Plan International USA, Inc.
d/b/a Plan USA

Local Innovation for Better Outcomes for Neonates Project (LIBON)

PLAN Nepal Child Survival Project XXII
Sunsari, Parsa, and Bara Districts of Nepal

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LIST OF ACRONYMS

AHW	Auxiliary Health Worker
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BCC	Behavior Change Communication
BPP	Birth Preparedness Package
CA	Contracting Agency
CB-IMCI	Community-based Integrated Management of Childhood Illness
CB-NCP	Community-based Neonatal Care Package
CBO	Community-based Organization
CDK	Clean Delivery Kit
CDP	Community Drug Program
CHD	Child Health Division (MoHP)
CHW	Community Health Worker
CHX	Chlorhexidine
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
CSSA	Child Survival Sustainability Assessment
CSTS+	Child Survival Technical Support +
CWC	Community Welfare Center (Bara NGO Partner)
DAG	Disadvantaged Group
DDC	District Development Committee
DHO	District Public Health Office
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DPHO	District Public Health Office
DTOT	District Training of Trainers
EOP	End of Project
FCHV	Female Community Health Volunteer
FE	Final Evaluation
FHD	Family Health Division (MoHP)
FP	Family Planning
GoN	Government of Nepal
HA	Health Assistant
HF	Health Facility
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HQ	Headquarters
HP	Health Post
IEC	Information, Education, Communication
IMCHO	Integrated Mother and Child Health Organization (Bara NGO Partner)
IMCI	Integrated Management of Childhood Illness
IOM	Institute of Medicine
ITN	Insecticide-treated Bednet
JHU	Johns Hopkins University
JSI	John Snow International
KPC	Knowledge, Practice and Coverage
LBW	Low Birth Weight
LIBON	Local Innovation for Better Outcomes for Neonates

LQAS	Lot Quality Assurance Sampling (statistical method)
MCHW	Maternal and Child Health Worker
M&E	Monitoring and Evaluation
MINI	Morang Innovative Neonatal Intervention
MNC	Maternal Neonatal (or Newborn) Care
MNCH	Maternal, Neonatal and Child Health
MoHP	Ministry of Health and Population
MOT	Mode of Transmission
MOU	Memorandum of Understanding
MTOT	Master Training of Trainers
NFHP	National Family Health Program
NGO	Non-governmental Organization
NHEICC	National Health Education and Information Communication Center
NHSP-IH	Nepal Health Sector Programme – Implementation Plan
NNH	Neonatal Health
NNM	Neonatal Mortality
OP	Output
OR	Operations Research
ORC	Outreach Clinic
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Center
PHCU	Primary Health Care Unit
PMP	Performance Monitoring Plan
PNC	Postnatal Care
POU	Point of Use
PSBI	Possible Severe Bacterial Infection
PVO	Private Voluntary Organization
PWG	Pregnant Women's Group
RCSD	Resource Center for Sustainable Development (Sunsari NGO Partner)
RHC	Reproductive Health Committee
RHCC	Reproductive Health Coordination Committee
RHFA	Rapid Health Facility Assessment
RYC	Ramgunj's Youth Club (Sunsari NGO partner)
SA	Supervision Area
SBA	Skilled Birth Attendance/Attendant
SHP	Sub Health Post
SLC	School Leaving Certificate
SM	Safe Motherhood
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TRM	Technical Reference Material
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization
WRA	Women of Reproductive Age

TABLE OF CONTENTS

ANNEXES

SECTION A: EXECUTIVE SUMMARY

LIBON has three impact-oriented and innovative sub-goals:

Sub-Goal 1: To reduce neonatal mortality in the districts of Sunsari and Parsa through the application of an integrated, community-based package of interventions and service delivery strategies.

Sub-Goal 2: To promote social inclusion and a fact-based decision making process for the planning and resource allocation of district-based child, maternal, and neonatal programs.

Sub-Goal 3: To assist the MOHP and other constituencies in the preparation and use of knowledge, policy, and investment products that will accelerate the reduction of neonatal mortality.

The LIBON project is a strong community based neonatal mortality reduction program based in three districts, Sunsari, Parsa and Bara in the Terai of Nepal where difficult terrain, limited communications, political unrest and extreme poverty and limited access to health services are the rule. The project focuses its key interventions to reach target populations of pregnant and post partum women and neonates and reaches more than 900,000 people. Key strategies to reduce maternal and neonatal mortality, improve family behaviors and increase access to quality services focus on the expansion of the Pregnant Women's Group implementing the new Government of Nepal's Community Based Neonatal Care Program (CB-NCP).

This LIBON strategy is closely linked to, and directly supports, the Ministry of Health and Population's new CB–NCP services particularly through LIBON's formation, training and support of Pregnant Women's Groups via the training and supportive supervision of Female Community Health Volunteers (FCHV). These FCHV's provide several major functions of support to the PWGs: 1) provide/administer certain supplies (iron, Vitamin A, de-worming medication); 2) organize, train, support and refer (and accompany) pregnant women in order to; 3) increase their access to prenatal, institutional delivery and post natal services and 4) link and inform health service providers on the needs of these women.

The LIBON PWG is a model of the empowerment of pregnant women to group together for support and advancement, meet regularly, and provide self and peer monitoring of key positive health behaviors, and to increase their access to prenatal, delivery and post natal services. The PWG model has significant support from the MOHP and has contributed to the development of Nepal's CB-NCP program. The operations research initiating the community based use of Chlorhexidine and Gentamycin was designed by LIBON as evidence based intervention to be added to the CB-NCP package.

Another key component of the LIBON project is the intense monitoring of project activities and interventions in a strong partnership between LIBON staff and central and district level Ministry of Public Health staff. This monitoring includes active monthly review of data at the sub health post, health post, and district levels with quarterly review at the central MOHP level. This regular data review is supported by the critical LIBON project input of LQAS baseline, Mid Term and (future) final data collection and analysis done jointly by LIBON and MOHP staff with faculty and staff from the Institute of Medicine (IOM). The development

of the capacity of IOM faculty and students to conduct LQAS is an integral part of LIBON's design.

A key major accomplishment of LIBON is the CB-NCP training that includes: the Training of Master Trainers, Training of Trainers and training staff at district, sub-district, health post and sub health post levels. These trained staff worked in turn to train more than 1250 FCHV's in the two new districts (Sunsari and Parsa). The project-trained FCHVs formed 237 PWGs in Sunsari and 115 groups in Parsa: FCHVs met monthly to organize, train and support these PWGs. In Bara, LIBON staff provided supportive supervision to FCHV's trained in Plan's previous two Child Survival grants that remained active and provided follow-up on the 323 PWGs who continue meeting some four years after the Bara CS project ended.

LIBON also developed and disseminated CB-NCP messages, including flip charts, key rings with laminated BCC messages and other materials. FCHV stressed these messages to PWG members in monthly meetings, thus reinforcing positive behavior changes. Mass media/radio messages were also developed to further support PW and family adoption of positive behaviors. The project's accomplishments are also attributed to the training provided and the subsequent improved services provided by the MOHP staff who provide prenatal care, institutional delivery and early and adequate neonatal and post natal care of themselves and their neonate as PWG members became aware of the importance of these services, and were able to abandon some of the stigma associated with pregnancy.

The project also developed approaches to include men, mothers in law and other decision makers to some extent in the PWG meetings to affect negative controls on women's access to services. Project interchanges with District and Village Development (DDC, VDC) and Health Management Committees (HMC) increased some financial incentives to FCHVs and PWGs and augmented health facility staffing. Finally, LIBON's participation in working groups and other meetings, documentation and sharing of data, operations research, and technical lessons learned strengthened support to advance government, NGO and international donor strategies and programs in neonatal health.

The MTE LQAS findings show Sunsari District has increased in almost all indicators, exceeding their EOP targets in many cases, including Skilled Birth Attendant delivery and post-natal check-ups, which were two of the greatest challenges in the other two Districts. Over half the LQAS indicators in Sunsari exceeded EOP targets (21 of the 39 indicators); 15 had improved: three indicators had declined from baseline. All the decreases in indicators were seen in that of the Coatrim for neonatal infection. This is reportedly due to the lack of supplies.

LQAS data revealed main issues in Parsa as: Low rates of four prenatal visits, low rate of post-delivery check-ups; lower rates of treatment of neonatal infection, and lower-than-national-average immunization rates. Post natal care access and quality are also reported low in the LQAS with the first check up post partum within 48 hours at about 30%. The rate of increase of most indicators in Parsa during the two years of the project is on target considering the short time elapsed since field-level training and Parsa's difficult operating environment. Ante natal care with four ANC visits has increased slightly.

Most LQAS indictors in Bara have fallen dramatically from 2006 indicators. Prenatal care coverage dropped significantly. Knowledge of neonatal danger signs decreased and

knowledge of danger signs during pregnancy and after delivery dropped more. Delivery by skilled health personnel up to a MCHW increased slightly. Interestingly, the knowledge of women in PWGs on neonatal danger signs did not decrease significantly and fully 323 (75%) of the PWGs remain active.

Constraints affecting the LIBON project include the difficult physical environment (distances and poor roads, limited electricity, poor communications, limited supplies, staff and equipment for services at facilities.) The security situation in the three districts has constrained project activities, increased stress and limited LIBON and MOHP staff providing services. Constraints caused by security situation are recognized but despite the limitations, LIBON and MOHP have continued their commitment to CB-NCP expansion.

Conclusions and Recommendations

LIBON Progress

LIBON's development and intensive implementation of the CB-NCP approach, training, monitoring/evaluation and supportive supervision, working directly with the MOHP from national to sub-health post and community levels has contributed significantly to the national scale up of the CB-NCP package and should continue.

Strategies for Success

Plan LIBON project has made significant progress through three main vehicles: an effective delivery model (PWGs); strong MOHP partnerships; strong local support by some VDC's to FCHV's and PWG's. This last was not part of the LIBON Design, but has proven invaluable to the success of a community-based program in a conflict-prone setting. It is in line with Plan's general methods of seeking to leverage local resources.

PWG Delivery Model and FCHV's

FCHV's have proved to be the lynchpin to positive maternal and neonatal outcomes: where they are literate, trained, and supported with both funds and supervisors, outcomes exceed expectations; the inverse also holds true (as was seen in Bara). Support via enabling conditions was sought with intensive collaboration between LIBON staff and the MOHP: joint development of the CB-NCP training/support package and its roll out as well as joint monitoring at various levels (SHP; PHC; Ilaka and District) has proven to be keys to success. The use of the PWG groups design was crucial because it allowed LIBON to build on eight years of experience in organizing and training FCHVs to identify, organize, train and support PW to increase care during pregnancy, delivery and post-partum, and to care for the neonate.

The PWG design also empowered pregnant women, reduced the stigma of pregnancy and increased their knowledge and promoted their access and use of services. The methodology has also recognized the critical role of other decision makers—mothers-in-law, husbands and PWG peers—and harnessed their support for pregnant women to access services and adopt positive behaviors. The use of self-reporting and community mapping within the PWG's supports identification and tracking of positive behaviors such as TT, four prenatal visits, post natal visits, etc. These self-monitoring exercises promote pregnant women via peer pressure to adopt positive behaviors and to seek services.

PWG Sustainability

Sustainability is a constant challenge to development programming. However, of the 430 PWGs previously formed in the pre-LIBON project in Bara, 323 (or 75%) PWGs are still functional as of August 2009. The main reasons for their sustainability are (1) support from VHWs/MCHWs, (2) supportive supervision and/or financial support from VDCs, (3) literate, motivated and active FCHVs, (4) sense of ownership by PWG/Mothers' Group, (5) live sharing of experiences of older members (now lactating mothers) during PWG meetings with pregnant women, (6) supply of PWG mat/Tikas and other materials, and (7) linkage of PWG meeting with ANC/PNC clinic or with primary health care outreach clinic.

FCHV's: Coverage and Incentives

In terms of coverage, areas with population-based FCHV's were found to perform higher than those with only 1 FCHV per VDC, no matter the population: Sunsari had population-based (and therefore more) FCHV's; Bara has only 1 per VDC. It is recommended by LIBON staff and confirmed by FCHV's and PWG members that a population-based FCHV distribution scheme be endorsed for scale-up.

In terms of incentives, the MOHP developed operational guidelines for an incentive scheme for targeted FCHV activities to improve CB neonatal care. The scheme rewards group FCHV results on five criteria: PW registered; PW counseled and delivered in a health facility; neonates weighed in the home; post-natal visits on 1st, 3rd and 7th day and, 29th day after delivery. Incentives are based on the entire FCHV group's performance. This scheme was developed deliberately, has the Minister's approval, and rewards the key FCHV cadre for specific actions. This MTE's findings reinforce those of the MINI trial in Nepal: that incentives overall improve FCHV performance and increase facility delivery rates among pregnant women.

De-Centralizing Support to CB-NCP: Look to the VDC's and Ilaka Reviews

Places where security has hindered MOHP staff and equipment deployment, some VDC's have picked up the slack and provided critical support—funds and SHP-level MOHP staff—to their communities, their FCHV's and their PWG's. The LIBON design could be adapted to develop a stronger and more de-centralized support role for sub-District-level agencies, particularly the DDC, VDC and HFMC to more formally support local health facilities and their staff, FCHV's, and PWGs. The MOHP can learn from the Ministry of Education's successes in accessing funds from the DDCs and VDCs.

Working closely with MOHP staff, LIBON supports monthly monitoring using MOHP data and performance reviews at the Ilaka level to assure progress, address constraints, ensure needed supplies, and make course corrections to the program as needed. These meetings have proven essential to enabling effective responses to program progress at the implementation level, where an ideal mix of management and staff can formulate action plans. It is recommended these Ilaka Review Meetings continue beyond the pilot.

Qualitative Data and Trend Analysis for Decision Making

Qualitative Data

In-depth analysis of patterns in the data or qualitative elucidation of causes was not as robust as quantitative analysis. There is thus a response to individual indicators and actions agreed to resolve them, but less of an overall strategic approach. There is also not complementary qualitative data that is collected; while field-level staff (both LIBON and MOHP) often

understand these issues, it is not systematically captured or documented for institutional learning and possible policy information.

The LQAS methodology contributes much to LIBON's capacity to monitor individual objectives with reliable data and has built capacity for LQAS in the IOM and MOHP. There is an opportunity to achieve even more by more in-depth analysis, to identify trends across larger intervention areas that would prompt program managers to identify more strategic level changes needed in project directions for the remainder of the project.

Trend Analysis
The LQAS methodology contributes much to LIBON's capacity to monitor individual objectives with reliable data and has built capacity for LQAS in the IOM and MOHP. There is an opportunity to achieve even more by more in-depth analysis, to identify trends across larger intervention areas (prenatal, delivery, post natal, etc) that would prompt program managers to identify more strategic level changes needed in project directions for the remainder of the project. In addition, LIBON staff intensively review HMIS data and other data and discuss monthly these with DPHO directors. There is currently little correlation between the periodic LQAS data and the monitoring of these HMIS data to guide program decisions. It is recommended that the Field Manager, Health Coordinator, U.S. Technical Backstop and the Project Steering Committee analyze and identify the finding of the HMIS data being intensively analyzed monthly, link these data with the LQAS findings for possible strategic changes that staff need to make in project implementation.

Involvement of other Decision Makers in Maternal and NN Health
LIBON currently involve men, mothers-in-law and fathers in law in PWG meetings to increase their awareness of PW needs and to garner their support for women to access services and get resources for care. Currently, some men attend the PWG sessions, however, the DHS 2006 data show that, in more than in 60.4% of decisions regarding health care, either men alone or men with their wives, participate in the decisions: this high rate of men's influence over a woman's access to services points to the need for a culturally appropriate approach to developing Father's Groups or other mechanisms of male support.

