kanchanpur
22.	Yagya Raj Chataut	Program Coordinator	FOLD

Child Survival and Health Grants Program Project Summary

Dec-27-2007

CARE
(Nepal)

General Project Information:

Cooperative Agreement Number:	**GHS-A-00-03-00014-00**
Project Grant Cycle:	**19**
Project Dates:	**(9/30/2003 - 9/29/2007)**
Project Type:	**Expanded Impact**
CARE Headquarters Technical Backstop:	**Khrist Roy**
Field Program Manager:	**Ram Sharan Pyakurel**
Midterm Evaluator:	**Baburam Devkota**
Final Evaluator:	**Ranjani Gopinath**
USAID Mission Contact:	**Dharmphal Raman**

Field Program Manager Information:

Name: **Ram Sharan Pyakurel**
Address: CARE-DOTI (PN-41 CSP II - Bal Bachau in Far West)REGIONAL OFFICE
Doti , Far Western Province -
Phone: 094-420518
Fax: 944-420519
E-mail: cspdoti@carenepal.org

Funding Information:

USAID Funding:(US $): $2,500,000 **PVO match:(US $)** $833,378

Project Information:

Description:

CARE's Bal Bachau (Child Survival) project's goal is to reduce child and maternal mortality and morbidity.
This a second phase under Expanded Impact Category. The project will work within the framework of IMCI although the main components are pneumonia case management, micronutrients- IFA, Vitamin A, deworming and Iodine Deficiency disorder, control of diarrheal diseases, and maternal and newborn care.

CB-IMCI, health system strengthening, quality assurance through PDQ, strengthening of Community drug program and Behavior Change Communication within BEHAVE framework will be primary technical strategies of the project.

The project will work for strengthening of local capacity by working with health facilities, local NGO/CBO's, coordination committees of Female Community Health Volunteers and enhancing of community ownership of health facilities through strengthened Health Facility Management Committees and local government (VDC/DDC) involvement in community health.

The project will work on cross cutting strategies like - linkages with other line agencies of HMG and stakeholders, focus on disadvantaged (ethnic or low-caste groups), integration with other CARE projects (in line with MSP approach of C-IMCI), promotion of community cohesion (through conduction of do no harm training and use of reflect approach) and focus on gender and child rights issues.

Location:

District of Kanchanpur, Doti, Dadeldhura and Bajhang.

Project Partners	Partner Type	Subgrant Amount
Feminist Dalit Organisation - Doti	Subgrantee	$20,716.00
SOURCE-Nepal - Doti	Subgrantee	$21,815.00
Nepal Red-Cross Society - Bajhang	Subgrantee	$8,678.00
Nepal National Dalit Society Welfare Organization (NNDSWO) - Dadeldhura	Subgrantee	$10,386.00
SAPROS Nepal- Bajhang	Collaborating Partner	
FCHV Coordination Committee - Kanchanpur	Subgrantee	$25,027.00
Samajik Samanta Abhiyah - Kanchanpur	Subgrantee	$8,553.00
Woman Deliverance Society - Dadeldhura	Subgrantee	$11,909.00
Bhumidev Samajik Jagaran Samittee - Bajhang	Subgrantee	$8,839.00
AWARD-Nepal - Bajhang	Subgrantee	$795.00
District Health Offices - Dadeldhura	Subgrantee	$6,719.00
District Health Office - Doti	Subgrantee	$18,214.00
Subgrant Total		$141,651.00

General Strategies Planned:

Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Participatory Learning in Action
Lot Quality Assurance Sampling
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ CS Project Team	PVOs/NGOs (Int'l./US) Local NGO Networked Group	Traditional Healers	National MOH Dist. Health System Health Facility Staff Other National Ministry	Health CBOs Other CBOs CHWs

Interventions/Program Components:

Nutrition (35 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Comp. Feed. from 6 mos.
- Maternal Nutrition

Pneumonia Case Management (35 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (30 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Hand Washing
- Feeding/Breastfeeding
- Case Mngmnt./Counseling

Target Beneficiaries:

Infants < 12 months:	31,388
Children 12-23 months:	30,167
Children 0-23 months:	61,555
Children 24-59 months:	84,949
Children 0-59 Months	146,504
Women 15-49 years:	227,220
Population of Target Area:	931,054

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**350**	**1149**	**30.5%**	**4.2**
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**468**	**643**	**72.8%**	**7.4**
Percentage of children age 0-23 months whose births were attended by skilled health personnel	**263**	**1310**	**20.1%**	**3.3**
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**775**	**1310**	**59.2%**	**4.9**
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	**230**	**313**	**73.5%**	**10.7**
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	**223**	**273**	**81.7%**	**11.7**
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**107**	**181**	**59.1%**	**13.3**
Percentage of children age 12-23 months who received a measles vaccine	**484**	**619**	**78.2%**	**7.7**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	**9**	**1310**	**0.7%**	**0.6**
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	**1127**	**1310**	**86.0%**	**5.4**
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	**87**	**445**	**19.6%**	**5.5**
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	**351**	**1310**	**26.8%**	**3.7**

Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**125**	**1310**	**9.5%**	**2.3**

Comments for Rapid Catch Indicators

* General Comment ; our intervention % is different in Kanchanpur where we wil implementing MNC (25 % of effort) and will reduce other interventions accordingly (% can be seen in project description)

1. The calculation of conifdence limit was done on the basis of a conservative estimate of design effect 2 but the true design effect may be slightly less or more than 2
2. Indicator # 11 is not a true represenation of the situation since it is an unprompted question in the KPC 2000 + module and it is unlikely that a mother will mention all four condition of handwashing . Either the indicator or the question needs to be revised
3. The calculation of indicator 13 is a little off base . We are trying to clean up data more and will report again on it
2. I am enclosing another table of RAPID CATCH indicators for Kanchanpur . We decided that our targets as well as results are too different for other districts i.e., Bajhang , Doti , Dadeldhura (second phase districts alone) which is covered in the table above

Rapid Catch Priority Indicators
Kanchanpur district

Indicator Numerator Denominator Percentage 95%Confidence interval

1. Percentage of children age 0-23 months who are underweight (-2SD from the median weight-for-age, according to the WHO/NCHS reference population). 112 296 38 30.1 – 46.2
2. Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child1 92 135 68 55.5 – 78.7
3. Percentage of children age 0-23 months whose births were attended by skilled health personnel (Note: Includes doctor, nurse, ANM, MCHW) 71 300 24 17.3 – 31.4
4. Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child (by card or reported verbally by mother) 196 300 65 57.1 – 71.8
5. Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours. 34 68 50 32.7 – 67.2
6. Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours. 59 71 83 66.1 – 92.9
7. Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday. 26 35 74 48.0 – 90.7
8. Percentage of children age 12-23 months who received a measles vaccine. 111 128 87 75.4 – 93.5
9. Percentage of children age 0-23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night. 5 300 2 0.4 – 5.7
10. Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection. 113 300 38 30.0 – 46.0
11. Percentage of mothers with children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and a after attending to a child who has defecated (washed hands in all four conditions). 48 300 16 10.7 – 23.1
12. Percentage of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment. 252 300 84 77.0 – 89.3
13. Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks. 86 148 58 46.1 – 69.3

KPC Survey
QUESTIONNAIRE

Identification

Household number | | | | |

Interview Date *
DD / MM / YY | | | |

Interviewer's Name: _____
District: ----------
VDC/Municipality:_____ Ward No.___
Name of the village: _____
Cluster Number _____

Information about mother

Name: _____ Age: (In Completed Years) * _____
Ethnicity: _____

Q N	Questions and filters	Answers	Answer or Code	Skip
2	Can you read?	1. Illiterate 2. Not been to school but can read & write 3. Primary (1-5 Class) 4. Middle (6-8 Class) 5. Secondary (9-10 Class) 6. Higher (above 10th Class		
3 *	How many children living in this household are under age five?	Number of children	_____ child	
4 *	How many of those children are your biological children? (You gave birth)	Number of children	_____ child	

Information about the youngest child who is below 24 months

QN	Questions and filters	Answers	Answer or Code	Skip

_____

_____

5 *	Based on response to Q 4 record the name, age and sex of two youngest children				
	Name	Sex	Age	Date of birth	
	Child 1 _____	_____	months	_____/_____/_____	
	(youngest child)			DD MM YY	
	Child 2 _____	_____		_____/_____/_____	
				DD MM YY	
	Calculate the age difference _____ months				
6	Who takes care of (Name) when you are away from the home?	A Mother/Father-in-law B Husband C Elder siblings D Other family members E Relatives F Neighbors/friends G Leave alone at home X Other	_____		

Nutrition and breastfeeding

QN	Question and filter	Answers	Answer	Skip

			or Code	
7 *	Did you ever breastfeed (Name)?	1Yes 0 No	___	**If No, Skip to 17**
8 *	How long after birth did you first put (Name) to the breast?	1 During the first hour of delivery 2 During 1to 8 hours of delivery 3 More than 8 hours of Delivery 4 Don't' remember 8 Others (Specify)	_____	
9	Did you squeeze the fluid from the nipple when you first put (Name) to the breast	1 Yes 0 No 9 Don't remember	_____	
10	During the first three days after delivery, did you give (NAME) the liquid that came from your breasts? ***(Use the local term for colostrums)***	1 Yes 0 No 9 Don't remember	_____	
11	During the first three days after delivery, did you give (NAME) anything else to eat or drink before feeding him/her breast milk?	1 Yes 0 No 9 Don't remember	_____	**If No or Don't remember Skip 13**
12	What did you give (NAME)? **Do not read the list** **Multiple responses possible** **Record all mentioned**	A Plain water B Commercially produced infant Formula C Other Milk (cow/buffalo/goat milk) D Fruit juice E Tea/ Coffee F Other liquid (Sugar water, Grape Water, Carbonated drink, Soup) G Cord, yogurt H Herbal traditional medicine X Other (specify) _____	_____ _____ _____ _____	
13	Are you currently breast feeding (Name)?	1 Yes 0 No	_____	**If yes, Skip 15**
14	For how long did you breastfeed (NAME)?	Number of months ***If less than one month, record "00" months.***	_____ months	
15	Does (Name) eat or drink anything else besides breast milk? ***In case mother says no confirm it by probing that nothing means no water or any solids.***	1 Yes 0 No	_____	**If No. Skip 17**
16	When did you start giving solid/semi solid food to (Name)?	Age of child	_____	
17	At what age of child should a mother start giving her child foods or liquids in addition to breast milk?	Age of child	_____ months	
18 *	Now I would like to ask you about the types of liquids (NAME) drank yesterday during the day and at night (during the last 24 hours). Did (NAME) drink any of the following liquids yesterday during the day or at night? **Read the list of liquids (a through x starting with "breastmilk").** **Multiple responses possible** **Record all mentioned**	A Breast milk B Plain water C Commercially produced infant formula D Other milk such as tinned, powdered or fresh animal milk E Fruit Juice F Any other liquids such as sugar water flavored water, tea, coffee, carbonated drinks, infusions, or soup broth X Other (specify) _____	_____ _____ _____ _____	

19	Did (Name) drink any liquid from bottle with nipple yesterday day or night	1 Yes 0 No	_____	
20	Now I would like to ask you about the types of foods and number of times (NAME) ate yesterday during the day and at night (during the last 24 hours). Did (NAME) eat any of the following foods yesterday during the day or at night? **Read the list of foods** **Multiple answers possible** **all the foods and number of times given to the child**	0 Nothing A Any food made grains (e.g. millet sorghum, maize, rice wheat porridge or other local grains) B Pumpkin, red or yellow yarn or squash, carrots or red sweet potatoes C Any other food made from root or tubers (e.g. white potatoes, white yarns, manioc, cassava) D Any green leafy vegetables E Mango, Papaya F Any other fruits and vegetables (e.g. bananas, apples/sauce, avocados, tomatoes) G Citrus fruits (lemon/orange) H Meat, poultry fish, shellfish or eggs I Food made from legumes (lentils, beans, soybeans, pulses or peanuts) J Cheese or yogurt K Any food made with oil fat, or butter X Others---------	---- times ---- times --- times ---- times ---- times --- times --- times --- times --- times --- times ---times	
21	How many times did you give the above foods, besides liquid, to (Name) yesterday day and night? ***(Count only full meal of the child, do not count liquids and other small snacks)***	-------- Number of times Don't remember	__times	
22	Do you know about Sarbottam pitho (Super flour)?	1 Yes 0 No	_____	**If No, Skip 26**
23	Is Surbottam pitho available in the local market?	1 Yes 0 No 9 Don't know	_____	
24	Did you give Sarbottam pitho to (Name) yesterday day and night?	1 Yes 0 No	_____	
25	Will you explain how do you prepare Sarbottam Pitho(Super flour)?	1 Correct 0 Incorrect	_____	
26	Do you have kitchen garden/land for producing vegetables and fruits?	1 Yes 0 No	_____	
27 27 A	If yes, Observe the kitchen garden and not if Vitamin A rich fruits and vegetables are available. If no kitchen garden, observe whether there is availability of vitamin A rich fruits/vegetables at home or not	1 Available 0 Not available 1 Available 0 Not available	_____	

Growth monitoring

28	Was (Name) weighed at birth?	1 Yes 0 No 9 Don't know	_____	
29	Does (Name) have a growth-monitoring card? (Observe the card)	1 Yes 0 No	_____	**If No, Skip 31**
30	Has the (Name) been weighed in the last four months? (Look at the growth monitoring card	1 Yes 0 No		

	and record ,if available)		____gm	

Maternal and newborn care

QN	Question and filter	Answers	Answer or Code	Skip
31	Did you see anyone for ANC (antenatal care) while you were pregnant with (Name)? (e.g. HP, mobile clinic or others)	1 Yes 0 No	_____	**If No, Skip 37**
32	Whom did you see? **Only one answer**	1 Doctor 2 ANM 3 MCHW 4 TBA 5 FCHV 8 Other	_____	
33	Do you have a maternal health card?	1 Yes 0 No	_____	**If No, Skip 35**
34	Record from the card A Number of ANC visits B Number of TT vaccines	Number of visits Number of TT vaccines	_____ _____	
35	How many times did you see someone for care during the Pregnancy? **For woman not having card**	Number of times	_____	
36	During your ANC were you counseled on the following? **Multiple answer possible** **Read the options**	1. Deliver preparation 2. Breast feeding 3. Child spacing 4. Immunization 5. Danger signs of pregnancy 6. No counseling	_____ _____ _____ _____ _____	
37 *	Before you gave birth to (Name) did you receive an injection (TT vaccine) in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?	1 Yes 0 No 9 Don't know	_____	**If No or Don't know, Skip 39**
38 *	How many times did you receive such an injection (TT vaccine)?	1 Once 2 Twice 3 More than two times 9 Don't know	_____	
39	During pregnancy did you consume iron pills/folic acid?	1 Yes 0 No 9 Do not know		**If No or Do not know, skip 41**
40	For how long did you consume iron pills/folic acid?	Number of ---------days	_____	
41	What danger signs/symptoms require immediate medical assistance during delivery? **Multiple responses possible Record all responses** **Don't read the options**	O Do not know A Fast and difficult breathing B Bleeding C Swelling on legs, arms, face D High fever E High blood pressure F Blurred vision G Anemia H Persistent vomiting I Failure to gain weight during pregnancy X Others----------		
42	Now I would like to ask you about the time when you gave birth to (Name)	A Home B Other's home C Cow shed/ shed		