VHWs, MCHWs and FCHVs were recognized for their role to date in educating these decision-makers in the homes of PW upon request. As discussed earlier in the section on Sunsari, there is the potential for LIBON to use a structured, more innovative approach for a more active involvement of men in promoting healthy maternal behaviors and assuring that the woman has access to institutional delivery. The woman's access to household resources for pre and post natal care seeking, adequate nutrition, safe institutional delivery, is also, in significant part, controlled by men: this issue could be addressed in a scaled-up CB-NCP in the form of Father's Groups or similar outreach to men by these health workers. A small operations research study could also be used to help LIBON assess attitudes and approaches may be considered worthwhile.

Decrease in Bara Indicators
The sharp decrease of Bara's indicators has been considerably affected by high levels of social unrest, militancy and lawlessness. This unrest has led to a sharp decrease in DPHO activity and staff in some areas.

There are some additional factors to consider:

- The baseline 2006 Child Survival indicators resulted from an 8-year direct implementation effort by Plan and involved 30 staff. Those indicators reported levels of 90% or better in many cases.
- Under LIBON, Plan's Child Survival staff in Bara were reduced from 30 to 2. This reflected the MOU signed between Plan and the MOHP in 2008, where the MOHP agreed to "maintain and sustain the interesting results" of Plan's earlier Child Survival program.

Given the decline of the indicators in Bara, the reactivation of that MOU will be a key part of Plan's response to this evaluation. Additional strategies such as de-centralizing bilateral and central support to sub-District level agencies may also prove successful in sustaining outcomes in a high-security environment.

Expansion of US Management and Technical Support

Annex three discusses many areas of management and technical backstopping support to the LIBON Nepal staff. More structured program and technical support would provide an opportunity for the Nepal staff to periodically pause to do a more in-depth analysis of program progress, assess in a structured way the key strategic issues and make decisions that could change some approaches or program direction.

***Table* 1: Summary of Major Project Accomplishments**			
Project Result/Objective #1: Increase family behaviors & access to quality services			
Project Inputs	**Activities**	**Outputs**	**Outcome**
CB- NCP curriculum BCC materials Radio messages	MTOT &TOT Cascade training: MOHP & FCHV Supp supervision PWG formation	Increased staff, PWG knowledge of + behaviors Increased access, ANC, delivery, PNC	Increased skilled delivery care. Increased first check by skilled provider - by district Decreased Vitamin A deficiency Increased care seeking for critical neonate care Initiated treatment of neonatal infections
Project Result/Objective # 2: Increased quality of MNC health through fact based decisions			
Project Inputs	**Activities**	**Outputs**	**Outcomes**
Baseline & MTE LQAS Quarterly review HMIS data	Training IOM & MOHP Intensive LIBON/DPHO review of facility & FCHV reports	Faculty, student and staff capacity developed Increased monitoring & adjustments based on data	Increased targeted care provision for ANC, delivery in institutions, post natal care Targeting of outreach clinics for vaccination coverage Effective supportive supervision focused on gaps in service indicators

Section B: Overview of the Project

LIBON Summary

The Local Innovation for Better Outcomes for Neonates (LIBON) project is part of the four-year Community-Based Neonatal Care Program (CB-NCP) pilot that USAID and the Nepal MOHP are sponsoring in ten Districts in Nepal; Plan Nepal is implementing this pilot in two Districts—**Sunsari and Parsa**; and is conducting a "learning lab" in a third District, **Bara**. Plan Nepal implemented two consecutive USAID Child Survival projects in **Bara** District[1]; Bara is now monitored for sustainability after hand-over to the MOHP, and does not implement the CB-NCP pilot components.

Overall Goal: To sustainably reduce neonatal mortality in Nepal	
Sub-Goal 1 To reduce neonatal mortality in the districts of Sunsari and Parsa through the application of an integrated, community-based package of interventions and service delivery strategies that include the MINI and the chlorhexidine field trials	
Design Strategy: Improved Family Behaviors	*Design Strategy:* Increase Access to Quality Services
Sub-Goal 2 To promote social inclusion and a fact-based decision making process for the planning and resource allocation of district-based child, maternal, and neonatal programs.	
Design Strategy: Improved District Health Delivery Systems	
Sub-Goal 3 To assist the MOHP and other constituencies in the preparation and use of knowledge, policy, and investment products that will accelerate the reduction of neonatal mortality.	
Design Strategy: Increased Capacity and Scale	

The three Districts where the project operates have a total population of over 1.8 million, or over 7% of Nepal's population; the LIBON project has over 900,000 direct beneficiaries (see table below). In the three Districts it serves, LIBON targets women of reproductive age and children under five, focusing specifically on pregnant and post partum women and neonates. The project is run by a team of six Plan managers and two dozen facilitators in Nepal (see Annex 10), and supported by managerial, compliance and technical advisors from Plan USA in Washington, DC.

Table 4. Direct Beneficiary Population by Age for LIBON Project: All Districts[2]

Direct Beneficiary Sub-Population	Number
Infants: 0-11 months	52,214
Children: 12-23 months	54,519
Children: 24-59 months	161,609
Children: 0-59 months	268,342
Women: 15-49 years	374,819
Total Population	**911,503**

Major partners include the MOHP, USAID, Nepal's Institute of Medicine (IOM), USAID's NFHP II, and the other INGO CB-NCP CA's. LIBON works with these key partners in close

[1] Child Survival XIII 2001-2006 FAO-A-00-97-00042-00 – combined final report

[2] GoN: Central Bureau of Statistics. 2002. *Population Census 2001: National Report*. Kathmandu, HMG/Nepal: National Planning Commission.

collaboration to share information, provide feedback, receive and use training such as in LQAS.

Institute of Medicine
Through an MOU, the IOM actively collaborates with LIBON on LQAS training and data collection: in addition to supplying LIBON with needed data, this partnership creates capacity among IOM faculty and students in LQAS methodology.

Ministry of Health and Population
MOHP staff are the primary and most critical partners of the LIBON project: they are counterparts and key implementers, and the ones who will continue implementing CB-NCP after the LIBON pilot concludes. MOHP staff at various levels have been increasing ownership of the CB- NCP, showing commitment to expanding and sustaining results.

INGO's / PVO's /CA's
Save the Children (US), Care Nepal, Helen Keller International, UNICEF and the Nepal Family Health Project (NFHP) II are all valuable collaborating partners. Monthly meetings, sharing of technical resources and exchange of feedback across the various partners implementing CB-NCP and similar projects has proven a valuable asset to LIBON.

USAID Mission/Nepal
Partnership with the Mission has been particularly active in providing technical oversight to the LIBON project in monthly meetings. USAID/Nepal also actively promotes coordination and interchange among partners and the mission's negotiations with the MOHP supported an active PVO role in the roll-out of the CB-NCP, enhancing Plan's capacity for quality program management.

Plan USA
Technical backstopping and program support from Plan USA was an integral part of the program strategy to provide technical resources, skills development, monitoring, operations research support to LIBON staff.

Technical Interventions
The heart of LIBON is the technical interventions designed to directly reduce neonatal mortality; this resides with Sub-Goal 1. LIBON's technical package in Sunsari and Parsa is a combination of three streams: the CB-NCP package, Child Survival (CB-IMCI) elements from the Bara CS Project, and a third component to address neonatal infection, modeled on chlorhexidine (umbilical antiseptic) and MINI (early detection and treatment of PSBI) field trials[3] conducted in Nepal between 2002 and 2006.

Table 2. Technical Intervention Components of Sub-Goal 1

Stream 1	*Stream 2*	*Stream 3*
CB-NCP Elements	**CB-IMCI Elements**	**Neonatal Infection**
• Tetanus toxoid to mother • Iron supplements during pregnancy • Skilled Birth Attendance • Hand washing and CDKs during delivery • Place newborn with mother; immediate BF	• Albendazole to mother for de-worming • Vitamin A during gestation for night	• CHX use on umbilicus for home deliveries • Community-Based PSBI diagnosis, referral and treatment

[3] CHX field trial, Sarlahi District, by Johns Hopkins University, Nepal Nutrition Intervention Project, and the IOM, 2002-2005; MINI field trial, Morang District, by JSI and Saving Newborn Lives' Initiative, 2004-2006.

• Drying and delayed newborn bathing • Four* ANC visits by skilled staff • Post-partum vitamin A to mother • Knowledge of newborn danger signs • Immediate referral of newborns with danger signs	blindness • LBW care: kangaroo care, immediate BF • 4 skilled provider check-ups: Post-partum days 1, 3, 7, 29	(cotrimoxazole by FCHV followed by gentamycin at an MOHP facility)

* This was changed to six ANC visits in 2009

Sub-Goal 1: Improving Family Behaviors and Increasing Access to Quality Services

The centerpiece and innovation of Sub-Goal 1 in terms of changing behavior is the Pregnant Women's Groups (PWG's). PWG's were first used by Plan Nepal's Child Survival program in 2003, and have proved effective vehicles to identify expectant mothers and create demand for services and sustained behavior change among these younger mothers, reducing neonatal and maternal mortality in Plan's previous CS project areas[4].

The PWG's are formed as an extension of Nepal's extant Mother's Groups, which meet monthly as an IEC/BCC vehicle, with the purpose of identifying pregnant mothers (as opposed to any mother, whose last pregnancy could've been decades ago) for key pre- and post-natal interventions proven to reduce maternal and neonatal deaths. This extension was in response to Plan staff noticing (in Bara's last CS project) that younger mothers were largely absent from the Mother's Groups and not participating in safe motherhood interventions.

Female Community Health Volunteers (FCHV's), also a standard part of the Nepal MOHP system and supervised by MOHP staff, organize and monitor these groups and conduct a significant portion of the CB-NCP interventions, educating women on their health and service needs (demand creation) in particular. These FCHV's provide several major functions of support to the PWGs: in addition to conducting sessions and administering medicines, they conduct a census of pregnant women in their communities (not previously captured by the MOHP), and act as their link to health service providers, giving providers data on these women and referring women to the providers.

Sub-Goal 2: Improving District Health Delivery Systems

Another key component of the LIBON project is the intense monitoring of project activities and interventions in a strong partnership with MOHP staff. This monitoring includes active monthly reviews of data at the sub health post, health post, and Ilaka levels with quarterly reviews at the District level. Ilaka Review Meetings are another Plan innovation carried over from its last CS project. All the monthly quality reviews use data from two sources: CB-NCP forms and HMIS facility data. These reviews are supplemented at three intervals (baseline, mid-term and end-of-project) with LQAS and CSSA data collected by LIBON and MOHP staff with faculty and staff from the Institute of Medicine (IOM). The development of the capacity of IOM faculty and students to conduct LQAS is an integral part of LIBON's design.

As a key part of the LIBON strategy to strengthen district health systems, the intense monitoring of project activities and interventions strengthened the district health delivery systems, working closely with the DPHO and facility staff to develop strategic and annual plans, jointly provide supportive supervision and regularly review HMIS and other data to measure progress and make adjustments to the interventions and strategy. Working closely

[4] See final report: Child Survival XIII 2001-2006 FAO-A-00-97-00042-00

with MOHP staff, LIBON supports monthly monitoring using MOHP data and performance reviews at the Ilaka level to assure progress, address constraints, ensure needed supplies, and make course corrections to the program as needed. In addition, the LIBON Project Coordinator and M&E Officer conduct a quarterly review of the data as a mechanism to provide feedback and direction to LIBON field staff and the MOHP.

LIBON's strategy also strengthened District and Village Development Committees and Village Health Committees to support the district health systems and the Pregnant Women's Groups. This support increased staff, supplies and incentives and strengthened the FCHV's role in CB-NCP. This part of the strategy could be further developed for a stronger and more de-centralized support role for sub-District-level agencies, particularly the DDC, VDC and HFMC to more formally support local health facilities and their staff, FCHV's, and PWGs in the future.

Sub-Goal 3: Increased Capacity and Scale

The operations research evaluating the community-based use of Chlorhexidine was designed to assess home (extra-facility) use of CHX in a nation where 80% of births still occur at home and neonatal sepsis is a leading cause of death; the evidence is intended to help decide if widespread facility and home-based use of CHX should be promoted as part of the final CB-NCP package.

SECTION C: DATA QUALITY - STRENGTHS AND WEAKNESSES

Data Processes Overview

Overall, this CB-NCP ten-District pilot is data-heavy, highly-monitored large-scale operations research effort to elucidate effective models to reduce maternal and neonatal mortality in Nepal. Plan as a partner in this effort is following the CB-NCP monitoring guidelines developed collaboratively by all implementing partners in its two CB-NCP Districts of Parsa and Sunsari. LIBON also conducts two additional data quality checks: LQAS and CSSA data collection at baseline, midterm and end of project. However, the LIBON project uses only CB-NCP forms, LQAS and CSSA, and internal quality control mechanisms (e.g., management and financial reviews) to assess its progress; no HMIS data was used to evaluate the LIBON project *per se,* so we cannot assess HMIS data in terms of CB-NCP.

That said, LIBON staff are actively involved in various monthly reviews of HMIS data with their MOHP counterparts for service quality control as a part of the District-level capacity building and system strengthening. This is part of the collaborative monitoring and quality control efforts LIBON staff conduct with their MOHP counterparts to assure quality access to services. LIBON and MOHP Staff at each level (SHP; HP/ORC; Ilaka; District) review HMIS indicators monthly to monitor progress against targets, ask about constraints at the facility levels, and support the development of action plans to remedy any shortcomings.

The LIBON project has employed the LQAS methodology and has trained IOM faculty and students and MOHP staff in this highly effective data quality monitoring tool. After each LQAS round, data are processed by an external consultant and then discussed extensively in a workshop with all implementing partners to evaluate progress, identify challenges, and develop an Action Plan to remedy any shortcomings. The last one of these was held in December 2009 (full report is available from Plan Nepal upon request). The LQAS has

produced reliable data for LIBON, and has led to development of District-level plans for CB-NCP monitoring and support, including a micro-planning session to address issues in Bara.

Strengths

Data Quality

Quantitative data overall is of high quality: early data validation at the sub-District levels, the LQAS, and data quality checks on both reveal strong data collection capacity at all levels of data collectors, from the Female Volunteers on up.

Ilaka Review Meetings

LIBON staff investment of time in reviewing these data has reportedly greatly strengthened the performance of MOHP staff in CB-CNP. The Ilaka Review Meetings have been found to be popular and effective vehicles for service quality assurance and control within the MOHP: the Ilaka level has been shown to be an ideal level—above individual Health Facilities but smaller than entire Districts—where problems can be identified by the implementers and managers who are best positioned to address them.

Pregnant Women's Census and Self-Monitoring

Perhaps the greatest strength of the CB-NCP monitoring system is it collects (through the FCHVs) data previously not captured: census of pregnant women and the services and behaviors they engage in at the household and community levels. This is invaluable information for informing and monitoring a community-based maternal and neonatal survival program in a country where roughly 80% of the women still deliver at home, and has been an incredible asset to results. The mere act of counting PW has been empowering, as we learned during our Field Validation efforts for this MTE, as it draws attention to pregnancy in a positive light: women see it as important and worthy of attention, and not so much something to hide. The self-monitoring technique used in the PWG's has also proven invaluable to behavior change: monitoring themselves in front of their peers has proved a powerful mechanism for data quality and BCC adherence.

Neonatal Death Records

Neonatal death records and verbal autopsies for neonates are critical for effective neonatal survival program design. Currently, any deaths that occur in a facility go into that facility's records and are submitted to the CB-NCP pilot M&E system; otherwise, neonatal deaths are only recorded in the DHS every five years with mother's recall. With the new CB-NCP PNC home visits, verbal autopsies of any neonatal deaths in the home are currently conducted by FCHV in the home with the mother and recorded on CB-NCP Form II. These neonatal deaths are discussed with all other NCP outcomes at the SHP level on a monthly basis, and any neonatal deaths recorded are discussed again at the monthly Ilaka Review Meetings. Discussions with MOHP representatives reflected that it was not the time to focus on neonatal autopsies although they plan to address this need in the relatively near future.