	Where did you give birth to (Name)?	D Hospital G Private clinic/Medical shop H PHC I HP/Sub HP X Other---------	_____	
43	Was it pre-decided on issues like where to go for delivery (Name), and to take the help of family in difficulty?	1 Yes 0 No		**If No Skip 45**
44	If pre-decided with the family, what was the decision? **Multiple responses possible** **Read all the responses**	A To take the help of TBA B To arrange expenses for delivery C Where to stay after delivery D Where to go in difficulty E Which transportation to be used F Helping person/organization for Transportation G Whom to conduct the household Work X Other----------	_____ _____ _____ _____	
45	Who assisted you with (Name's) delivery? **Multiple responses possible**	O No One A Doctor B Nurse/ANM C MCHW D Trained TBA E Untrained TBA F Female Community Health Volunteer G Family member _____ Specify relationship H AHW X Other _____	_____	**If No one Skip 47**
46	What type of assistance you got during delivery? **Multiple responses possible**. **Record all the responses**	A Massage B To cut the cord C To remove the placenta D Bathe the baby E Give food in time F Consolation/Patience G Check up the internal organs H Help to take out the baby during Delivery X Other (Specify) _____	_____ _____ _____ _____ _____ _____ _____ _____ _____	
47	At the delivery of (Name) who tied and cut the cord?	1 Doctor 2 Nurse/ANM/ 3 MCHW 4 Trained TBA 5 Untrained TBA 6 FCHV 7 Family member _____ Specify relationship O Self 8 Other _____Specify	_____	
48	What instrument was used to cut the cord?	0 Don't remember 1. New razor blade 2. Old blade 3. Sickle/knife 4. Bamboo blade 8 Other-------	_____	

49	**Depending on the response to <u>Q 42</u>, ask this question, if the birth of (Name) was <u>NOT</u> given in the hospital.** Was a safe birth kit used during this delivery of (Name)?	1 Yes 0 No 9 Don't Know/not certain	_____	**If No or Don't know, Skip 51**
50	From where was the safe birth kit brought?	9 Don't know 1 Medical store 2 General store 3 From TBA/FCHVs 8 Other places -----	_____	
51	What type of immediate care was given to the newborn (Name)? **Multiple responses possible** **Record all responses**	0 Don't Know A Bathed B Wrapped with warm cloth C Fed the newborn immediately D Cleaned face/Nose E Clean eyes F Wipe body X Other	_____ _____ _____ _____ _____ _____	
52	What danger signs/symptoms require immediate medical assistance during delivery? **Multiple responses possible** **Note all the responses**	O Don't know A Prolonged labour B Convulsions C Excessive bleeding D Placenta not expelled within 30 minutes after delivery of baby E High fever F Lower abdominal pain G Mal-presentation X Other _____	_____ _____ _____ ___	
53	After (Name) was born, did anyone check on your health?	1 Yes 0 No	_____	**If No, Skip 58**
54	By whom were you checked?	1 Hospital/Doctor 2 Nurse/ANM 3 MCHW 4 Trained TBA 8 Other _____	_____	
55	How many days or weeks after the delivery of (Name) did the first check take place?	1 Within two days 2 Within 3-5 days 3 Within 5-9 days 4 After 10 days 8 Other (Specify) _____	_____	
56	At that time, did the person check on (Name)'s health as well?	1 Yes 0 No	_____	**If No Skip 58**
57	If checked, what advice was given? **Multiple responses possible**	1 Protect from Infection 2 Bathe the baby timely 3 Visit HF in fever or when looks pale 4 About breastfeeding 5 Keep the baby warm 6 Immunization 7 Family Planning 8 Other (Specify) _____	_____	

58	What danger signs/symptoms requires medical advice / help/ treatment after delivery? **Multiple responses possible** **Note all the responses**	O Don't Know A Fever B Excessive bleeding C Vaginal discharge with foul smell D Lower abdominal pain E Convulsions F Redness around the breast G Pale and weak H Repeated vomiting X Other (Specify) _____	_____ _____ _____ _____ ____	
59	What signs shows that the newborn is ill? **Multiple responses possible** **Note all the responses**	O Don't Know A Unable to suck the breast B Fast or difficult breathing C Not active D Redness around the cord E Red/discharging eyes F Convulsions G Cyanosis H Crying I Jaundice J Stiffness K High fever X Other (Specify) _____	_____ _____ _____ _____ ____	
60	Did you take a **Vitamin A** capsule within 45 days of delivering (Name)	1 Yes 0 No 9 Don't know	_____	

Child immunization

61 *	Do you have a card where (Name's) vaccinations are written down? If Yes, ask ' May I see it please?'	1 Yes, seen by the interviewer 2 Not available (lost/misplaced/not in home) 0 Never had a card 9 Don't know	_____	**If No or Don't know Skip 63**
62 *	Record information exactly as it appears on (name's vaccination card	**Day Month Year** **BCG** _____ _____ _____ **Polio 1** _____ _____ _____ **Polio 2** _____ _____ _ _____ **Polio 3** _____ _____ _____ **DPT 1** _____ _____ _____ **DPT 2** _____ _____ _____ **DPT 3** _____ _____ _ _____ **Measles** _____ _____ _____ **Vitamin A** _____ _____ _____		
63 *	Did (Name) ever receive an injection to prevent measles? **For child not having EPI card**	1 Yes 0 No 9 Don't know		
64	Ask about other vaccine **Circle number of time vaccine given**	BCG: 0, 1 DPT: 0, 1, 2, 3 Polio: 0, 1, 2, 3		

Integrated Management of Childhood Illness (IMCI)

65 *	Sometimes children get sick and need to receive care or treatment for illness. What are the signs of illness that would indicate your child needs treatment? **Do not prompt** **Record all the responses**	O Do not know A Looks unwell or not playing Normally B Not eating or drinking C Lethargic or difficult to walk D High fever E Fast or difficult breathing F Vomits everything H Convulsions X Others (Specify) _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
66 *	Did (Name) experience any of the following in the past two weeks? **Read choices and record all mentioned by the respondents**	O No problem at all A Blood in stool B Diarrhoea C Cough D Difficult breathing E Fast breathing/short, quick Breathing F Fever G Malaria H Convulsions X Others (Specify) _____ _____	_____ _ _____ _ _____ _ _____ _ _____ _ _____ _ _____ _ _____ _	
67 *	When (Name) was sick, was he/she offered less than usual to <u>drink</u>, about the same amount or more than usual to drink? **Read the options**	9 Donot know 1 More than usual 2 same as usual 3 Less than ususl 0 others------	_____	
68 *	When (Name) was sick, was he/she offered less than usual to <u>eat</u>, about the same amount or more than usual to eat? **Read the options**	9 Donot know 1. More than usual 2. same as usual 3. Less than ususl 0 others------	_____	

<u>Other Childhood Diseases</u>

Diarrhoea

69	After how many loose stools do you consider (NAME) to be suffering from diarrhea?	Number of loose stool	_____ times	
	Based on <u>Q 66</u> Ask Questions from 70 to 75 if the child experienced diarrhea in the last two weeks			
70	What did you do (Name) to treat diarrhea? **Multiple response is possible** **Record all the responses**	O Did nothing A Sugar, salt, Solution/ORS B Cereal based ORT C Injection D Rice Starch E Antibiotics or anti-diarrheals F Herbal Medicine G Infusion such as saline X Others (Specify) _____	_____ _____ _____ _____ _____ _____ _____ _____	

71	Did you Breastfeeding (Name) during diarrhea? **Read the options**	1 More than usual 2 Same as usual 3 Less than usual 4 Stopped completely 5 Baby can not suck the milk	_____	
72	Was (Name) offered less than usual to drink, about the same amount or more than usual to drink? **Read the options**	1 More than usual 2 Same as usual 3 Less than usual 4 Stopped completely 5 Only breast milk	_____	
73	Was (Name) offered solid/semi solid food less than usual to eat, about the same amount, or more than usual to eat? **Read the options**	1 More than usual 2 Same as usual 3 Less than usual 4 Stopped completely 5 Only breast milk	_____	
74	Did you seek treatment (advice) from someone for (Name) for diarrhea?	1 Yes 0 No	_____	**If No, Skip 76**
75	Whom did you seek advice or treatment for diarrhea? **(Multiple response possible record all mentioned)**	A Hospital B Health post/sub health post/PHC C Out reach Clinic D Private clinic/medical shop E Community Health Workers (VHW/MCHW) F. FCHV G. Faith healer H. Relatives, neighbors and friends X Other (Specify) _____	_____	
76	What danger sing/symptoms would cause you to seek advice or treatment (Name) diarrhea? **Multiple responses possible** **Record all mentioned**	O Don't Know A Vomiting B Fever C Dry mouth, sunken eyes, sunken fontanel D Continuation of loose motion (14 days or more) E Blood in stool F Loss of appetite G Weakness or tiredness H Got Thirsty X Other (Specify) _____	_____ _____ _____ _____ _____ _____ _____ _____	
77	What are the sings of diarrheal dehydration? **Multiple responses possible** **Record all mentioned**	O Don't know A Eyes look dull and sunken B No tears C Dry tongue D Thirsty E Skin becomes dry and when pulled goes back slowly X Other (Specify)	_____ _____ _____ _____ _____ _____ _____	
78	Do you know how to prepare ORS?	1 Yes 0 No	_____	**If No, Skip 80**
79	If yes, ask her how does she prepare it?	1. Prepares correctly 0 Prepares incorrectly	_____	
80	Do you have a toilet at your home?	1 Yes 0 No	_____	**If No, Skip 82**
81	If yes, do you use it?	1 Yes, use regularly 2 Yes, use occasionally 0 No	_____	

82 *	When do you wash your hands with soap/ash? **Do not prompt** **Record all mentioned**	A.Never B Before preparing and having food C Before feeding children D After defecation E After attending a child who has defecated X Others-----	_____ _____ _____ _____ _____	

Acute Respiratory Infection (ARI)

83	What sings/symptoms does a child with pneumonia (Local term) have? **Do not prompt** **Multiple responses possible** **Record all**	O Don't Know A. Fast or difficult breathing B. Chest indrawing C. Fever D. Cough E. Unable to suck/drink F. Unable to wake up X. Other ---------(Specify)	_____ _____ _____ _____ _____ _____	
84	What are the signs / symptoms of respiratory infection that would cause you to take (Name) to a health facility? **Do not prompt** **Multiple responses possible** **Record all the responses**	O Don't know A. Fast or difficult breathing B. Chest indrawing C. Loss of appetite D. Fever E. Cough F. Unable to suck/drink G. Unable to wake up X Other (Specify) _____	_____ _____ _____ _____ ____	
85	Where do you seek treatment first when your child (Name) suffers with Pneumonia?	1. Hospital/Doctor 2. PHC 3. SHP/HP 4. AHW/MCHW 5 Private clinics 6 FCHVS 8 Other (Specify) _____	_____	
Based on <u>Q 66</u> Ask Questions 86 and 87, if the child experienced Fast breathing in the last two weeks				
86	Did you seek advice or treatment for the cough/fast breathing?	1 Yes 0 No	_____	**If No. Skip 88**
87	Where and with whom did you seek advice or treatment? **Multiple responses possible**	A Hospital B Health post/sub HP C Primary health care center D ANM, AHW E Private Clinics F Community Health Workers (VHW/MCHW) G FCHV H TBA I Faith healers J Relatives/Friends K Ayurvedic Vaidya X Others (Specify)	_____	

<u>Malaria</u>

QN	Question and filter	Answers	Answer or Code	Skip
88	Has (Name) been ill with fever with chill and sweating in the last two weeks?	1 Yes 0 No 9 Don't Know	_____	**If No or Don't know Skip 90**

89	If Yes, where was (Name) taken? **Multiple responses possible**	A. Nowhere B. Hospital/doctor C. Nurse/ANM/CMA D. SHP/HP E. VHW/MCHW F. Private clinic G. FCHVS X. Other--------	_____	
90	Do you know how malaria can be prevented? **Do not prompt** **Multiple responses possible** **Record all mentioned**	O Don't know A. Use bed net B. Use wire nets to the doors and windows C. Make smoke D. Cover the pits E. Use Mosquito coils F. Clean the surroundings G. Insecticide Spraying X Other (Specify)	_____ _____ _____ _____ _____ _____ _____ _____ _____	
91 *	Do you have any bed nets in your house?	1 Yes 0 No	_____	**If No Skip 94**
92 *	Who slept under the bed-nets last night? **Circle all that apply**	1 Child (Name) 2 Respondent 3. Other family members---------- 8 Other individuals (Specify) _____	_____ _____ _____	
93 *	Was the bed-net ever soaked or dipped in a liquid to repel mosquito or bugs?	1 Yes 0 No 9 Don't know	_____	

HIV/AIDS

94 *	Have you ever heard of an illness called AIDS?	1 Yes 0 No	_____	**If No, Skip 96**
95*	What can a person do to avoid getting AIDS or the virus that causes AIDS? **Multiple responses possible** **Record all mentioned**	O Do not know A Nothing B Abstain from sex C Use condom D Limit sex to one partner/stay faithful to one partner E Limit number of sexual partners F Avoid sex with prostitute G Avoid intercourse with persons of the same sex H Avoid sex with the persons who have many sex partners I Avoid sex with persons who inject drug intravenously J Avoid blood transfusions K Avoid injection sharing L Avoid kissing M Protect from mosquioto bites N Seek protection from traditional healers P Avoid sharing razor, blades X Others _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	

Other Questions

96	Do you know any FCHV close to your place?	1 Yes 0 NO		**If no,Skip 98**

97	If yes,What kinds of services are provided by FCHVs? **(Multiple response possible, record all responses)**	O Don't know A. Vitamin A distribution B. ORS distribution C. Condom/Pills distribution D. Health education and counseling E. Mothers groups meeting F. Vaccination X Others		
98	What kinds of salt do you use in your Home?	1.Powder salt(iodized) 2.Crystal(Dhike) salt 3. Others----------		
99	Have you heard about iodine?	1.yes 0 No		**If no, Skip 101**
100	What are the different sources of iodine?	1.salt 8.others----------		
101	Are you involved in any local community organization (mothers groups, micro-credit groups, forest consumer groups etc.)?	1. yes 0. No 3.Do not exist		**If no or do not exist skip 103**
102	If yes, what types of activities are carried out by the organization?	1 Health related 2. Income generating 3. Agriculture/ forestry related 8. others---------		