Weaknesses

Lack of Documented Qualitative Data

LQAS is a systematic and effective method serving two purposes: monitoring progress towards the quantitative CB-NCP indicators, and data quality assurance; however, it is limited to quantitative data: under the current structure, one critical limitation is that only quantitative data is systematically collected. Also, the role and use of the CSSA may also need to be clarified and strengthened if it is to be considered a useful information tool for use after the pilot. It should also be remembered that Plan is using LQAS and CSSA tools for the

CB-NCP pilot only, and this is not a part of the MOHP data collection, monitoring system, or data quality assurance.

During Plan's MTE, we conducted a brief field validation exercise to explore the qualitative side of the LQAS indicators: this proved an invaluable source of information for this report—understanding the "why" and "how," and forming recommendations. While qualitative issues are drawn from field staff experience and discussed verbally in monthly review meetings and reflected in action plans, there is no formal qualitative data collection at this time, so while field managers are well aware of qualitative factors impacting their programs, this information is not systematically captured or recorded for higher-level (District and Central) analysis, where it could be vital to turning all this data into useful decision-making information.

One key obstacle is politics: it is generally not a viable option for staff of inferior levels of any hierarchy to criticize gaps and shortcomings of higher levels, such as the slow filling of health post staff, reimbursements or supplies, especially in this conflict-charged political situation; the lack of a structured qualitative data collection system is another. This poses a significant barrier to addressing qualitative issues that have a great impact on women's and neonatal health in an effective way.

Recommendations

Qualitative Data Capture
Standardizing qualitative data collection and analysis into the CB-NCP (or larger community health) system would be a great asset to informing upper-level management decisions regarding program design and quality control. What this could look like: at the Ilaka level, qualitative and tacit knowledge impacting health outcomes and health behaviors could be collected via standardized methodologies with key informants every six months. Focus Groups and In-Depth Interviews with PW and RDW, family decision makers, community leaders and members done in a statistically-valid sampling frame could produce this information.

It would be recommended that different data collectors from the ones collecting quantitative monitoring data with the same beneficiaries be used to reduce reporting bias, but that data collection expertise continue to be fostered within the IOM and MOHP ranks. Each Ilaka could then have a review session and send its recommendations and Action Plans to its D(P)HO to be reviewed semi-annually, and sent again to the Central level annually. In the absence of an independent review agency for non-financial sectors in Nepal, an external review may also be needed.

Trend Analysis
Although MOHP staff make changes and adjustments at their facility, Ilaka and DPHO levels as a result of their multiple monthly quality reviews, there was not clear evidence to periodically assess changes in trends. Strong monitoring of CB-NCP, HMIS and other data would benefit from (less frequent) periodic status reports that, at the macro level, highlight trends in performance. LIBON works with micro level adjustments that are good examples of data use at their source for management (often facility-level) decisions, and uses LQAS at MTE for District-level management decisions (LQAS and CSSA data are collected at the District level); but there remains a need for trend analysis by both sub-District and District-level staff to identify larger issues meriting concern that occur above the level of the single

indicator. Graphic presentations of data over time, similar to the ones produced for this MTE Evaluation Team (see Annex 13) are recommended.

Streamline Monitoring Data Post-Pilot
Overall, while this pilot was designed to be data rich to maximize learning, monthly monitoring at multiple levels may prove burdensome and redundant; it may be better for scale-up to reduce some of these to quarterly intervals. In terms of data collection, the many data collection forms used in the pilot phase (currently there are seven) may need to be streamlined before being fully integrated into the MOHP HMIS, as they demand significant amounts of time that providers could be dedicating to patient care. It should also be remembered that not all data leads to information; it the end of this CB-NCP pilot, all data should be reviewed by those who collected and those who used them to assess their value for the final M&E system before incorporation in the HMIS.

Neonatal Death Verbal Autopsies
While an invaluable part of the CB-NCP effort, neonatal mortality counts could use improvement in the verbal autopsy part, as knowing why neonates die, especially in the home, without the benefit of clinical staff to determine cause of death. Currently, CB-NCP Form II has a pictorial check box to record a neonatal death, but no place to record why. Form III (the referral form) has many of the same symptoms that may be useful for a verbal autopsy; it may be very useful to adapt Form III to include a checkbox for "Verbal Autopsy" and facilitate a record of why the baby died. FCHV's will likely require a bit of training on how to perform a verbal autopsy, but this is likely very similar to the other interview skills they are already given; facility staff may also need some training on this. It should be noted, however, that MOHP staff interviewed for this MTE felt they did currently have the capacity for this extra duty; it is recommended therefore this be considered for adaptation during the scale-up phase after the CB-NCP pilot is completed.

Chlorhexidine Update
As part of this LIBON project contract, Plan Nepal is required to perform operations research with the NFHP II; it was decided in June 2009 that a population-based trial on CHX use at the community and household level would be done[5]. At the time of this MTE, these efforts are on schedule. CHX has been distributed to all levels of Health Facilities in Parsa and all levels of staff have been trained and began using it in Hospitals in December. The last batch of FCHV training should be completed be the end of May. Tubes of the CHX is its final form (single use; 3g; NRs.18) is just beginning distribution to public outlets (pharmacies and medical *pasals*), and public IEC campaigns will be conducted in May and June. Data collection at the household level from cord cutters on its use is scheduled for August and September.

Special Section on Bara – *Checking the Data*

There was a sharp decline in Child Survival indicators in Bara District recorded in the last LQAS survey (Dec 2009) in almost all indicators. Concern caused by this alarming drop called for a second review of data methodology to ensure data accuracy. The data review is detailed below, but in brief, the data was found to be sound; contextual factors and incomparability between data systems (HMIS; NFHP; CS) are largely to account for the

[5] See LIBON Year 2 Annual Report 2009 for CHX OR Design

"surprise" aspect in Bara's indicators. It should also be noted that the greatest drops were in immunization: in Bara, only card coverage was counted (not actual), and the security situation has caused limitations in commodities and MOHP staff mobility. This indicator has been corrected in the CB-NCP program areas (only actual immunization confirmed by verbally by mother or facility record, not card confirmation, is not recorded).

Bara LQAS Process – December 2009

Plan provided a four-day training on LQAS techniques to Bara's DHO supervisor, the Ilaka In-charge, NGO partners and Plan staff. The District was divided into the same seven Supervision Areas (SAs), the same sample size was used as in the Plan CS-XVII Final Evaluation in 2006 for comparability; households were selected at random. Data collection teams were pairs, and data was hand-tabulated and checked within three days after collection. These numbers were then entered into EPInfo software and reports generated; random checks to cross verify between hand tabulation and EPInfo results.

Findings from Bara were openly shared and discussed by each survey team within each of the seven Supervision Areas. Analysis was guided by comparison of December 2009 findings to baselines, decision rules, Child Survival program averages and monitoring targets. Bara' LQAS results were analyzed and discussed by MoHP Regional and Central offices, the Bara DHO, INGO and local partners, Plan staff. The key outcome of this collaborative de-briefing was the micro-planning session proposed by Plan to address the drops in Bara's indicators.

Below is a table comparing key indicators between LQAS and HMIS data; they are comparable, except for differences between immunization card coverage and actual, which is to be expected.

Table - Select 2009 Indicators from Bara District

Indicator	HMIS (2065/66)	LQAS 2066
TT2 coverage	18%	14% (Card)
PNC first visit	37%	40%
Iron tab during pregnancy	76% (repeat)	86%
Postpartum vitamin "A"	66%	67%
DPT	95%	22% (Card)
Measles	95%	21% (Card)
ANC first visit	55%	40%

The NFHP-II MTE data has been reviewed and indicators are significantly different then Plan's LQAS data—both indictor definitions and units of analyses—and therefore, not comparable to Plan or the District data. Plan's Bara Program Unit Manager also confirmed the extraordinary political circumstances of Bara: large swaths of sub-District health posts remain vacant; VHW and MCHW posts go unfilled for months or even years at a time; FCHV's are slow to be recruited, less literate and more behind in training than their counterparts in Sunsari and Parsa. The security situation restricts movement of MOHP staff to the communities they serve; even the DPHO himself spent only and average of 30 minutes per day in the office due to security issues. Shootings, extortion and kidnapping were not uncommon. Plan staff are confident the LQAS indicators from Bara are correct: the issue lies not with the data quality, but with the political context.

SECTION D: ASSESSMENT OF PROGRESS TOWARD THE ACHIEVEMENT OF PROJECT RESULTS

Prior to the mid term evaluation, Plan Nepal actively assessed progress as part of the preparation of its second Annual Report in December of 2009. In addition, LIBON recently performed the LQAS and CSSA on its three program areas in Bara, Sunsari and Parsa districts. To avoid duplicating the second Annual Report, this section will focus more on information from the field validation visits combined with annual reports and the LQAS, CSSA survey data (December 2009 and March 2010). Annex 6 shows LQAS results in table and graphic form, and a complete copy of the MTE LQAS and CSSA data plus the proceedings and outputs of the stakeholder review workshop held with LIBON partners in December 2009 is available.

Generally speaking, Parsa District is on course with its progress toward targets; Sunsari District has significantly increased progress, in many cases, it has reached its end of project indicators. Sunsari's above average progress is reportedly due to more and better trained sub-District level health staff; younger and better-educated FCHV's; more birthing facilities; a full Plan Nepal Core program set and staff, including CB-IMCI and HIV; and slightly better security.

Bara District (which is a "learning lab" for Child Survival and Plan community mobilization mechanism, not CB-NCP) has declined in almost all indicators, some, dramatically from baseline, largely due to the political situation and sharp decrease in DPHO activity and staff in some areas. In addition, the LIBON staffing of Bara was lowered significantly in line with its change from an active Child Survival area to one in which indicators were to be maintained by the MOHP in a MOU signed with Plan in July 2008.

<u>Sunsari District</u>
The LIBON project began forming and organizing PWGs in Sunsari in July 2008; implementation of CB-NCP was started in April 2009 (after awaiting approval for the national curriculum to be finalized). To date there are 237 active PWG's, 16 Birthing Centers and two EmOC venues in Sunsari. One VDC in Sunsari had a PHC with a Birthing Clinic but no Outreach Clinic (Harinagara VDC); another VDC one had the opposite (Bhaluwa VDC); and Baklauri had both. All MCHWs in Sunsari have been upgraded in their training to the ANM level. Key informants interviewed during this MTE field validation exercises include three PWG's with a total of 28 members; 11 FCHV's; 23 SHP-level staff across five VDCs and the DPHO of Sunsari; seven LIBON staff from Sunsari were also interviewed.

The latest round of LQAS data show Sunsari District to have excelled, exceeding even EOP targets in many cases, including SBA delivery and post-natal check-ups, which were two of the greatest challenges in the other two Districts. Of the 39 indicators measured, 15 had improved, over half exceeded EOP targets (21/39); and three (3) had declined from baseline (treatment of neonatal infection). Knowledge of danger signs during and after delivery; danger signs among newborns; and newborn care (drying, warming, and avoiding bathing for 24 hours) rose almost 40%. All indicators for antenatal and delivery care indicators showed increases of more than 20 percentage points (ANC checks, receipt of iron tablets, single doses of albendazole; and birth attended by a skilled provider).

Rapid Catch indicators showed great increases in SBA; PNC visits; and early breast feeding. Curiously, Sunsari was the only district to show an *increase* in Immunization Card verification, but a *decrease* in DPT immunization by mother's recall.

Parsa District

Plan Nepal began implementing LIBON's CB-NCP interventions in Parsa in second year of the project (2008), one year later than Sunsari. There are five Plan Nepal LIBON offices in Parsa: one housed at the Parsa DPHO, and the other four field offices are housed in the same building as Parsa's government health facilities to facilitate coordination with MOHP for CB-NCP. (However, Plan has no other program activities in Parsa.) There were 115 active PWGs in Parsa in March 2010 with a total of 811 pregnant women members: of these 89% are illiterate and 90% were classified as disadvantaged: 28% were Dalit/ untouchable; 56% were Janajati; and 6% were Muslim 6%. Parsa also has three public hospitals to support CB-NCP referrals and provide services.

Infrastructure issues in Parsa are challenging and include intermittent electrical supply (load shedding) and transportation issues, both poor roads and security (strikes/bandhs) that make travel and extension of the staff into outreach clinics and provision of support to FCHVs and PWGs more difficult.

The LQAS data collection of February 2010 showed many of Parsa's indicators to have increased and even surpassed the EOP targets. For example, skilled birth attendance increased from 38.5% in 2008 to 46.6% 2010 (the EOP target for 2011 is 45%); mothers who know at least two danger signs of pregnancy increased from 51% to 91.5% (EOP is 70%); and mothers who recalled at least three counseling points during ANC visits increased from 17% to 56.7%, also surpassing the EOP target of 50%. All the indicators of antenatal and delivery care increased and almost all post-natal indicators increased, with the exception of a second post-natal visit and treatment of sick newborns (CB-NCP training for FCHVs on this topic was ongoing at the time of data collection).

ANC with four ANC visits has increased slightly: six ANC visits, the new MOHP norm, is lower reflecting some progress toward the new, more ambitious norm. Post natal care access and quality are also reported low in the LQAS with the first check up post partum within 48 hours at about 30% and second check up at 3-7 days very low. There is a low level reported for the low dose Vitamin 'A' supplementation to pregnant women but this is reportedly because Parsa has not been designated as a pilot district for the distribution of low dose Vitamin A.

All trainings on CB-NCP and chlorhexidine application by health workers were completed in 2009; twelve batches of FCHV trainings on CHX are completed, with remaining 29 batches ongoing as of March 2010.

Bara District

Final evaluation indicators from that project (CSXXIII) in 2006 were used as the baseline indicators for the "learning lab" that Bara is operating as for this LIBON project (Bara is not one of the ten CB-NCP pilot Districts). Most LIBON LQAS indictors in Bara have fallen dramatically from 2006 indicators. Prenatal care coverage dropped significantly; knowledge of neonatal danger signs decreased although knowledge of danger signs during pregnancy and after delivery dropped more. Delivery by a skilled health personnel up to a MCHW increased slightly. Cord care was very low, dropping significantly (likely because CHX and

CB-NCP are not part of the MOHP pilot taking place before national roll out). Interestingly, the knowledge of mothers on neonatal danger signs did not decrease significantly. Finally, indicators for knowledge of three danger signs of pneumonia and of diarrhea declined some 30 % and 50% respectably.

It has been noted that the 2006 indicators were extremely high (most over 95%), so decline to some degree after program closure may have been inevitable. There are 323 active PWG's in Bara, down from 430 in 2006 at the end of the last Child Survival program. Yet, this means that 75% of the PWGs have continued for nearly four years on their own, a positive result for sustainability. In terms of facilities, there is no Outreach Clinic or Birthing Clinics in Saphi VDC 5 where we visited, and the SHP is "sometimes closed" (there's no 24-hour facility in the area). VHW and MCHW posts in VDC's visited (Saphi) had been vacant for over two years, and only five of nine District FCHV's had received CB-IMCI training.

The few indicators that have not fallen are related to Child Survival (e.g., breastfeeding practices) and not dependent on facilities, pointing to the eight years of previous Child Survival programming in Bara and issues with the supply side of health care (as opposed to demand). EPI *card* coverage is particularly low: from over 70% down to just over 20% in two years, but *actual* immunization is in line with national averages. This indicator (card coverage) has already been corrected (card plus actual coverage) in the CB-NCP M&E Guidelines that are now being implemented in the 10 pilot Districts. Other child care behaviors have also dropped: diarrhea cases are up and care is down. Cord care was very low (likely because CHX and CB-NCP are not being rolled out in Bara), and neonatal care indicators were mixed.

SECTION E: DISCUSSION OF THE PROGRESS TOWARD ACHIEVING RESULTS

Contextual Factors

General elections in Nepal in 2008 brought in new leadership, resulting in rapid and frequent turnover and many vacant posts during the leadership transition in the government, including in the MOHP. Also, a national draft constitution is being finalized with further delays in filling posts and advancing regular duties of the government until this is decided.