Anthropometry

QN	Question and filter	Answers	Answer or Code	Skip
103	May I weigh (Name) and measure his height	1 Yes 0 No		
104	If mother agrees, take the weight and height of the child and measure the MUAC of Child and mother. Weight of (Name) Height of (Name) MUAC of child (Name) MUAC of Mother (Name)	 _____ gm _____ cm _____ cm _____ cm		

Thanks the respondent

Supervisor's Name: _____ Checked Date | | | |

DD / MM / YY

* Indicate the information at must be collected as of RAPID CATCH Questionnaire

HEALTH FACILITY FORM

District:

Designation: (Please Circle)
01 Medical Officer
02 HA/Sr. AHW
03 Staff Nurse
04 AHW
05 ANM
06 MCHW
07 VHW
08 Other----------

Name of respondent:

Type of health facility: (Please circle)
01 PHCC
02 HP
03 SHP

Name of Health facility:
VDC/Municipality:

A. Staffing

S.#	Position	Sanctioned Posts (#)	Filled Posts (#)	Present on the day of visit (#)	Deputation (from/to)
1.	Medical Officer				
2.	HA/ Sr. AHW				
3.	Staff Nurse				
4.	AHW				
5.	ANM				
6.	MCHW				
7.	VHW				
8.	Lab assistant				

B. Stock situation: (Record these information from stock register / LMIS forms)

S.#	List of Commodities	Stock Balance Update as of ---------	Emergency Order Point (EOP)	If stock< EOP Did you made emergency order?
1.	Iron/folic acid tab.			
2.	ORS packets			
3.	Cotrim. Pd. (100/20) tab.			
4.	Vit. A capsules			
5.	Chloroquine tab.			
6.	Primaquine tab.			
7.	Condom			
8.	Pills			
9.	Depo povera			
10.	IUD(Copper T)			

Note: LMIS form/register not filled.

C. Essential instruments/ equipment

(Ask if following instruments/equipment are available in the health facility and check if they are operational/functional)

S. #	List of instruments	Available		Functional		Currently in use Y/N
		Yes	No	Yes	No	
1.	Stethoscope					
2.	Foetoscope					
3.	BP instrument					

4.	Weighing machine - Adult - Baby - Infant					
5.	Vaginal speculum					
6.	Labor table					
7.	Measuring tape (for height measurement)					
8.	ARI timer					
9.	ORT corner set(Glass, plastic jug, spoon, ORS pkt., bucket)					
10	Safe Delivery Kit					

D. Infrastructure and facilities(Please circle in the appropriate answers)

1. Is separate/ private space for ANC/PNC check up available?
   01 Yes 02 No
2. Do you have standard treatment schedule? 01 Yes 02 No
3. How many PHC/ORC clinics do you have? ---------
4. How many PHC/ORC clinics are regularly functioning?---------
5. How many EPI clinics do you have? -------
6. How many EPI clinics are regularly functioning? --------
7. Do you have regular supply of vaccines from the district health office?
   01 Yes 02 No
8. Do you have any plan on what and when to provide different health services?
   01 Yes 02 No
9. Do you have following guidelines available at your health facility?

a. Diarrhea management guideline 01 Yes 02 No
b. ARI management guideline 01 Yes 02 No
c. Nutrition related guideline 01 Yes 02 No
d. Maternal and child health guideline 01 Yes 02 No
e. others---------- 01 Yes 02 No

10. Is IEC material displayed on following components?

a. Child health (including CDD/ARI, IMCI etc) 01 Yes 02 No
b. Maternal health (ANC, NC, PNC) 01 Yes 02 No
c. HIV/AIDS 01 Yes 02 No
d. others--------- 01 Yes 02 No

E. Supervision (Please circle in the appropriate answer or fill numbers)

1. Did any one made supervision visits to your health facility within last six months?
   01 Yes 02 No
2. If yes, number of supervision visits:
   a. From Central/ Regional level ---------- times
   b. From district level ---------- times
   c. From other health facilities (PHCC/HP) ---------- times
   d. From NGOs ---------- times
3. Do you have supervision plan? (Please check) 01 Yes 02 No
4. Did you/your staff made any planned supervision visits to health facilities, PHC/ORC, EPI clinic, Volunteers with in last six months? 01 Yes 02 No
5. If yes, number of supervision visits
   a. to health facilities --------times
   b. to FCHVs --------times
   c. PHC/ORC--------times
   d. EPI clinic--------times

Name of Interviewer/Date **Name of Supervisor/Date**

In Depth Interview Guideline for District Public Health Officer
***Bal Bachau* (Child Survival Project) Final Evaluation**
CARE Nepal

Name of the Interviewer_____
Date_____

Greet
Introduce Self
Preamble: You would be aware that the Government of Nepal and CARE Nepal have been implementing a Child Survival Program, *Bal Bachau* program in this district/in four districts. We are here as to understand the successes and failures of the program and seek your perspective. This will enable us to disseminate good practices and also improve upon the strategies that did not work, in our future projects. This will be a confidential discussion and your name will not be attached to your quotes. We anticipate the discussion to take about half an hour. Do we have your permission to proceed?
If response no, move to the next available DPHO.
If response yes, continue with the questions.

Location_____

Name of the Interviewee_____

Total months of association with the Project:_____
Total years in the health department:_____

1. What have been the main activities of the project in the communities of your district?
2. What activities have been carried out with the health department at district, PHCCs, HPs and SHP level? If not forthcoming probe for training, meetings, joint supervisions, private public partnerships and health facility strengthening.
3. What has been your role in these activities? Please describe.
4. How has this project affected the ability/skills of health staff in your district? Do you think that the Capacity Building strategy delivered expected outcomes? What gaps do you think still exist in the capacities of the health workers to deal with child survival?
5. How will the Capacity Building of the new health functionaries be funded after the project?
6. Its been reported that FCHVs drop out of the program. Has the project addressed this issue? How would you tackle this problem in the coming future?
7. Are you a participant in the HFMC? Please describe its activities and some achievements. Please also identify areas which you feel the functioning of the HFMC has not been as envisioned.

8. How has this project affected the way care is being provided in your health facilities? Is there still scope for improvement? If so how do your think that can be brought about?
9. How has the project affected the availability of essential drugs and equipment to your health functionaries? If it has improved then do you think it will continue to remain following the closure of the project?
10. Were you a participant in the PDQ process? If so how useful do you perceive the process to be?
11. Does the District health facility have a history of partnering with local NGOs for health/other activities, prior to the project?
12. What has been the role of local NGOs in this project?
13. Have you partnered with any NGOs for activities other than those of the CSP? If yes for which activities?
14. How has the project activities affected the community perception of public health delivery systems? Has it improved, remains the same?
15. How has the morbidity profile among children changed in your district in the last five years? Can you substantiate with some statistics?
16. In your opinion has the project reached the marginalized groups? Have you observed any increase in number of these communities accessing care?
17. Has the project met the desired results anticipated by you? If so how, If not in which aspects?
18. Could you highlight some of the successes of the program?
19. How will the district administration sustain (ask those for which have received positive responses)
    - the interest generated in the community;
    - skills which have been strengthened (refreshers)
    - future skill upgradation (fresh trainings)
    - ensuring quality care through HF
    - mainstreaming of marginalized communities
    - partnership with NGOs, civil societies, DDCs, VDCs, FCHVCCs

Thank you indeed for your insightful remarks.