In spite of these major changes, LIBON continues to work at the local and district levels in the three districts in the Terai with socially and economically disadvantaged groups engaged in agriculture and small business enterprises. Although the current MOHP infrastructure is limited and in poor condition, the MOHP facility staff discussed their commitment to reducing maternal and neonatal mortality. They stated that the LIBON supported training has helped increase their technical skills in CB-NCP and the LIBON's ongoing supportive supervision helped to keep the focus of services, health behavior changes needed and other efforts for measurable results.

Sunsari

Sunsari is recognized as having more and better trained sub-District level health staff; younger and better-educated FCHVs and more birthing facilities. In addition, in Sunsari the LIBON program is complemented by a full Plan Nepal Core program's set of health interventions, including CB-IMCI and HIV services. In addition, the MOHP, and LIBON staff are able to work within a slightly better security situation than in the other two LIBON

supported districts. The recent CB-NCP trainings and initial package of supplies to FCHVs and health facilities has supported the CB-NCP roll out and has contributed to Sunsari's recent high performance.

The decreases in Sunsari's indicators were seen entirely in anti-biotic treatment (Coatrim) for neonatal infection, although the diagnosing of PSBI by a health worker also increased from a high; this is reportedly due to the low supplies and that CB-NCP training on newborn sepsis treatment was just completed in January 2010.

PWG's and FCHV's

PWG members interviewed in Sunsari provided high recall rates of CB-NCP package components and key interventions, and reported good relations and services with providers of all levels, from FCHVs, ANMs and VHWs, and facilities (ORCs, SHPs/HPs and PHCs) with which they have direct contact. Women noted ANC and Facility Delivery as the strongest/ most heavily promoted components of the program. Many women in the PWGs were able to correctly name neonatal danger signs and care practices, including taking their neonate to a Health Post for antibiotics for an infection.

It is interesting that changes in behavior and care seeking are somewhat higher for the neonate than for the woman herself and could signify that, although the women have been supported and empowered in the PWGs, their concern for their own health is still not as much a priority as is that of their neonate.

Supply Side: Services

D(P)HO staff in Sunsari stated that in the Laukahi area/VDC the staff were able to increase actual immunization rates (with rates higher than Parsa and Bara) due to the availability of a freezer, allowing for cold-chain maintenance. The staff discussed that they also provided after-hours service in the sub health posts and there were usually adequate supplies and equipment (including two ambulances, in Laukahi). The MOHP staff, working closely with LIBON staff, have raised awareness levels by health promotions and Outreach Clinics: this is credited with the increases in facility deliveries.

Quality Assurance

Joint DPHO/LIBON monthly review meetings at the Ilaka level, initiated as a key input of the LIBON project, support facility staff and FCHVs to acquire additional skills and receive direct supportive supervision by D(P)HO and LIBON staff. This was cited as key to Sunsari's strengthening of their district health system and contributed to the improvement of indicators.

Challenges

Challenges in Sunsari includes: the high level of staff turnover within the District MOHP and the need for refresher trainings were mentioned by all as a need for expansion and for the critical sustainability component. Challenges discussed by the PWG members in Sunsari included the following: mainly, that the CB-NCP program had just started and they were recently adopting the new positive behaviors and beginning to access new services. Traditional practices surrounding childbirth and needing more support for FCHVs were also mentioned as priorities for improvement. MOHP staff were generally optimistic in their ability to expand these services. MOHP staff claimed no trouble with the Facility Delivery Incentives, either receiving or dispensing the funds.

Facility Delivery

The Bhaluwa VDC cited their lack of a Birthing Center for the lower facility delivery rates in their area; Baklauri's Birthing Center is only three months old. Another challenge was the continuing beliefs that a woman who has had no problems during her prenatal period and, especially if she has previously delivered at home without problem, does not need to deliver in a facility. PWG members discussed the reimbursements for institutional deliveries and that do not cover the costs of transportation and other needs for the delivery as a major issue for them in their attempt to access care. To date, despite the MOHP policy of promoting and providing institutional deliveries, some of the HP and SHP staff and some of the FCHV still do not actively counsel women and advocate that women deliver in a health facility.

Neonatal Infection

The practice of bypassing sub health posts to access higher level services was also mentioned as a challenge. SHP staff state that women are going directly to the hospital (bypassing sub health posts for diagnosis of neonatal infections). There is not a clear idea why women are by-passing lower level facilities, especially for treatment of neonatal infections with antibiotics. SHP staff state that their facility/SHPs regularly has the antibiotic supplies. Further analysis of the situation is needed as some staff identified the challenge that FCHVs need more training to diagnose NN infections and to refer properly up the chain of facilities designated to treat neonatal infections.

Parsa

Field Findings from the PWG's and FCHV's

The PWG we met in Mahuwan VDC was only formed a year before (March 2009); they meet monthly. The PW and FCHV's claimed iron and other meds to be in "good supply" with good adherence among mothers, but report their FCHV had been sick the last few months and she still awaits training on neonatal danger signs and infection. Support from the SHP was lacking at times; and negative cultural practices (such as sequestering the mother and newborn until the umbilical stump falls of, about 5-10 days). These all affected pre-natal, post-natal and newborn care access and quality.

Facility Delivery

The facility delivery rates in Parsa, though more than double the national average at 50%, did have some obstacles to higher rates: delivery incentives of NRs.500 provided by the GoN to encourage institutional deliveries was not enough to cover costs of transport (ambulance costs were quoted at NRs.1000), food and prescription medicines, and that reimbursements were slow to come from the DPHO.

FCHV's also cited regular logistic supply as a major concern after receiving training: they do not have CDK's and say the SHP does not supply them, which is a cause for concern given both the high home delivery rates, and may account for some of the neonatal sepsis/ PBSI indicators. Women also cited the need to continue educating husbands and mothers-in-law, who decide whether a woman may be taken to hospital.

Neonatal Infections

Concerning the low neonatal infection indicators, cases are being referred directly to the hospitals (instead of CHW's or MCHW's) by untrained FCHV's for the following reasons: FCHV's still await training; supervision, support, and staff at the SHP/HP level are lacking; and the proximity of two hospitals (Pokharia District Hospital, 7km away, which has a Birthing Center and can offer basic EmOC; and Narayani Sub-regional Hospital, 20km,

which can provide comprehensive EmOC). Lack of training in neonatal danger signs and care was also cited as reason for the lower PNC check-up rates in Parsa. Interestingly, a very high level of newborns who were seriously ill were being seen by a qualified health provider (over 90%) was reported; perhaps pointing to FCHV's, women and communities' increased awareness and response to BCC messages on care seeking behavior.

Immunization Cards

The immunization rate reported by "card use" in Parsa which are low is not of particular concern, most likely due to the fact that most mothers have lost their immunization cards since the plastic cover they came with stopped being replenished annually. However, it was reported that each time a mother returns for a round of child immunizations, the health workers start a new record with a "first" shot, instead of continuing the previous record (many women's records show multiple "first" immunizations recorded only). There are opportunities for LIBON to work with the D(P)HO and facilities to retrain and supervise on this.

Local Strengthening of Health Delivery Systems: VDC's Increase Support

Staffing has been reported as a major issue in the Public health sector in Parsa. In terms of strengthening health systems, the VDC's in Parsa in general are increasing their support for FCHV's. The VDC visited during this MTE had allocated NRs.200/FCHV/month, although FCHV's say the payment comes only quarterly or semi-annually. The VDC provided FCHV's NRs.10,000 on top of the NRs.50,000 FCHV endowment in last year. FCHV's are slated to get a sari/uniform allowances of NRs.3,000/year, but the DPHO has not distributed the funds yet. FCHV's also request more job supplies like torches, umbrellas and bicycles.

Global Learning and Contributions to Scale

Parsa contributes to MOHP policy level advances by providing learning from the many experiences of training and now expanding CB-NCP and in the operations research on Chlorhexidine and Gentamycin use at community level. These lessons learned will be transmitted to MOHP's Family Health Division in expanding CB-NCP nationwide, shared with other partners, and will be further documented for global learning.

Bara

Context

Security and political instability issues in Bara are some of the most severe in Nepal: MOHP staff turnover has been as much as six times in the last two years in some key posts. Many DPHO staff assigned to various levels reportedly stay at the District level due to threats, kidnappings and shootings: many work on health issues less than one hour per day due to the unrest and needs to address security issues. Bara also has intermittent electric supply and difficult transportation issues, further complicating MOHP support to District and lower level MOHP staff and offices in terms of staffing, supplies, training, and other support.

The most notable finding was that the posts of VHW and MCHW—who provide supervision, refresher trainings and supplies to FCHV's—overall have a vacancy rate in Bara of 35%, and some posts have been vacant in this area for the last two years. The local VHW, who (according to PW and FCHV's) was well trained, supported the FCHV's in their PWG sessions, and used to conduct regular immunization in EPI clinic retired over two years ago. The position of VHW was then phased out, so will not be replaced, according to the SHP that held his post. The PWG/MG then pressured the VDC hired a new VHW and MCHW

themselves. A VHW was secured, and even trained in CB-IMCI by the FCHVs, but the VDC did not provide him a monthly salary in time and he left. Again, FCHVs pressured the government to fill this VHW slot that has been vacant in SHP for last two years, this time with a monthly payment of Rs. 6000; this recruitment is underway.

FCHV's also cited inconsistent supplies in iron, cortim and zinc, and in training: only five of nine FCHV's in the District have received CB-IMCI training, and some still await training on childhood pneumonia, which may explain why childhood illness indicators (diarrhea care, antibiotics to sick children, pneumonia) have dropped. FCHV's also mentioned managerial issues: the rotation basis assignment to VHW, and inconsistent leadership and support.

PWG's and FCHV's

Pregnant women's groups are still functioning in most areas in Bara, (323 in August 2009, over 75% of the 430 that were functioning in 2006). Behaviors have fallen in knowledge and care seeking, particularly related to facility-based services and commodities. Still, the PWG members interviewed said they felt "empowered": now they are a constituency aware of their rights, and can demand as group to MOHP as Duty Bearer. Many of the illiterate women claim the full program (SM and CS) are "a lot to remember," and requested more visual aids. Women also mentioned heavy workloads at home and family burdens as obstacles to adhering to all behaviors, but did note that they are managing a local savings and credit scheme within their PWG/MG. Older mothers seemed to have better recall and knowledge than younger members, pointing to a drop in the quality of messaging in the last couple years.

FCHVs, however, are continuing BCC sessions in their own initiation after phasing out the Plan Nepal's Child Survival Project. In Madhuwan VDC, they use the interest from the FCHV endowment fund from the government to buy PWG supplies. They have also initiated a PWG fund from members at NRs.5/member/month; they currently have NRs.500. They have started to revolve the fund by lending the money among themselves. The replacement of retired FCHV's has also started locally: two posts vacated are being filled by their daughters-in-law. The two replaced FCHVs have received basic training from government health system (but not CB-NCP).

Facility Delivery

When asked about the low facility delivery rate in Bara, mothers mentioned poor service and equipment, fear/doubt (especially among the illiterate), and expense, beyond what the incentive provided. Mothers and FCHV's both said there's "no need" to refer to a facility if the birth isn't complicated, and the new MCHW is a certified ANM, so is can provide SBA at home; they also cited delay in Delivery Incentives from the District. Women also requested a birthing centre in their local SHP; however, there is not enough space; the local VDC itself is planning to construct a room in the existing building to accommodate one.

The ANM of the local SHP has her own birthing centre in her home. She refers some deliveries to the Nijgadh birthing center, one supported by Plan Nepal about ten years back. Whenever she gets complicated deliveries she refers to Narayani Sub-regional Hospital.

MOHP Perspective

Changes in FHD policy and leadership have impacted SM and CS indicators in Bara. ORS is no longer part of the essential medicines list; this may partly account for the poor performance of diarrhea prevention and home treatment. Lower actual EPI coverage in Bara may be largely due to the phasing out and multiple vacancies of VHW's and MCHW's (the

staff that conduct EPI) across the District, compounded by limited mobility due to the security situation. The Saphi VHW and MCHW were retired over two years ago and the VHW not yet replaced; the MCHW was replaced just this month (March), so the FCHV's have had no supervision, support, or monitoring for some time.

LIBON Staff Perspective

LIBON staff cited self-reporting and self-monitoring within the PWG's has increased demand for PWG's to be established in each ward in Bara (currently, there is only one at the VDC level; there are nine wards per VDC). They also noted that the delivery incentives began in 2008 have increased facility delivery, but only at the hospital (not SHP) level, due to lack of proper birthing facilities below the tertiary level.

VDC Support

In terms of VDC support, VDC's have linked PWG to VSL group in both Bara and Parsa, so PWG's have their own funds (Nrs2-5/ from each PW/ month): this empowers women in general, and they've established emergency delivery transport fund. Saphi VDC has a community stipend for FCHV's (NRs.100–400), in addition to the standard MOHP FCHV fund (NRs. 50,000 per VDC) for their regular emergency fund.

In response to the low LQAS findings, stakeholders at the December 2009 LQAS Review Meeting discussed corrective steps. A comprehensive micro-planning curriculum on family and child health has been developed by WHO and it has been drafted for piloting in two Districts in Nepal so far—Ramechhap and Lamjung. Plan Nepal has proposed this model be used in Bara; a planning session is currently scheduled but not confirmed.

Conclusions

Overall, the issues of political instability (resulting in MOHP staff turnover); security threats; the newness of the CB-NCP program; traditional practices; and limited transport were identified as major contextual factors that has affected CB-NCP efforts across LIBON's program areas in the Terai. Progress was largely credited to CB-NCP training and supplies; dedicated health workers and FCHV's, where present; and local D(P)HO staff, and District and Village Development Committee (VDC) support. VDCs, especially in Bara, have done a commendable job on increasing their financial support to FCHVs.