Focus Group Discussion Topic Guide for Mothers Group and Reproductive Age Group Mothers who are not members of Mothers Group
***Bal Bachau* (Child Survival Project) Final Evaluation**
CARE Nepal

Topic	Discussion/Transitions
Introduction and Greeting	Facilitator's and Observer's name
Purpose of FGD	We have been working on a project to improve maternal and child health in Name of the District/Ilaka/Village. Because you are mothers and belong to this mothers group we would like to learn from you about your opinions about **pregnancy, nutrition, labor, delivery, postpartum, child care, nutrition, childhood diseases and related** issues. Your ideas can help us understand how our project performed and inform us about any changes that we can incorporate in our future projects to improve maternal and child care. May we begin the discussion? (Allow for those who do not want to participate in the discussion leave).
No right or wrong answers	We would just like to know your frank opinion. There is no right or wrong answers to any of the questions. This is not a test. We just want to learn from you
Length of time	The discussion would take about an hour
Talking to one another	As we will be discussing about each of your opinions, it will be important that we do not talk at once because we will want to hear each other so we should not talk together. Every body should try and participate and every body will be given a chance to put forth their views. If you have any queries they would be addressed at the end
Explain note taking Confidentiality	(Name of Observer/reporter) will be writing down some of the things that we will be talking so we can remember later. Does anyone object? We are the only ones who will know your names, we will not use any names in our reports
Checking understanding **Clarify**	Does everyone understand what I have said? Does anyone have any questions?
Participants introductions (Warm up)	**Please introduce yourselves**
Let us begin:	NOTE: This is a comprehensive list of questions and will be modified following feedback from all concerned.

General	• Have you heard of the *Bal Bachau* program?
	• What activities are being done under this program? • Has this program made any difference to the way you lead your lives in your community?
	• Can you name some good things about the program • Can you name some things that the program should have done in addition to its activities?
	• Is there a FCHV who visits your community? What is her name? How often does she visit? • Which other functionary visits your community? What are their names? How frequently do hey visit your community?
Child Health	• What are the common health problems among children of this community?
	• What do you do when children fall ill? • Is it possible to prevent children from falling ill? • How can we prevent children from falling ill?
Diarrhea Control	• Can diarrhea be prevented? • Can you name a few things that can be done to prevent diarrhea? • Does everyone in the community practice these behaviors? • If no then why?
	• What do you do when children get diarrhea? (go to the appropriate question based on the responses of the women) • Where do you get ORS from? • How do you prepare the ORS? • What do give your child to eat and drink during an episode of Diarrhea? • Where did you learn to do this? (restrict this question for positive practices) • How do you know that the child needs to see a doctor? (check for responses on signs of dehydration) • Has there been a complicated diarrhea case in your community or a death (death is an optional q and may be deleted based on CARE Nepal's perspective on appropriateness). Why do you think that happened? • What role has the health worker or the FCHV played to prevent and control diarrhea in your community? • What do you think will happen once CARE staff visiting your communities and the project comes to an end? (could use this as a final question or may be used after every intervention to get specifics on sustainability of practices)
Pneumonia Control	• Let us talk about pneumonia now. Are there children in your community who have had pneumonia?

	• Why do children get pneumonia, can we prevent this? • Can you name a few things that can be done to prevent pneumonia especially in young infants?
	• How do you know that a child has pneumonia? • What do you do when the child has pneumonia? • What do give your child to eat and drink during an episode of pneumonia? • Where did you learn to do this? (restrict this question for positive practices) • Has there been a complicated diarrhea case in your community or a death (death is an optional q and may be deleted based on CARE Nepal's perspective on appropriateness). Why do you think that happened? • What role has the health worker or the FCHV played to prevent and control diarrhea in your community? Probe and document details on respiration counting, provision of drugs (cotrim) and follow up.
Nutrition	• Now we will discuss a little about what you feed your children and the pregnant lactating mothers and how. Let us start with young infants.
	• When is the infant put to breast? Why? • How long is the infant breast fed • When is the infant given additional food? • For any positive practices enquire – why do you do so or who taught you to do so? • What additional food is given to children? • What about when infants are infants get ill? • How can you tell that a child hasn't been fed properly • Are there any malnourished children in your community? • What role has the health worker or the FCHV played in improving the state of these children? • Has there been malnourished child who fell ill and got complications or died? (Death is an optional q and may be deleted based on CARE Nepal's perspective on appropriateness).
	• What kind of salt you use at home? Why? (if answer iodated salt then ask the next question) • Why should we use the two-child salt? What happens if we don't? • Is worm infestation a problem among children? • What problems can worm infestation lead to in children? • Have children received any medication for this from anyone? If yes how often? • Are you aware of Vitamin A? • What does Vitamin A do?

	• Have children in your community received Vitamin A? If yes from whom? • What kind of foods provides children with rich nutrients? Name them
Immunization	• Let us talk about childhood vaccines now. Can you name some of the vaccines that children receive in infancy?
	• What diseases do these vaccines prevent? • Who vaccinates the children of your community? • Are there mothers who do not get their children vaccinated? Why? • Can a child of 2-3 years who has not been vaccinated also be vaccinated? • What role has the health worker or the FCHV played in ensuring vaccination for your children? • Have there been any children with DPT/Polio or measles in the past 4-5 years? Were there any complications?
Malaria (for Kanchanpur)	• Is Malaria a problem in your community? • What causes malaria? • Can anything be done to prevent malaria?
	• Have you been provided with nets under the project? • If yes do you use them? Are there community members who do not use them, then why?
	• When do you assume that a person has malaria? • What do you do then? • What does the health care giver do when you report to them? • What do you advice and drugs do you receive from the Health Worker? • What role has the health worker or the FCHV played in malaria prevention and treatment? • What other activities are being undertaken by the health workers to control malaria (probe further on spraying activities and its acceptance)
Maternal Health	• Now we will talk a little about pregnancy and related topics. • How many of you are pregnant at the moment?
	• Can you name some complications associated with pregnancy? • Why are these caused? • Can you name a few things a woman can do to prevent these complications? • What are the preferences regarding aspects of behavior/care of complications in P/L-D/PP?
Antenatal Care	• How many times should a woman be seen by the HW during pregnancy? • Are there some women who do not? If so then why?

	• What does the HW do during a check up? • What drugs and advice do you receive from the HW? • Why is TT important? How many TT should a pregnant woman receive? • Why is IFA important? Do women consume the IFA that is given by the HW? If not why? • What kind of salt should a pregnant woman consume? Why?
	• What kind of diet should a pregnant woman consume and why? • What kind of diet do women in this community generally consume? • Has FCHV and HW's visit made any changes in the practices of the community? • Do women generally get any rest during pregnancy? • What roles do your husband and mothers-in-law play during pregnancy?
Delivery	• Where do women generally deliver in your community? • What preparations are made for delivery (probe to find out about a birth plan) • Are you aware of a Safety Delivery Kit? • Is it available in your community? • Why should it be used? • Who delivers the baby? • Probe for reasons of not using a skilled birth attendant if response is such. • What is done immediately after the delivery • What role has the FCHV or the HW played in deliveries in the community? • Has there been a complicated pregnancy, where women had to betaken to a bigger hospital? What happened – positive and negative consequences and why? • What has been the experience of women who deliver in the health center (needs to be replaced with appropriate word) • Have there been any deaths of a pregnant woman? Why do you think that happened? – ? (Death is an optional q and may be deleted based on CARE Nepal's perspective on appropriateness). • What community resources or support systems exist to assist women in getting care? – (this can be used as a general question at the end of the discussion to ascertain community resources and support to the health of mother and child.)
Postnatal Care	• What care is provided to a women post delivery? • Is the woman given any check up by HW? • What else does she receive from the HW? • What complications can arise during the postpartum phase?