Section F: Discussion of Potential for Sustained Outcomes, Contribution to Scale, Equity, Community Health worker Models, and Global Learning

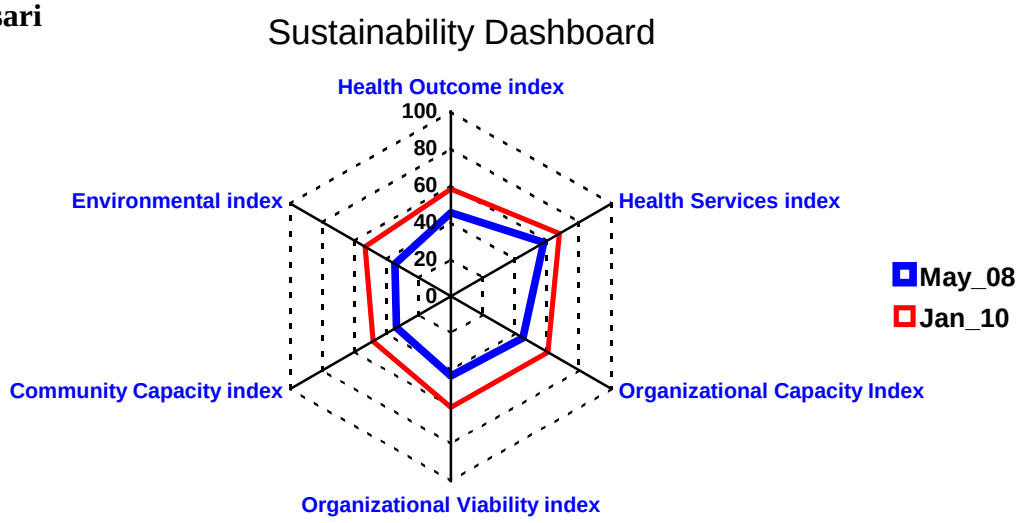
Potential for Sustained Outcomes

Plan Nepal's LIBON project used the Child Survival Sustainability Assessment (CSSA) framework tools for its baseline survey at the DIP stage in 2007 and also in MTE in 2010. This not only provided and assessment base for planning but was the overall conceptual framework for LIBON. This framework served to mount a multi sectoral approach to involve DDCs , VDCs and representatives of other sectors to strengthen their commitment to the CB-NCP interventions and assure their support for the CB-NCP and broader community and facility based activities of the health system and expand support to them across other sectors to sustain project achievements

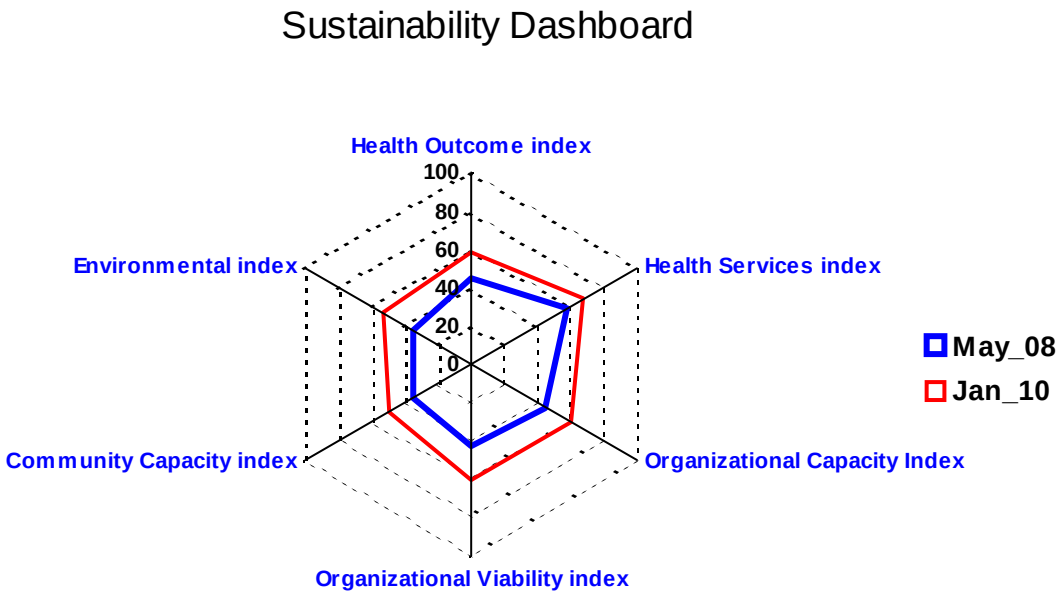
From the Sustainability Dashboard graphics below, it shows both Sunsari and Parsa districts improved their sustainability indices from baseline. Although all indicators have improved,

Health Services, Environmental and Organizational Viability indices show higher levels of improvement in Sunsari.

Sunsari



Parsa



In Parsa, Health Services, Organizational Capacity and Organizational Viability indices show above average improvement from baseline.

CSSA as a sustainability assessment tool also serves as the base for LIBON's phase out plan. The CSSA assessment has been used to establish baseline capacity, and to set the stage for periodic multi sectoral meetings to support the CB- NCP expansion. It will need to be studied and adapted to not only involve multi sector stakeholders in expanding and supporting CB-NCP which was its initial focus, but also to include specific planning with dates certain for the pass over of full responsibility and for the sustaining (institutionally and financially) of the post project operations after LIBON project inputs have ceased.

The lessons learned from Plan's eight years of strengthening the health systems in Bara, with significant staffing level and active/direct implementation activities until project end, calls for LIBON to adapt its approach and to gradually phase over support to the MOHP, DDCs,

VDCs and other actors in Parsa and Sunsari. This phase over will require training and capacity building of these agents and, to the extent possible, accept the assumption of full ownership and responsibility for sustaining the interventions at adequate levels. MTE discussions with MOHP at every level showed recognition of their role in assuming leadership, and included varying responses of their readiness, and discussed needs for gradually assuming full, sustainable ownership.

The approaches to financial sustainability have also been successfully initiated. The project works with PWG and FCHV who have been mobilized to request/pressure their district development committee or village health committee for funding for the local hire of health facility staff to provide CB-NCP services. There has also been assumption of responsibility for financing at multiple levels for financial sustainability. This represents a significant and intentional commitment of the GON to sustain CB-NCP.

LIBON project has not invested on operational cost of the project to government. For example, GON MOHP is providing the performance based incentives to FCHVs. Local VDC fund is mobilized for the hiring of the local health staff in some health facilities and supporting some incentives for the monthly review meeting of the FCHVs in health facilities.

The project is creating demand for health services by mobilizing existing Mother's Groups and supporting existing and establishing new Pregnant Women Groups. Raising the awareness of pregnant women and their family members on dangers signs encourages use of health services and facilities and also to demand additional services. The staff person in charge of the health facility is the member of local government body in each VDC: he influences decisions on support to health services. It is interesting that the Ministry of Education has leverage considerable financial support from the VDCs: the health staff and LIBON can perhaps learn from their example.

The LIBON project is doing capacity building working in the existing health system of MOHP through their existing staff. The responsibility for direct implementation and sustainability responsibility clearly rests with the MOHP. LIBON supports one time costs like training with materials such as the training manuals, flip charts, job aids, forms and formats equipments like color coded thermometer, color coded weighing scale, mucus extractor and resuscitation bag and mask. LIBON is working with the MOHP to plan and budget for the operational costs of materials and equipment replacements for sustainability.

Increased and more frequent meetings of the Plan-MOHP high-level Steering Committee would increase policy-level support for increased expansion, collaboration and sustainability. This high level quarterly review of progress should keep the central levels of the MOHP substantially involved and committed to support of the CB-NCP.

This productive interchange among INGO partners should continue to actively seek input on technical and management issues for the duration of the CB-NCP pilot.

<u>Contributions to Scale-Up</u>

The chlorhexidine study in Parsa of non-facility use of CHX on newborn umbilicus stumps to prevent infection is one of four pilot Districts piloting CHX for the MOHP Nepal; the final evaluation will inform newborn health policy (Sub-Goal 3). This is highly relevant as neonatal sepsis is one of the top causes of neonatal mortality in Nepal.

The third stream of LIBON's technical suite of CB-NCP interventions will inform scale-up of community-based neonatal infection. This stream involves the diagnoses and treatment with cotrim (cotrimoxazole and trimithoprim) for newborns with possible bacterial infection by FCHV's, with referral to local health facilities and clinical staff (VHWs/MCHWs) for an injection of gentamycin as needed.

The Pregnant Women's Group (PWG) approach has been developed and refined in Plan's previous two child survival projects and is greatly contributing to scale up. More than 75% of the PWGs formed in Bara are operating nearly four years after the Plan CS support has stopped.

Attention to Equity

Aside from the larger gender equity issues associated with poor maternal and child health outcomes in Nepal, the types of equity being addressed by the LIBON project within that frame are primarily ethnic identity: Dalit and other disadvantaged communities and persons in geographic areas are far from health facilities with limited access of health services. The Dalit and disadvantaged communities were identified by Nepal Census report 2001 form DDC/VDC. LIBON sought out and prioritized first the rural/dispersed areas that were shown in the data to have limited services. The limited access of the health services wards (villages) were indentified by discussing with local health institute staff and also analyzing immunization rates of the concerned wards (villages). LIBON works with the MOHP to address these disadvantaged groups.

To ensure equitable access to services, LIBON formed PWG where there was less coverage and in areas (wards) of relative disadvantage within the districts. The LIBON project also identified that 64% of PWG members are illiterate and 64% are from ethnic groups. Please the table below on the disadvantaged ethnic and illiterate populations served.

PWG Summary information of Parsa and Sunsari by March 2010									
Name of Districts	# of PWG	# of Pregnant Mothers	Literacy # and percent		Ethnic Group				DAP
			Yes	No	D	J	M	O	
Sunsari	246	1958	896	1062	450	578	0	930	0
Parsa	115	811	93	718	224	459	51	77	2
Total	**361**	**2769**	**989**	**1780**	**674**	**1037**	**51**	**1007**	**2**
			36%	**64%**	**24%**	**38%**	**2%**	**36%**	
Note:	1 PWG= about 8 pregnant women		D = Dalit	J = Janajati	M =Muslim	O = Other	DAP = Differently Able People		

LIBON formed PWGs where there was less coverage and in areas (wards) of relative disadvantage within the districts. There are 2,336 pregnant women members in these PWGs, of which 24% are Dalit (so called "untouchables"), 38% are Janajati (a deprived group) and 2% are Muslim (a minority religion in the region). In total, approximately 64% of the women reached through the PWGs are from disadvantaged populations[6].

First, these populations were strategically targeted to mitigate endemic discrimination. Second, the PWGs are small and are comprised of neighbors who know and trust one another. Moreover, they are relatively homogenous, thereby avoiding traditional animosities

[6] See PWG Summary Table in the LIBON 2009 Second Annual Report, p.2

between some cultural groups. Third, the social mapping technique allows for illiterate mothers (64% of total) to easily absorb the information. These various approach demonstrate that LIBON outreach to marginalized, disadvantaged women.

The Role of Community Health Workers

FCHV's
The primary CHW of interest in the LIBON model is the FCHV, who provides support and services to the PWG. FCHV's comprise the volunteer cadre of Nepal's MOHP approved and supported "community health volunteer" with ranks in every VDC nationwide and are trained, supported and respected by the MOHP and the community, and are the critical CHW. Detailed information is included in the CHW Matrix is provided in Annex 7.

Incentives
FCHV are not government paid staff: they are volunteers selected from Mother's Groups and are socially respected and responsible persons. However, the MOHP has recently established an incentive scheme for the FCHV that will provide stipends to reward their work in MN care. Formal studies such as the Community- Based Maternal and Neonatal Care study of December 2007 have documented their work.

To supervise and support the FCHV, there is one MCHW and one VHW in each health facility: they provide support and supervision to the FCHVs. Since the FCHV's receive joint supervisory support from LIBON and MOHP staff, and the MOHP recognizes the importance of the FCHV, their continued support after project end is likely.

Contributions to Global Learning
CHX and Neonatal Infections
Both the CHX trial of community-based use and the PSBI protocols will be key findings at the end of project in 2011/12.

Pregnant Women's Groups
The LIBON project has continued the use of PWG's that initially proved successful in the previous child survival project in Bara District. When project staff noticed that pregnant women and mothers of under-five children weren't participating in interventions as expected and key project messages weren't being delivered, it came up with a strategy to rejuvenate mothers' groups -- the creation of Pregnant Women's Groups. With support from Plan Nepal's LIBON Project, 308 new PWGs were formed in two districts: 195 in Sunsari and 113 in Parsa. The PWG has been documented as a best practice and shared at national and international levels. The PWG video in English and Nepali was produced. The PWG approach was selected for a panel presentation during the GHC 2009 Annual Conference in a panel entitled "Better Beginnings: Improving Neonatal Outcomes," and will be the topic on a invitation-only panel hosted by ICRW at the 2010 Women Deliver Conference in Washington DC.

SECTION G: CONCLUSIONS AND RECOMMENDATIONS

LIBON Progress
LIBON's development and intensive implementation of the CB-NCP approach, training, monitoring/evaluation and supportive supervision, working directly with the MOHP from

national to sub-health post and community levels has contributed significantly to the national scale up of the CB-NCP package and should continue.

Strategies for Success
Plan LIBON project has made significant progress through three main vehicles: an effective delivery model (PWGs); strong MOHP partnerships; strong local support by some VDC's to FCHV's and PWG's. This last was not part of the LIBON Design, but has proven invaluable to the success of a community-based program in a conflict-prone setting. It is in line with Plan's general methods of seeking to leverage local resources.

PWG Delivery Model and FCHV's
FCHV's have proved to be the lynchpin to positive maternal and neonatal outcomes: where they are literate, trained, and supported with both funds and supervisors, outcomes exceed expectations; they inverse also holds true (as was seen in Bara). Support via enabling conditions was sought with intensive collaboration between LIBON staff and the MOHP: joint development of the CB-NCP training/support package and its roll out as well as joint monitoring at various levels (SHP; PHC; Ilaka and District) has proven to be keys to success. The use of the PWG groups design was crucial because it allowed LIBON to build on eight years of experience in organizing and training FCHVs to identify, organize, train and support PW to increase care during pregnancy, delivery and post-partum, and to care for the neonate.

The PWG design also empowered pregnant women, reduced the stigma of pregnancy and increased their knowledge and promoted their access and use of services. The methodology has also recognized the critical role of other decision makers—mothers-in-law, husbands and PWG peers—and harnessed their support for pregnant women to access services and adopt positive behaviors. The use of self-reporting and community mapping within the PWG's supports identification and tracking of positive behaviors such as TT, four prenatal visits, post natal visits, etc. These self-monitoring exercises promote pregnant women via peer pressure to adopt positive behaviors and to seek services.

PWG Sustainability
Sustainability is a constant challenge to development programming. However, of the 430 PWGs previously formed in the pre-LIBON project in Bara, 323 (or 75%) PWGs are still functional as of August 2009. The main reasons for their sustainability are (1) support from VHWs/MCHWs, (2) supportive supervision and/or financial support from VDCs, (3) literate, motivated and active FCHVs, (4) sense of ownership by PWG/Mothers' Group, (5) live sharing of experiences of older members (now lactating mothers) during PWG meetings with pregnant women, (6) supply of PWG mat/Tikas and other materials, and (7) linkage of PWG meeting with ANC/PNC clinic or with primary health care outreach clinic.

FCHV's: Coverage and Incentives
In terms of coverage, areas with population-based FCHV's were found to perform higher than those with only 1 FCHV per VDC, no matter the population: Sunsari had population-based (and therefore more) FCHV's; Bara has only 1 per VDC. It is recommended by LIBON staff and confirmed by FCHV's and PWG members that a population-based FCHV distribution scheme be endorsed for scale-up.

In terms of incentives, the MOHP developed operational guidelines for an incentive scheme for targeted FCHV activities to improve CB neonatal care. The scheme rewards group FCHV results on five criteria: PW registered; PW counseled and delivered in a health facility;

neonates weighed in the home; post-natal visits on 1st, 3rd and 7th day and, 29th day after delivery. Incentives are based on the entire FCHV group's performance. This scheme was developed deliberately, has the Minister's approval, and rewards the key FCHV cadre for specific actions. This MTE's findings reinforce those of the MINI trial in Nepal: that incentives overall improve FCHV performance and increase facility delivery rates among pregnant women.

De-Centralizing Support to CB-NCP: Look to the VDC's and Ilaka Reviews
Places where security has hindered MOHP staff and equipment deployment, some VDC's have picked up the slack and provided critical support—funds and SHP-level MOHP staff—to their communities, their FCHV's and their PWG's. The LIBON design could be adapted to develop a stronger and more de-centralized support role for sub-District-level agencies, particularly the DDC, VDC and HFMC to more formally support local health facilities and their staff, FCHV's, and PWGs. The MOHP can learn from the Ministry of Education's successes in accessing funds from the DDCs and VDCs.

Working closely with MOHP staff, LIBON supports monthly monitoring using MOHP data and performance reviews at the Ilaka level to assure progress, address constraints, ensure needed supplies, and make course corrections to the program as needed. These meetings have proven essential to enabling effective responses to program progress at the implementation level, where an ideal mix of management and staff can formulate action plans. It is recommended these Ilaka Review Meetings continue beyond the pilot.

Qualitative Data and Trend Analysis for Decision Making

Qualitative Data
In-depth analysis of patterns in the data or qualitative elucidation of causes was not as robust as quantitative analysis. There is thus a response to individual indicators and actions agreed to resolve them, but less of an overall strategic approach. There is also not complementary qualitative data that is collected; while field-level staff (both LIBON and MOHP) often understand these issues, it is not systematically captured or documented for institutional learning and possible policy information.

The LQAS methodology contributes much to LIBON's capacity to monitor individual objectives with reliable data and has built capacity for LQAS in the IOM and MOHP. There is an opportunity to achieve even more by more in-depth analysis, to identify trends across larger intervention areas that would prompt program managers to identify more strategic level changes needed in project directions for the remainder of the project.

Trend Analysis
The LQAS methodology contributes much to LIBON's capacity to monitor individual objectives with reliable data and has built capacity for LQAS in the IOM and MOHP. There is an opportunity to achieve even more by more in-depth analysis, to identify trends across larger intervention areas (prenatal, delivery, post natal, etc) that would prompt program managers to identify more strategic level changes needed in project directions for the remainder of the project. In addition, LIBON staff intensively review HMIS data and other data and discuss monthly these with DPHO directors. There is currently little correlation between the periodic LQAS data and the monitoring of these HMIS data to guide program decisions. It is recommended that the Field Manager, Health Coordinator, U.S. Technical Backstop and the Project Steering Committee analyze and identify the finding of the HMIS

data being intensively analyzed monthly, link these data with the LQAS findings for possible strategic changes that staff need to make in project implementation.

Involvement of other Decision Makers in Maternal and NN Health
LIBON currently involve men, mothers-in-law and fathers in law in PWG meetings to increase their awareness of PW needs and to garner their support for women to access services and get resources for care. Currently, some men attend the PWG sessions, however, the DHS 2006 data show that, in more than in 60.4% of decisions regarding health care, either men alone or men with their wives, participate in the decisions: this high rate of men's influence over a woman's access to services points to the need for a culturally appropriate approach to developing Father's Groups or other mechanisms of male support.

VHWs, MCHWs and FCHVs were recognized for their role to date in educating these decision-makers in the homes of PW upon request. As discussed earlier in the section on Sunsari, there is the potential for LIBON to use a structured, more innovative approach for a more active involvement of men in promoting healthy maternal behaviors and assuring that the woman has access to institutional delivery. The woman's access to household resources for pre and post natal care seeking, adequate nutrition, safe institutional delivery, is also, in significant part, controlled by men: this issue could be addressed in a scaled-up CB-NCP in the form of Father's Groups or similar outreach to men by these health workers. A small operations research study could also be used to help LIBON assess attitudes and approaches may be considered worthwhile.

Decrease in Bara Indicators
The sharp decrease of Bara's indicators has been considerably affected by high levels of social unrest, militancy and lawlessness. This unrest has led to a sharp decrease in DPHO activity and staff in some areas.

There are some additional factors to consider:

- The baseline 2006 Child Survival indicators resulted from an 8-year direct implementation effort by Plan and involved 30 staff. Those indicators reported levels of 90% or better in many cases.
- Under LIBON, Plan's Child Survival staff in Bara were reduced from 30 to 2. This reflected the MOU signed between Plan and the MOHP in 2008, where the MOHP agreed to "maintain and sustain the interesting results" of Plan's earlier Child Survival program.

Given the decline of the indicators in Bara, the reactivation of that MOU will be a key part of Plan's response to this evaluation. Additional strategies such as de-centralizing bilateral and central support to sub-District level agencies may also prove successful in sustaining outcomes in a high-security environment.

Expansion of US Management and Technical Support
Annex three discusses many areas of management and technical backstopping support to the LIBON Nepal staff. More structured program and technical support would provide an opportunity for the Nepal staff to periodically pause to do a more in-depth analysis of program progress, assess in a structured way the key strategic issues and make decisions that could change some approaches or program direction.

SECTION H: ACTION PLAN FOR RESPONSE TO THE EVALUATION FINDINGS

Recommendation	Action Plan	Stakeholders to be involved	When to complete	Lead Role
Sustainability of results of CS and CB-NCP	Planning meeting including LQAS results review. One key consideration is the July 2008 MOU between Plan and the MOHP where MOHP agreed to "maintain and sustain all interesting results" achieved by Plan in Bara. Also, alternate sustainability mechanisms will be explored with DDCs and VDCs, based on initial successes where VDCs have supported FCHVs and MCHWs.	CHD, FHD, NFHP, Plan, D(P)HO, DDCs and VDCs	May 2010	HC and PC LIBON
Further support to increase PNC	CB-NCP FCHV Flip chart does not emphasize PNC. However, another MOHP program, the Birth Preparedness Plan (BPP) by FHD includes PNC. Coordinate with FHD for FCHV BPP refresher training	FHD, CHD, NFHP, D(P)HO	May 2010	HC and PC at central and DLC/HPC at district level
M & E need qualitative information as well as quantitative for trend analysis	Meeting with IOM to plan qualitative research works by selected students	IOM, Plan	June 2010	PC and HC
Decentralizing Support by involved Ilakas and VDCs	Plan will review the monitoring system and will design a quarterly management report and consultation process	Plan, VDCs	June 2010	M & E Officer, PC and HC
Expansion of US Management and Technical Support	Plan USA will work with Plan Nepal to design and maintain systematic support to the field	Plan USA and Plan Nepal	July 2010	Plan's LIBON Evaluation Team
Consider adding more qualified female field staff	Plan Nepal management agrees and will follow affirmative action in the filling of three current vacancies.	Plan Nepal HR and Field Office Managers in the three districts	April 2010	PC

ANNEX-1: LIBON RESULTS HIGHLIGHT

BEST PRACTICE: Pregnant Women's Groups

Background on Pregnant Women's Groups: The Local Innovation for Better Outcomes for Neonates (LIBON) project has continued the use of innovative Pregnant Women's Groups (PWGs) that initially proved successful in a previous child survival project in Nepal. When project staff noticed that pregnant women and mothers of under-five children weren't participating in interventions as expected and key project messages weren't being delivered, it came up with a strategy to rejuvenate mothers' groups -- the creation of Pregnant Women's Groups. With support from Plan Nepal's LIBON Project, 308 new PWGs were formed in two districts: 195 in Sunsari and 113 in Parsa. Each LIBON PWG comprises 7-15 pregnant women (averaging 8) living within 10 minutes walk of one another in the same village. They meet once a month to discuss pregnancy, what the danger signs are, how to prepare for delivery and newborn care. With the help of Mothers' Group members, Female Community Health Volunteers, project staff and Local Health Facility staff, PWGs draw Social Maps, where each member of the group locates their house and marks their status on prenatal visits, TT use, iron use, birth preparedness, etc. This social map is updated during monthly meetings and becomes an accountability tool for pregnant women in the group. The PWG has been documented as a best practice and shared at national and international levels. The PWG approach was selected for a panel presentation during the GHC 2009 Annual Conference in a panel entitled "Better Beginnings: Improving Neonatal Outcomes."

Results Highlights: The implementation of 308 new PWGs in Plan Nepal's LIBON Project has yielded two new promising practices. The first is equitable outreach to marginalized groups. The second relates to explanations for high levels of PWG sustainability.

PWG Sustainability

Sustainability is a constant challenge to development programming. However, of the 430 PWGs previously formed in the pre-LIBON project, 323 (or 75%) PWGs are still functional as of August 2009. The main reasons for their sustainability are (1) support from VHWs/MCHWs, (2) supportive supervision from local health facility workers or CBOs, (3) literate, motivated and active FCHVs, (4) sense of ownership by PWG/Mothers' Group, (5) live sharing of experiences of older members (now lactating mothers) during PWG meetings with pregnant women, (6) supply of PWG mat/Tikas and other materials, and (7) linkage of PWG meeting with ANC/PNC clinic or with primary health care outreach clinic.

ANNEX-2: LIST OF PUBLICATIONS AND PRESENTATIONS RELATED TO THE LIBON PROJECT

Year and Month	Title/ Topic
May 27- May 31, 2009	Presented the article on Pregnant women group participation and reduction of neonatal and maternal mortality rates in 36th Annual International Conference on Global Health, Omni Shoreham Hotel, Washington, DC, USA
2009 (Nov)	Published article on "Pregnant Women's Groups and the Impact on Newborn's Mortalities in Bara District, Nepal" NEPHA (Nepal Public Health Association) Newsletter, Volume #1 , Issue # 2, Pg 8, November 2009 and also in the Souvenir of Peri-natal Society of Nepal (PESON)
2009 (Jun)	Published article on Plan Nepal Khabar "Reducing neonatal and infant mortality through women's participation", Kathmandu, Nepal.
2009 (April)	Published article on Plan Nepal Khabar "Empowerment of pregnant women's group", Kathmandu, Nepal.
2008 (May)	A report on "Child Survival Sustainability Assessment (CSSA) Framework Report May 2008, Sunsari, Nepal", Kathmandu, Nepal.
2008 (Feb)	A report on "Rapid Health Facility Assessment (R-HFA) Report Feb 2008, Sunsari, Nepal", Kathmandu, Nepal.
2008 (January)	A report on "Lot Quality Assurance Sampling (LQAS) Report January 2008, Sunari and Parsa, Nepal", Kathmandu, Nepal
2008 (January)	Local Innovation for Better Outcomes for Neonates (LIBON) brochure

ANNEX 3: PROJECT MANAGEMENT EVALUATION

Planning

Planning has been a relative strength due to its high degree of inclusiveness. The involvement of the Child Health Division and the Family Health Division of the MOH has been critical to maintaining progress in a fluid operating environment. The project's coordination with the MOH at national and district level has allowed the roll-out of the CB-NCP training package to continue despite a series of strikes/bandhs that have led to re-scheduling of training dates.

For example, in March 2009, an activity plan was developed to ensure the full roll-out of the CB-NCP training package and the full collection and analysis of the LQAS data in time for the Mid-Term Evaluation. All those goals were met, at least in part, due to the flexibility shown by Plan and partners, a flexibility resulting from a sense of co-ownership of the initiative.

The DIP work plan and budget were largely practical and continue to guide program implementation. Major adjustments are not foreseen, barring significant adverse external factors.

Supervision of Project Staff

The program is now thoroughly integrated into Plan Nepal's field structure in Bara, Parsa and Sunsari. LIBON field staff are supervised directly by the LIBON project coordinator. The supervisory roles of the LIBON project coordinator and the managers of Plan Nepal's field offices in the project area were re-clarified one year ago. This clarification was a joint effort of Plan Nepal's Country Director, National Program Manager and the Program Management backstop at Plan USA. These clarifications smoothed implementation.

On a national level, the LIBON project coordinator reports to the National Health advisor and this has led to the propagation of LIBON's successes into more of Plan Nepal's Neonatal and Maternal health programs. Plan Nepal's new five-year strategic plan proposes to scale-up several of LIBON's approaches throughout Plan Nepal's area of influence.

Human Resources and Staff Management

In Nepal, staff morale and cohesion are good and one notes a high-level of dedication. Relations with FCHVs, VDCs and MOH staff are also warm and productive. Plan's Human Resource procedures and processes are thoroughly documented. MOUs with key partners like the MOH and IOM are in place and are being followed. Staff turnover in the field has been low, despite difficult working conditions.

On the other hand, in Plan USA, the backstopping team has seen several changes. This has led to gaps in the institutional memory and has affected the depth and variety of the technical support provided. To the extent possible, the continuity of the current Plan USA backstopping team for the remaining two years of the program is recommended.

Financial Management

Plan's Financial Management systems are a relative strength of this program. One example of this strength is the recent A-133 audit which resulted in no findings.

The project continues to follow the budget developed for the DIP (revised, 2009). The LIBON project coordinator shows a high level of knowledge of the budget's line items and actively references the budget is his work. Within Plan Nepal, the Finance Manager and Grants Manager are both highly skilled in budget development and can provide support as needed. Plan USA also has capabilities for Budget Modifications as well as USAID Rules and Regulations.

Logistics

Plan Nepal has a dedicated procurement section which provides support for all logistics. Two examples of that support include the timely and discounted printing of the CB-NCP training materials and the timely and cost-effective procurement of the Chlorhexadine lotion utilized in the Operation Research activity. The MTE did find significant issues of logistics and supplies from the MOHP impacting the project in various places; most of this was due to the security situation, which limited transport, but it should be noted that while many Health Facilities and FCHV's were wanting in some (not all) basic supplies, CB-NCP supplies were not an issue, suggesting that supplies may have been more a communication or priority, not security, issue.

Information Management

There are two major information management processes used in LIBON: quantitative data collection for monitoring purposes; and quality control review meetings with MOHP counterparts to identify and resolve performance issues. Special assessments used in LIBON include the LQAS, CSSA, and CHX Operations Research with NFHP II. (The CHX Operation Research data collection has not occurred yet: it is scheduled for late 2010/early 2011.)

Overall, this CB-NCP ten-District pilot is data-heavy, highly-monitored large-scale operations research effort; Plan as a partner in this effort is following the CB-NCP monitoring guidelines and forms in its two CB-NCP Districts of Parsa and Sunsari. LIBON is also using two additional data tools—LQAS and CSSA—to monitor progress against targets and sustainability of achievements: LQAS for quantitative data for all three Districts, and the CS Technical Support Group's 2004 CSSA methodology for Bara only. Both are intensive efforts and conducted only at baseline, mid-term and end of project, which for LIBON means 2006, December 2009 and either late 2011 or early 2012.

LQAS was selected as the statistical sampling method for the LIBON pilot to assure quantitative data quality and progress towards indicators. CSSA looks at a variety of components in an attempt to assess sustainability: (1) health status and services; (2) facility capacity and viability, and (3) community capacity and socio-economic and political environment. Plan has trained several IOM faculty and students and MOHP staff in the LQAS and CSSA methodologies, and capacity here with Plan and these partners is considered a strength of the program.

<u>Data Collection: Process Overview</u>

Primary CN-NCP monitoring data is currently collected by two major mechanisms: provider CB-NCP forms and LQAS. These methods collect different data. Primary CB-NCP data on pregnant and recently-delivered women and their babies is collected at two levels: community and facility, is collected per event (e.g., a delivery, a PNC visit) and collated in monthly CB-NCP forms by various providers (see chart below). LQAS is a statistical sampling method designed as a quality

check of target outcomes, and is collected three times during this project: baseline, mid-term and end of project.

Community-level CB-NCP Data

Health Care Provider	Form	Content
FCHV	CB-NCP Form I	Census of PW
	CB-NCP Form II	NCP service record (of FCHV services, e.g post-natal visit)
	CB-NCP Form III	Treatment record/ Referral form
VHW and MCHW	CB-NCP Form IV	Service record (of services received from VHW, MCHW or ANM only, like immunizations and ANC visits in OCs)

At the community level, FCHVs collect census and service data from all PW in their area, both PWG/MG members and non-members, as well as all RDW; VHWs and MCHWs collect service data from these women directly also, and then combine their records with FCHV records and aggregate this data at the Health Facility (SHP, HP, or PHC) level. VHW and MCHW community services include ANC in Outreach Clinics and mother and child immunizations. This data is aggregated and then sent to the District, and then Central levels. As this is still a pilot phase, CB-NCP data is not yet integrated into the national HMIS.

Facility-level CB-NCP Data

Health Care Provider	Form	Content
ANM, Nurse, AHW, HA or MD	CB-NCP V	HF delivery service records
	CB-NCP VI and VII	Compilation Sheets of Forms II-V

At the facility level, both CB-NCP Forms V-VII and standard HMIS forms are used; HMIS data is fed in to the national HMIS database; CB-NCP forms are also sent up the MOHP chain, but currently kept separate. Data at this level include records on ANC visits, facility deliveries, and any post-delivery services provided to mother or child.

Quality Assurance

LQAS and CSSA results are analyzed by Plan staff with DPHO and Municipality health administrators and local NGO partners after each collection (baseline; MTE; Final). The last LQAS and CSSA Review for LIBON was the mid-term conducted in December 2009 and a full report was produced by an external consultant (see Annex 12). The major outcomes of the meeting were a list of recommendations and three Action Plans, one for each District, for the timeframe of MTE till EOP. One new activity resulting in this quality review was the scheduling of a Micro-Planning session for all Bara health stakeholders to address the sharp decline in its indicators; this session should take place in 2010. This session is evidence that these tools have greatly enhanced MOHP's ability to assure quality of both data and service delivery performance in these two Districts.