	• Has there been any such example in the community? • Why did it happen and what could have been done to prevent that?
Family Planning	• How many children would you like to have? • What age difference would you like to maintain between your children and why? • What do you do to maintain this difference? • What role does the FCHV/HW play in supporting this? • What facilities are available to you to achieve this? • Do you receive support from your husband or mother-in-law?
HIV/AIDS	• Have you heard of HIV/AIDS? • How does the disease spread? • What can we do to prevent this? • Where did you receive this information from?
Additional questions based on specific interventions	• Is there a child club in your community? • What are the activities of this club and the impact of these activities? • Is there a *Dabi* group in your community? How has this affected the community? • Is there a community drug depot in a facility close to you? • Is there a separate cotrim depot as well? • How has this affected the community? • Has there been a special drive to identify and care for the malnourished community? If yes how has that affected the community? • Have you heard the radio program • Have you watched the documentary? • Have you seen the TV serial?
Sustainability questions	• What do you think will happen once CARE staff visiting your communities and the project comes to an end? • Have you ever shared the information you received through the project with other community members? • What can be done so that the good things you have learnt and facilities being provided to you continue?
Summary	Mention main themes discussed and participant's responses. Is there anything else that we talked about that I forgot to mention?
Closure	Thank you for your time. Do you have any questions that you would like to ask? I am not sure that I will be able to answer all of them, but I will try (Record all questions do not lecture)

During FGD

Recorder should keep notes by making cards for each section/question. Note responses on each card of respondents by numbering them as R-1 from the left of the facilitator and going clockwise around the room. Note if participants seem to all be agreeing with a statement or if there is a visible disagreement among participants when someone is speaking. Write down any quotes on a separate sheet provided for quotes. Note those quotes which are emphatic, well articulated and summarize the general feelings of the group for a particular topic. Responses during the introduction (all questions from introduction of facilitators through participant introductions) can be grouped together.

After conducting the FGD

Immediately after the session the facilitators should:

a. Review the notes for clarity and understanding
b. Compare and record observations about the group not readily clear from the notes
c. Discuss and record any insights or ideas that the interview created while they are fresh in your mind
d. Prepare a summary of the FGD for your team

In Depth Interview Guideline for Medical Officer PHCC/HP in Charge/SHP Incharge
***Bal Bachau* (Child Survival Project) Final Evaluation**
CARE Nepal

Name of the Interviewer_____
Date_____

Greet
Introduce Self
Preamble: You would be aware that the Government of Nepal and CARE Nepal have been implementing a Child Survival Program, *Bal Bachau* program in this district/in four districts. We are here as to understand the successes and failures of the program and seek your perspective. This will enable us to disseminate good practices and also improve upon the strategies that did not work, in our future projects. This will be a confidential discussion and your name will not be attached to your quotes. We anticipate the discussion to take about half an hour. Do we have your permission to proceed?
If response no, move to the next available facility manager.
If response yes, continue with the questions.

Location_____
Type of Facility_____

Name of the Interviewee_____
Total months of association with the Project:_____
Total months in the current facility:_____
Staff in the facility

Staff Position	Sanctioned	Functioning	Trained in C-IMCI (ask and fill this column after you have asked question 2)

1. What have been the main activities of the project in the communities of your district?
2. What activities have been carried out with the staff of PHCC? If not forthcoming probe for training, meetings, joint supervisions, private public partnerships and health facility strengthening. Name the kind of trainings.
3. Could you please answer a few technical questions for us?
   a) How do you recognize a child with pneumonia?
      - Fast breathing (more than 60/min for 0-2 months children and more than 50/min for 2-60 months children)
      - Other (specify) _____
      - Don't Know
   b) How do you recognize a child with dehydration?
      - Dull and sunken eyes
      - Tearing
      - Dry tongue
      - Thirsty
      - Dry/non elastic skin
      - Other _____

4. Did these trainings and activities succeed in bridging the perceived gaps? If yes to what extent?
5. What has been your role in these activities? Please describe.
6. Are you supported by your supervisors (those who are from the higher facility say district) in implementing your activities? What guidance have you received and how often do you receive it? Has the frequency changed over the project duration? Please name some of the visitors who have made supervisory visit to your facility in the last three months.
7. How are you being supported by the VDCs/DDCs? Please list the contribution.
8. How has this project affected the ability/skills of health staff in your facility? Do you think that the Capacity Building strategy delivered expected outcomes? What gaps do you think still exist in the capacities of the health workers to deal with child survival?
9. Do you believe that the capacity building activities will continue after the project?
10. How has the project affected the support of FCHVs to your facility and your community activities?
11. Have you experienced FCHV drop outs in your area? Has the project addressed this issue? How would you tackle this problem in the coming future?
12. Are you a participant in the HFMC/CMC? Please describe its activities and some achievements. Please also identify areas which you feel the functioning of the HFMC/CMC has not been as envisioned.

13. How has this project affected the way care is being provided in your health facilities? Is there still scope for improvement? If so how do your think that can be brought about?
14. How has the project affected the availability of essential drugs and equipment to your health functionaries? If it has improved then do you think it will continue to remain following the closure of the project? Observe drug availability.

ORS	y/n	##
Cotrim	y/n	##
IFA	y/n	##
Vitamin A	y/n	##

15. How has the CDP program changed since the project onset?
16. Were you a participant in the PDQ process? If so how useful do you perceive the process to be?
17. Does your PHCC have a history of partnering with local NGOs for health/other activities, prior to the project?
18. What has been the role of local NGOs in this project?
19. Have you partnered with any NGOs for activities other than those of the CSP? If yes for which activities?
20. How has the project activities affected the community perception of public health delivery systems? Has it improved, remains the same?
21. How has the morbidity profile among children changed in your district in the last five years? Can you substantiate with some statistics?
22. How has the project affected the community health behaviors? Can you give us some examples?
23. In your opinion has the project reached the marginalized groups? Have you observed any increase in number of these communities accessing care?
24. Has the project met the desired results anticipated by you? If so how, If not in which aspects?
25. What has been the role of your facility staff in engaging community members?
26. Could you highlight some of the successes of the program?
27. How will the district administration sustain (ask those for which have received positive responses)
    - the interest generated in the community;
    - skills which have been strengthened (refreshers)
    - future skill upgradation (fresh trainings)
    - ensuring quality care through HF
    - mainstreaming of marginalized communities
    - partnership with NGOs, civil societies, DDCs, VDCs, FCHVCCs

Thank you indeed for your insightful remarks.

In Depth Interview Guideline for Project Advisory Committee
***Bal Bachau* (Child Survival Project) Final Evaluation**
CARE Nepal

Name of the Interviewer_____

Date_____

Greet

Introduce Self

Preamble: You would be aware that the Government of Nepal and CARE Nepal have been implementing a Child Survival Program, Bal Bachau program in this district/in four districts. We are here as to understand the successes and failures of the program and seek your perspective so as to share to a larger group of people the initiatives that worked and also improve upon the strategies that did not work, in our future projects. This will be a confidential discussion and your name will not be attached to your quotes. We anticipate the discussion to take 30-45 minutes. Do we have your permission to proceed?