There are multiple performance quality checks: each month, LIBON staff regularly work with facility staff to review quantitative data at several levels. Every HF has its own internal quality

review each month with its facility and outreach staff (including FCHV's) that Plan participates in, often facilitating and supporting. Then, continuing a mechanism Plan began in its Child Survival grant in Bara in 2004, an Ilaka[1] Review Meeting reviews performance of all HF's in that area monthly. In-Charges and clinical staff from each HF in that Ilaka and the Ilaka In-Charge look at both CB-NCP data and HMIS data from all facilities within that area. These Ilaka Review Meetings have been praised by the MOHP staff as keys to success and service quality control. Assessments of quantitative data are then conducted every six months at the District level, and annually at the Central MOHP level.

LIBON's monitoring and impact data been used beyond this CSGHP project: it has informed both MOHP decisions about resourcing and enacting maternal and neonatal health programs across their districts (not just Plan program areas), as well as informed curricula at the IOM, which trains future health professionals in Nepal.

Quality control reviews of CB-NCP processes (services, knowledge and skills of HCP's) are scheduled to be done within three months after all training is done and periodically thereafter (from three to six months, depending on DPHO decision); as training has only finished in this past quarter, Plan has not conducted these checks yet, so Plan cannot yet assess these.

Technical and Administrative Support

The Nepal Family Health Project (NFHP) has been a useful collaborator and source of information. Plan and NFHP coordinate closely on the Operations Research component examining different modalities for the provision and use of Chlorhexadine in the communities. NFHP is also a useful source for data triangulation. This collaboration should continue throughout the remaining life of the project.

Plan USA support to the field has been significant in the preparation of the DIP, the first annual report, the second annual report and this mid-term evaluation. Plan USA support is also evident in the annual work plans and budgets, quarterly reviews of the same, the project management structure, the M&E system and the design and implementation of the Operation Research component. Plan USA has provided support for compliance with USAID rules and regulations and the recent A-133 audit.

Management Lessons Learned

The Plan Nepal team for LIBON is very strong and has extensive institutional memory of LIBON as well as its predecessor Child Survival project in Bara. Stability in the Plan USA backstopping team (both Program Management and Technical Advisors have changed since the project began) would allow Plan USA to add more value to the management of LIBON and the current backstopping team should ideally remain in place for the remaining two years of the program. The Plan USA Technical Advisor has field experience in Nepal and speaks Nepali fluently. She spent a month in Nepal in 2009 and five weeks in Nepal so far in 2010. Even so, the US support has tended to focus on field visits and major deliverables and should be improved to a level of continuous accompaniment of the project.

[1] Note: an Ilaka is an administrative unit within Nepal: it is between the District and Village levels.

As is true with any project, the lower level (meaning, closer to daily implementation) staff have the best understanding of results due to constant contact with implementers and beneficiaries at a local level; conversely, higher-level staff understand local success and their factors less. Some HFMT's invite a representative FCHV to attend quarterly meetings; standardizing this and like mechanisms, such as the Ilaka Review Meetings, may be a good way to ensure this exchange of perspectives.

In terms of Information Management, we recommend along three lines:
(1) Streamlining monitoring -- both data forms and frequency of review, post-pilot to restore the balance of time spent implementing and providing services to quality control. It has also been noted that frequent monthly reviews at multiple levels leads to a certain degree of redundancy, and often obscures trends only obvious at longer time intervals, such as quarterly.

(2) Including qualitative mechanisms in standard/ required data collection systems, such as semi-annual qualitative data collection. This could be achieved with the development of standardized instruments (e.g., focus group and key informant interviews) to be used in statistically-valid sampling frames, and this information then analyzed and reviewed at semi-annually at HFMT meetings and annually at the Central level.

(3) Standardizing Review Meetings Ilaka Review Meetings have proved effective management tools and popular with MOHP staff and should be considered for national implementation, but considered to be held quarterly, not monthly. Another lesson elucidated from field validation visits was the value of having representatives from all MOHP levels attend quarterly or semi-annual District HFMT Review Meetings: this allows a "closing" of the gap in knowledge between upper and lower-level MOHP staff, and can facilitate more effective management of delivery issues.

ANNEX-4: LIBON WORK PLAN

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Start-up and Administration:																			
Hire and train LIBON Staff	√	√			√													HRM, PC	Completed
Purchase equipment	√	√	√															Admin, PC	Completed
MOUs with IOM, NFHP and MoHP		√	√															CD, PC, HC	Completed
Execution of MOUs with DDC and DHO				√	√													PUM, PC, DLC, HPC, Asst DLC,	Completed in Sunsari and process is ongoing in Parsa
Preparation of DIP		√	√															CMT, PC, HPC, USNO	Completed
DIP sharing with USAID – USA			√															HC, PC, USNO	Completed

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Prepare and sign formal agreements with partners (NGO/CBO/DHO/IOM) to implement the LIBON program in Sunsari, Parsa and Bara districts		√	√	√				√				√						CD, PUM, HC, PC, HPC, DLC, Asst DLC	Completed as per planned
DIP revision and resubmission			√	√															Completed
Result 1: Increased Access to NNH Services in Sunsari and Parsa																			
Design and preparation of modules on Community Based Newborn Care Package (CB-NCP) jointly Child Health Division (CHD), MoHP		√	√	√	√													HC, PC	Completed
Master Training of Trainers (MTOT) on CB-NCP (5 persons each from Sunsari and Parsa) in Kathmandu organized by CHD			√	√	√													HC, PC	Completed

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
District Training of Trainers (DTOT) on CB-NCP in Sunsari and Parsa districts (*Ilaka* In charge and DHO staff)				√	√	√	√											PC, HPC, DLC, Asst DLC	Completed
Training on CB-NCP at *Ilaka* (sub-district) level in Sunsari and Parsa districts				√	√	√			√				√					PC, HPC, DLC, Asst DLC	Completed
Training on CB-NCP at Sub-health post level in Sunsari and Parsa districts							√			√								HPC, DLC, Asst DLC	Completed

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Formation of pregnant women group (PWG) linking with local health facility in Sunsari and Parsa districts and strengthening of existing PWG in Bara district			√	√	√	√	√	√	√	√	√	√	√	√	√			HPC, DLC, Asst DLC	246 PWGs and 115 PWGs formed in Sunsari and Parsa district respectively. 82% PWG has followed up and functional out of 430 in Bara.
Pilot Emergency Referral system in one *Ilaka*											√	√	√					HC, PC, DLC, Asst DLC	Need technical support

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Train FCHVs on CB-NCP of interventions in Sunsari and Parsa districts					√	√	√	√	√	√	√							HPC, DLC, Asst DLC	1030 FCHVs trained from Fifty one batches in Sunsari and 222 FCHVs trained from Twelve batches in Parsa. FCHV level training on CB-NCP has been completed in Sunsari and in Parsa district, remaining 29 batches FCHV level training has been planned and it is on going.

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Result 2: Increased Demand for NNH Services in Sunsari and Parsa																			
Dissemination of CB-NCP message to community (mother) groups by FCHVs through using BCC methods and materials in Sunsari and Parsa districts						√	√	√	√	√	√	√	√	√	√	√		HPC, DLC, Asst DLC	On going
Support on BCC (flip chart, key ring with message) material of CB-NCP to FCHVs in Sunsari and Parsa districts					√	√	√	√	√	√								PC, HPC, DLC, Asst DLC	Provided during CB-NCP training
Mass media (radio) BCC messages							√	√	√	√	√	√	√	√	√	√	√		Completed in Year 2 and is going on .
Result 3: Increased Quality of NNH Services in Sunsari and Parsa																			
FCHV participate in monthly monitoring and decision making meeting at the village level in Sunsari and Parsa districts			√	√	√	√	√	√	√	√	√	√	√	√	√	√		HPC, DLC, Asst DLC	Ongoing

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Support implementation of CB-NCP of service (Supportive supervision and monitoring) in Sunsari and Parsa districts						√	√	√	√	√	√	√	√	√	√	√		HC, PC	Ongoing
Review meeting on CB-NCP at VDC, district , region and national level											√	√	√	√	√	√		PC, HPC, DLC, Asst DLC	On target
Monthly review meeting in Ilaka (sub-health post and *Ilaka* in-charges) and district (DHO staff and *Ilaka* in-charges) level in Sunsari, Parsa and Bara districts		√	√	√	√	√	√	√	√	√	√	√	√	√	√			HPC, DLC, Asst DLC	Ongoing
Training in application of LQAS and CSSA for MoHP, IOM, and District level stakeholders in Sunsari, Parsa and Bara districts		√	√	√					√	√			√	√	√	√		HC, PC, M&EO, HPC, DLC, Asst DLC	Completed during baseline and midterm evaluation and planned for FE

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
KPC survey application using LQAS in Sunsari, Parsa and Bara districts		√	√	√					√	√			√	√	√	√		PC, M&EO, HPC, DLC, Asst DLC	LQAS data is used for program monitoring and planning by Plan Nepal and D(P)HOs
RHCCs prepare annual strategic and operational plans in Sunsari, Parsa and Bara districts			√			√				√				√				PC, HPC, DLC, Asst DLC	Completed for 1st and 2nd years and planning for 3rd year.
Quarterly meeting of RHCCs in Sunsari, Parsa and Bara districts			√	√	√	√	√	√	√	√	√	√	√	√	√			PC, HPC, DLC, Asst DLC	Ongoing
Result 4: Strengthened support for NNM reduction in Nepal																			
Publication on Neonatal health in Nepal (in coordination with CARE)					√				√				√			√		HC, PC	The newsletter is in progress to print

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Coordination and sharing meeting with USAID, NFHP, Care, MIRA and others INGOs working on neonatal program	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√		HC, PC	Ongoing
Meeting with District stakeholders in Sunsari, Parsa in regard to municipality approach for community mobilization					√		√				√							PC, LDC, Asst LDC	Ongoing
Bi-annually steering committee meeting	√		√			√		√			√		√		√			CD, HC, PC	SC met only twice in Year 1, and 2, the meetings is planned bi-annually only in the year 3.

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
LIBON staff participate in the neonatal/sub-committee technical group of the Child Health Division		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√		HC, PC	Ongoing
IOM student apprenticeships and internships in LIBON implementation sites				√				√			√	√			√	√		HC, PC	Two MPH students did thesis work in Sunsari in 2 year. Planned in Parsa/Bara in year 3.
Plan, conduct and share Operations Research study/results on priority NNH topic							√	√	√	√	√	√	√	√	√			HC, PC	The OP research for CHX: CHX distribution and along with training is on going in Parsa.
Presentation if results in international forum															√			HC, PC, HQ backstops	Will occur in Year 3 as planned

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Monitoring and Evaluation:																			
Submit financial and program reports to Plan USA	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√		PC, AFA, GA	Ongoing
Baseline study (LQAS, CSSA, IHFA)		√																HC, PC, M&EO, HPC, DLC, Asst DLC, AFA	Completed
Technical Assistance visits from Plan USA staff		√		√	√			√		√			√			√		HQ backstops	Ongoing
Mid-term evaluation										√								HC, PC, M&EO, HPC, DLC, Asst DLC, AFA	Completed

Major Activities	Year 1				Year 2				Year 3				Year 4				Etc.	Personnel	Comments
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Oct – Dec 2007	Jan – Mar 2008	Apr – Jun 2008	Jul – Sep 2008	Oct – Dec 2008	Jan – Mar 2009	Apr – Jun 2009	Jul – Sep 2009	Oct – Dec 2009	Jan – Mar 2010	Apr – Jun 2010	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011			
Final Evaluation																√		HC, PC, M&EO, HPC, DLC, Asst DLC, AFA	Will occur in Year 4 as planned
Collaboration with USAID:																			
Monthly meeting with USAID funded partners on child survival		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√		HC, PC	Ongoing
Quarterly coordination meeting with USAID, Local Mission	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√		HC, PC	Ongoing
Reporting: Annual, Mid-term, Final Evaluation to USAID					√				√		√		√			√		HC, PC, M&EO, AFA	Completed

ANNEX-5: LIBON CATCH WORK PLAN

Rapid Core Assessment Tool for Child Health (CATCH) of *Jun 2006 and Dec 2009 Bara*

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Reasons for achieving or not
			SENTINEL MEASURE OF CHILD HEALTH AND WELL-BEING					
1	M1 & M2	Underweight Children	Percentage of Children age 0-23 months that is underweight (-2 SD from the median weight-for-age, according to the World Health Organization (WHO)/National Center for Health Statistics (NCHS)	29	5.45	13.2	4.06	- Due to increase in early initiation and high coverage(83%) of exclusive breastfeeding - BCC through PWG - Increase livelihood of women
2	M3	Birth Spacing	Percent of children age 0-23 months that was born at least 24 months after the previous surviving child	69.4	12.90	62.5	12.68	-
3	M1	Delivery Assistance	Percent of children age 0-23 months whose birth were attended by skilled health personal upto MCHW	42.1	8.39	45.9	8.47	-

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Reasons for achieving or not
4	M1	Maternal Tetanus Toxoid (TT)	Percent of mothers with children age 0-23 months that received at least TWO tetanus toxoid injections before the birth of their youngest child.	63.2	8.20	14.3	5.95	- HW are reluctant to give MCH cards - Loss of card and mothers not giving importance of the card
5	M1	Exclusive Breastfeeding	Percent of children age 0-5 months that was exclusively breastfed during the last 24 hours	100.0		82.9	8.47	
6	M1	Complementary Feeding	Percent of children age 6-9 months that received breast milk and complementary foods during the last 24 hours	95.7	4.81	91.9	8.80	
7	M2	Full Vaccination	Percent of children age 12-23 months that is fully vaccinated (against the five vaccine preventable diseases) before the first birthday **(card confirmed only)**	66.9	8.00	19.5	6.74	Less importance on card holding & Loss of card
8	M2	Measles	Percent of children age 12-23 months that received a measles vaccine **(card confirmed only)**	72.2	7.62	21.1	6.93	Less importance on card holding & Loss of card
9	M1 & M2	Bed nets	Percentage of children age 0-23 months that slept under an insecticide-treated net (in malaria risk areas) the previous night	1.5	1.46	97.7	2.52	Introduction of ITN bed net distribution program.

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Reasons for achieving or not
10	M3	HIV/AIDS	Percent of mothers with children age 0-23 months that cited at least TWO known ways of reducing the risk of HIV infection	51.1	8.50	29.3	7.74	
11	M2	Hand Washing	Percent of mothers with children age 0-23 months that reported they wash their hands with soap or ash before food preparation and feeding children and after defection and attending to a child who has defecated	63.2	8.20	33.1	8.00	Less participation of delivered women in Mother's Group
			MANAGEMENT/TREATMENT OF ILLNESS					
12	M1 & M2	Danger Signs	Percent of mothers of children aged 0-23 months that knew at least TWO signs of childhood illness that indicate the need for treatment	99.6	0.74	93.2	3.02	BBP package in PWG & MG
13	M1 & M2	Sick Child	Percent of sick children age 0-23 months that received increased continued feeding during an illness in the past two weeks	94.5	6.00	75.3	9.63	Less participation of delivered women in Mother's Group
14	M1 & M2	Sick Child	Percent of sick children age 0-23 months that received increased fluids during an illness in the past two weeks	92.7	6.86	44.2	11.09	Do

Note:

Indicators indicated (indicator # 13 and 14) are merged in generic RAPID CATCH but the Plan Nepal; CS Project in the same indicators has been collecting information separately.