If response no, move to the next available PAC member.

If response yes, continue with the questions.

Location_____

Name of the Interviewee_____

Designation_____

Months served as a PAC Member_____

1. What is the role of the PAC?

2. Is the role defined for the PAC adequate? If not how would you want to see the role expanded?

3. Can you name some of the activities you undertake as a PAC member? (Probe further for attending meetings, role in problem solving, field visits, monitoring/supervision)

4. Through which modality do you receive information about the project activities?

5. Could you please briefly tell us what your understanding of the project strategies or activities is?

6. In your opinion have these activities of the project been appropriate for the needs of the community?

7. And have the strategies been developed in response to the environment of the community and health delivery systems?

8. Project has made focused efforts to bring the marginalized communities into its fold. In your opinion has this focus translated into results?

9. In your opinion how has the PAC been contributing to the Project?

10. It is often felt that once a project comes to an end the special focus it brings begins to dilute. In your opinion which are the aspects which will continue beyond project life and why? (Probe to cover all aspects of sustainability if it is not forthcoming)

11. Which are the aspects which may not continue and why?

12. Can CARE make any efforts in the final stages of the project or through its participation in various advocacy forums to address outcomes which may not sustain?

13. What were the major successes of the project?

14. Could you list some areas which did not work as well?

15. Would you like to add anything further that may help us design improved projects in the future?

Thank the interviewee for their time and invite to the debrief workshop if appropriate.

In Depth Interview Guideline for MCHW/VHW
***Bal Bachau* (Child Survival Project) Final Evaluation**
CARE Nepal

Name of the Interviewer_____
Date_____

Greet
Introduce Self
Preamble: You would be aware that the Government and CARE have been implementing a Child Survival Program, *Bal Bachau* program in this communities. We are here as to understand the successes and failures of the program and seek your perspective. This will enable us to disseminate good practices and also improve upon the strategies that did not work, in our future projects. This will be a confidential discussion and your name will not be attached to your quotes. We anticipate the discussion to take about half an hour. Do we have your permission to proceed?
If response no, move to the next available worker.
If response yes, continue with the questions.

Location_____
Type of worker and facility_____

Name of the Interviewee_____
Total months of association with the Project:_____
Total months in the current position:_____

1. What have been the main activities of the project in the communities of your district?
2. What activities have been carried out with the staff of PHCC? If not forthcoming probe for training, meetings, joint supervisions, private public partnerships and health facility strengthening. Name the kind of trainings.
3. Could you please answer a few technical questions for us?
   a) How do you recognize a child with pneumonia?
      - Fast breathing (more than 60/min for 0-2 months children and more than 50/min for 2-60 months children)
      - Other (specify) _____
      - Don't Know
   b) How do you recognize a child with dehydration?
      - Dull and sunken eyes
      - Tearing
      - Dry tongue
      - Thirsty
      - Dry/non elastic skin
      - Other __

c) What are the key messages you would give a pregnant woman?
- 4 ANC check ups
- 2 TT injections
- Better nutrition and rest
- IFA and deworming
- Skilled birth attendant
- Birth planning
- Safe delivery kit
- Post natal Vitamin A

4. Did these trainings and activities succeed in bridging the perceived gaps? If yes to what extent?
5. What has been your role in these activities? Please describe.
6. Are you supported by your supervisors (those who are from the higher facility say district) in implementing your activities? What guidance have you received and how often do you receive it? Has the frequency changed over the project duration? Please name some of the visitors who have made supervisory visit to your facility in the last three months.
7. How are you being supported by the VDCs? Please list the contribution.
8. How has this project affected the ability/skills of health staff in your facility? Do you think that the Capacity Building strategy delivered expected outcomes? What gaps do you think still exist in the capacities of the health workers to deal with child survival?
9. Do you believe that the capacity building activities will continue after the project?
10. How has the project affected the support of FCHVs to your facility and your community activities?
11. Have you experienced FCHV drop outs in your area? Has the project addressed this issue? How would you tackle this problem in the coming future?
12. Is there a FCHV CC in your area? How has this affected the functioning of the FCHVs? What role do you play in these CCs?
13. What is your relationship with the FCHVs? What role do they perform and how does this differ from your role?
14. Are you a participant in the HFMC/CMC? Please describe its activities and some achievements. Please also identify areas which you feel the functioning of the HFMC/CMC has not been as envisioned.
15. How has this project affected the way care is being provided in your health facilities? Is there still scope for improvement? If so how do your think that can be brought about?
16. How has the project affected the availability of essential drugs and equipment to your health functionaries? If it has improved then do you

think it will continue to remain following the closure of the project?
Observe drug availability.

ORS	y/n	##
Cotrim	y/n	##
IFA	y/n	##
Vitamin A	y/n	##

17. How has the CDP program changed since the project onset?
18. How many mothers groups are there in your coverage area? How often do you get to interact with them? Do you think the mothers will continue to be grouped after the project staff stops visiting the communities? What can be done to sustain them?
19. What materials has the project provided to generate awareness and change behavior? Do you have some of these with you? Which tool did you think worked the best? Which will you use once the project comes to an end?
20. What has been the role of local NGOs in this project?
21. How has the project activities affected the community perception of public health delivery systems? Has it improved, remains the same?
22. How has the morbidity profile among children changed in your district in the last five years? Can you substantiate with some statistics?
23. How has the project affected the community health behaviors? Can you give us some examples?
24. What activities in your opinion will continue and which ones wont following the closure of the project?
25. Any other comments

Thank you indeed for your insightful remarks.

Bal Bachau (Child Survival Project) CARE Nepal
Framework for Final Evaluation (Qualitative)

Methodology and Tools

1. At Community Level

Groups/Individuals Addressed	Tools	Numbers/ District			
		Kanchanpur	Doti	Dadeldhura	Bajhang
Mother's Groups (MG)	Focus Group Discussions (FGDs)	6	6	6	6
Women of reproductive age group (non-members of the MG/husbands and MILs?	FGDs	4	4	4	4
FCHVs	In Depth Interviews (IDIs)/FGDs if time permits	5/2	5/2	5/2	5/2
Local Resource Persons	IDIs		2	2	
FCHV CC members	IDIs	2	1	1	
VDC members	IDIs	2	2	2	2
DDC members	IDIs	2	2	2	2
Dabi group members	FGDs	1-2	1	1	1
VHW/MCHW/ANMs	IDIs	5	5	5	5
Health facilities – SHP/HP/PHCCs	Facility assessments	4	4	4	4
HFMC members	IDIs	2	2	2	2
Community Health Management Committee members	IDIs	1	1	1	1
Child clubs	FGD	1			
Cotrim depots	Observation/meeting	1-2			
Traditional Healers	FGD/IDIs depending on availability		1/2	1/2	1/2

2. At District Level

Groups/Individuals Addressed	Tools	Numbers/ District			
		Kanchanpur	Doti	Dadeldhura	Bajhang
DPHO	IDIs	1	1	1	1
Private drug retailers	Meeting		1		
Civil Society	Meeting	1			
Political leaders	Meeting			1	
Media	Meeting				1
Other NGOs and INGOs (depending on availability)	Meeting	1			1
PAC Members	IDI	1		1	

2. Regional Level Meetings

- RDO
- Officials of SWC
- NGOs/INGOs (depending on availability)
- PAC Members

3. National Level Meetings

- NEPAS/NHTC
- PAC
- Other NGOs and INGOs (depending on availability)
- USAID
- SWC officials