ANNEX-6: MIDTERM KPC REPORT – LQAS RESULTS

1.1 Result - 1 Community Outreach Mechanisms Expanded, Sunsari

1.1 Result - 1 Community Outreach Mechanisms Expanded, SunsariSN KPC	Objective	Indicator	Baseline (Jan 08)	Mid-term Jan 2010	Results (+ -)	EOP target Sep. 2011	Explanation of progress
	Antenatal						
5	To maintain or decrease the incidence of maternal and neonatal tetanus	Percent of mothers of children aged 0-5 months protected against tetanus by getting second dose of TT vaccine	83.5%	90.2%	6.7	Maintain	
6	To increase the percent of pregnant women receiving adequate antenatal care	Percent of mothers of children aged 0-5 months with 4 times ante-natal visit who were checked by ANM or AHW or Staff Nurse or HA or doctor	29.1%	53.3%	24.2	55%	Government maternity incentive scheme, PWG, Message through FM
7	To increase the percent of pregnant women receiving adequate antenatal care	Percent of mothers of children aged 0-5 months with 6 times ante-natal visit who were checked by ANM or AHW or Staff Nurse or HA or doctor	8.8%	21.8%	13	35%	
8	To increase the percent of pregnant women receiving adequate antenatal care	Percent of mothers of children aged 0-5 months with 4 times ante-natal visit who were checked by MCHW, ANM or AHW or Staff Nurse or HA or doctor	43.5%	69.1%	25.6	65%	Government maternity incentive scheme, PWG, Message through FM
9	To increase the percent	Percent of mothers of children	13.7%	26.3%	12.6	40%	Government

	of pregnant women receiving adequate antenatal care	aged 0-5 months with 6 times ante-natal visit who were checked by MCHW, ANM or AHW or Staff Nurse or HA or doctor					maternity incentive scheme, PWG, Message through FM
10	To decrease the percent of women and newborns with iron deficiency anemia	Percent of mothers of children aged 0-5 months receiving iron foliate tablets/caps at least for 4 months ***(120 tablets)*** during their pregnancy	63.2%	85.6%	22.4	80%	Regular supply of iron and increased ANC visit
11	To decrease the percent of women and newborns with iron deficiency anemia	Percent of mothers of children aged 0-5 months receiving iron foliate tablets/caps at least for 6 months ***(180 tablets)*** during their pregnancy	47.7%	75.1%	27.4	75%	Regular supply of iron and increased ANC visit
12	To increase the percent of pregnant women experiencing night blindness who receive treatment	Percent of mothers of children aged 0-5 months suffering from night blindness during their pregnancy and receiving low-dose vitamin A (25,000 IU)*	10.3%	14.3%	4.0	45%	Low dose Vit 'A' intervention not introduced
13	To decrease percent of pregnant women suffering from helminthes during pregnancy	Percent of mothers of children aged 0-5 months receiving a single dose of albendazole (400 mg) after completion of three month of last pregnancy	62.8%	80.7%	17.9	85%	Increased ANC Visit
	Delivery						
15	To increase percent of women accessing skilled delivery care	Percent of mothers of children aged 0-5 months whose birth was attended by a skilled provider (doctor or nurse or HA or AHW or ANM)	45.3%	67.7%	22.4	55%	Government maternity incentive scheme, Increased

							number of trained SBA, PWG, Message through FM
16	To increase percent of women accessing skilled delivery care	Percent of mothers of children aged 0-5 months whose birth was attended by a skilled provider (doctor or nurse or HA or AHW or ANM or MCHW)	46.7%	69.1%	22.4	60%	Government maternity incentive scheme, Increased number or trained SBA, PWG, Message through FM
	Postnatal						
23	To maintain or increase percent of sick newborns receiving care	Percent of mothers with children aged 0-5 months whose newborn children with signs of severe illness were seen **(visited)** by a qualified public or private provider	89.1%	97.2%	8.1	maintain	
24	To increase percent of newborns receiving a check up from a skilled provider within two days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a first checkup by a skilled provider (doctor or nurse or HA or AHW or ANM) within the first two days of birth	29.5%	60.0%	13.5	55%	Increased number of birthing center, institutional deliveries, trained health providers
25	To increase percent of newborns receiving a check from a skilled provider up within two days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a first checkup by a skilled provider (doctor or nurse or	30.9%	61.1%	30.2	60%	Increased number of birthing center, institutional deliveries,

		HA or AHW or ANM or MCHW) within the first two days of birth					trained health providers
26	To increase percent of newborns receiving a second check up from a skilled provider within 3-7 days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a second post-natal checkup by a skilled provider (doctor or nurse or HA or AHW or ANM) within 3-7 days after birth	0.7%	2.5%	1.8	25%	Cultural barrier –not allowed go freely outside home till 21 days
27	To increase percent of newborns receiving a second check up from a skilled provider within 3-7 days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a second post-natal checkup by a skilled provider (doctor or nurse or HA or AHW or ANM or MCHW) within 3-7 days after birth	0.7%	2.5%	1.8	25%	Cultural barrier –not allowed go freely outside home till 21 days
30 ***	To prevent infection among newborns	Percent of newborns whose umbilical stump was first applied with chlorhexidine 4% within 24 hours of birth	0%	1.1%	1.1	40%	CHX application in newborn umbilicus intervention not introduced
32	To decrease percent women and children with Vitamin A deficiency	Percent of mothers of children aged 0-5 months who received vitamin A (200,000 IU) within 45 days after delivery	60.4%	75.1%	14.7	80%	
33*	To increase treatment of infection among neonates	Percent of neonates with PSBI diagnosed by a health worker or FCHV **(Merge)** within 48 hours of onset 60%	69.2%	80.0%	10.8	90%	
34	To increase treatment	Percent of neonates with PSBI	17.9%	10.0%	-7.9	60%	Very initial stage

	of infection among neonates	given a first dose of oral antibiotics **(Cotrim)** within 48 hours of onset					of program implementation
35	To increase treatment of infection among neonates	Percent of neonates with PSBI given a first dose of oral antibiotics **(Cotrim)** within 48 hours of onset for 3 days	2.6%	35.0%	32.4	50%	
36*	To increase treatment of infection among neonates	Percent of neonates with PSBI given a first dose of oral antibiotics **(Cotrim)** within 48 hours of onset for 3 to 5 days	17.9%	15.0%	-2.9	65%	
	Cross Cutting – Social Inclusion						
	To increase access to health information and services among DAGs**	Percent of DAG members participating in PWGs					
	To increase participation of DAG and representation of the needs of DAG in Health Facility Management Committees / VDC level	Percent of HFMC with participation of DAG members					

1 Community Outreach Mechanisms Expanded (Table)
Result 1: Increased Access to NNH Services in Parsa

1.1 Community Outreach Mechanisms Expanded

SN KPC	Project Objective	Indicator	Baseline (Feb 08)	Mid-term (Feb 2010)	Results (+ -)	EOP target Sep. 2011	Explanation of progress
	Antenatal						
5	To maintain or decrease the incidence of maternal and neonatal tetanus	Percent of mothers of children aged 0-5 months protected against tetanus by getting second dose of TT vaccine	88.7%	88.3%	-0.4%	Maintained	
6	To increase the percent of pregnant women receiving adequate antenatal care	Percent of mothers of children aged 0-5 months with 4 times ante-natal visit who were checked by ANM or AHW or Staff Nurse or HA or doctor	24.7%	39.3%	14.6%	55%	
7	To increase the percent of pregnant women receiving adequate antenatal care	Percent of mothers of children aged 0-5 months with 6 times ante-natal visit who were checked by ANM or AHW or Staff Nurse or HA or doctor	6.5%	13.8%	7.3%	35%	Wide dissemination of message on at least 4 visits protocol
8	To increase the percent of pregnant women receiving adequate antenatal care	Percent of mothers of children aged 0-5 months with 4 times ante-natal visit who were checked by MCHW, ANM or AHW or Staff Nurse or HA or doctor	30.0%	44.1%	14.1%	55%	
9	To increase the percent of pregnant women	Percent of mothers of children aged 0-5 months with 6 times ante-natal visit who	6.9%	14.2%	7.3%	40%	Wide dissemination of message on

SN KPC	Project Objective	Indicator	Baseline (Feb 08)	Mid-term (Feb 2010)	Results (+ -)	EOP target Sep. 2011	Explanation of progress
	receiving adequate antenatal care	were checked by MCHW, ANM or AHW or Staff Nurse or HA or doctor					at least 4 visits protocol
10	To decrease the percent of women and newborns with iron deficiency anemia	Percent of mothers of children aged 0-5 months receiving iron foliate tablets/caps at least for 4 months during their pregnancy	44.1%	50.2%	6.1%	70%	Inadequate iron supply from DPHO
11	To decrease the percent of women and newborns with iron deficiency anemia	Percent of mothers of children aged 0-5 months receiving iron foliate tablets/caps at least for 6 months during their pregnancy	25.9%	32.0%	6.1%	60%	Inadequate iron supply from DPHO
12	To increase the percent of pregnant women experiencing night blindness who receive treatment	Percent of mothers of children aged 0-5 months suffering from night blindness during their pregnancy and receiving low-dose vitamin A (25,000 IU)*	0%	15.6%	15.6%	35%	Parsa is not pilot district for low dose Vitamin 'A' supplementation to pregnant women
13	To decrease percent of pregnant women suffering from helminthes during pregnancy	Percent of mothers of children aged 0-5 months receiving a single dose of albendazole (400 mg) after completion of three month of last pregnancy	37.7%	41.3%	3.6%	65%	Pregnant women receive albendazole tablet during ANC check up only
	Delivery						
15	To increase percent of women accessing	Percent of mothers of children aged 0-5 months whose birth was attended by a	38.5%	46.6%	8.1%	45%	Introduction of government

SN KPC	Project Objective	Indicator	Baseline (Feb 08)	Mid-term (Feb 2010)	Results (+ -)	EOP target Sep. 2011	Explanation of progress
	skilled delivery care	skilled provider (doctor or nurse or HA or AHW or ANM)					maternity incentive scheme
16	To increase percent of women accessing skilled delivery care	Percent of mothers of children aged 0-5 months whose birth was attended by a skilled provider (doctor or nurse or HA or AHW or ANM or MCHW)	41.3%	49.4%	8.1%	50%	Introduction of government maternity incentive scheme
	Postnatal						
23	To maintain or increase percent of sick newborns receiving care	Percent of mothers with children aged 0-5 months whose newborn children with signs of severe illness were seen by a qualified public or private provider	93.5%	98%	4.5%	maintain	
24	To increase percent of newborns receiving a check up from a skilled provider within two days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a first checkup by a skilled provider (doctor or nurse or HA or AHW or ANM) within the first two days of birth	23.9%	31.2%	7.3%	50%	Community level FCHV training is still continuing
25	To increase percent of newborns receiving a check from a skilled provider up within two days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a first checkup by a skilled provider (doctor or nurse or HA or AHW or ANM or MCHW) within the first two days of birth	25.9%	34%	8.1%	50%	Community FCHV training is still continuing

SN KPC	Project Objective	Indicator	Baseline (Feb 08)	Mid-term (Feb 2010)	Results (+ -)	EOP target Sep. 2011	Explanation of progress
26	To increase percent of newborns receiving a second check up from a skilled provider within 3-7 days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a second post-natal checkup by a skilled provider (doctor or nurse or HA or AHW or ANM) within 3-7 days after birth	1.2%	0%	-1.2%	25%	Community FCHV level training still level continuing.
27	To increase percent of newborns receiving a second check up from a skilled provider within 3-7 days of birth	Percent of mothers with children aged 0-5 months (and their newborns) who received a second post-natal checkup by a skilled provider (doctor or nurse or HA or AHW or ANM or MCHW) within 3-7 days after birth	1.2%	0%	-1.2%	25%	Community level training is still continuing.
30 ***	To prevent infection among newborns	Percent of newborns whose umbilical stump was first applied with chlorhexidine 4% w/in 24 hours of birth	0%	2%	2%	40%	CHX just beginning.
32	To decrease percent women and children with Vitamin A deficiency	Percent of mothers of children aged 0-5 months who received vitamin A (200,000 IU) within 45 days after delivery	47.8%	42.9%	-4.9%	75%	Inadequate supply of Vitamin 'A' for routine use like in child diarrhea after mother's delivery
33*	To increase treatment of infection among neonates	Percent of neonates with PSBI diagnosed by a health worker or FCHV within 48 hours of onset	36.4%	52.9%	16.5%	75%	Community level FCHV training is still continuing.

SN KPC	Project Objective	Indicator	Baseline (Feb 08)	Mid-term (Feb 2010)	Results (+ -)	EOP target Sep. 2011	Explanation of progress
34	To increase treatment of infection among neonates	Percent of neonates with PSBI given a first dose of oral antibiotics within 48 hours of onset	0%	5.9%	5.9%	40%	Community level FCHV training is still continuing
35	To increase treatment of infection among neonates	Percent of neonates with PSBI given a first dose of oral antibiotics within 48 hours of onset for 3 days	0%	0.0%	0.0%	45%	Community level FCHV training is still continuing
36*	To increase treatment of infection among neonates	Percent of neonates with PSBI given a first dose of oral antibiotics within 48 hours of onset for 3 to 5 days	0%	17.6%	17.6%	40%	Community level FCHV training is still continuing
	Cross Cutting – Social Inclusion						
	To increase access to health information and services among DAGs**	Percent of DAG members participating in PWGs	0%	28%	28%		
	To increase participation of DAG and representation of the needs of DAG in Health Facility Management Committees / VDC level	Percent of HFMC with participation of DAG members		NA	NA		

BARA

Table 5: Comparison of coverage percentage for key indicators collected between the period of (January 2006 as baseline and December *2009 as LIBON MTE findings & results*) of Bara district

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
			BREAST FEEDING AND CHILD NUTRITION INDICATORS					
1	M1	Breastfeeding Initiation	Percent of children aged 0-11 months who are breastfed with in the first hour after birth	66	8.04	98	2.07	Dissemination of five key newborn messages through FM in local dialect
2	M1	Exclusive Breast feeding Rate	Percent of infants aged 0-5 months who were fed breastfed milk only in the last 24 hours	100		83	8.47	Still high coverage
3	M1	Complementary Feeding Rate	Percent of infant aged 6-9 months who received breast milk and solid foods in the last 24 hours	96	4.81	92	8.80	Maintained
4	M2	Continued breastfeeding	Percent of children aged 12-23 months who are still breast feeding	85	12.23	88	5.53	Maintained
5	M2	Vitamin "A" Coverage	Percent of children aged 12-23 months who received a vitamin A does in the last six months	99	1.47	91	4.87	National campaigning by mobilizing FCHV

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
			CHILDHOOD IMMUNIZATION INDICATORS					
6	M2	Possession of vaccination Card	Percent of Children aged 12-23 months who have a Vaccination Card	74	7.41	25	7.34	Less distribute the EPI cards as take time to fill up due more children to immunize
7	M2	EPI Access	Percent of children aged 12-23 months who received DPT 1 **only card coverage**	71	7.68	23	7.10	Do
8	M2	RAPID Catch Indicator: Measles Vaccination Coverage	Percent of children aged 12-23 months who received measles vaccine **only card coverage**	72	7.62	21	6.93	Do
9	M2	Drop Out Rate	Percent of drop out- rates between DPT1 and DPT 3	3	3.38	6	8.14	- VHW and MCHW immunization services - weak monitoring and supervision due to security and political influence

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
10	M2	Rapid Catch Indicator EPI Coverage	Percent of children aged 12-23 months who received BCG, DPT3, OPV3 and measles vaccines before the first birthday **only card coverage**	67	8.00	20	6.74	Less distribute the EPI cards as take time to fill up due more children to immunize
11	M2	EPI Coverage II (Liberal Criterion)	Percent of children aged 12-23 months who received OPV 3 **only card coverage**	72	7.62	22	7.02	Do
			SICK CHILD					
12	M1 & M2	Maternal Knowledge of child danger sign	Percent of mothers of children aged 0-23 months who know at least THREE signs of childhood illness that indicate the need for treatment	98	1.78	75	5.22	Mother's group meeting not regular, less practice of counseling to mothers during ANC at HF
			DIARRHEA INDICATORS					
13	M1 & M2	Diarrhea prevalence	Percent of children aged 0-23 months with diarrhea in the last two weeks	21	4.87	29	5.45	

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
14	M1 & M2	ORT use during a Diarrhea Episode	Percent of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/ or recommended home fluids (RHF)	60	12.95	23	9.45	None functioning of ORT corner set. Shortage of ORS supply
15	M1 & M2	Increased breastfeed During a Diarrhea Episode	Percent of children aged 0-23 who received breastfed same amount or more during diarrhea in last two weeks.	95	6.00	75	9.63	No regular and effective MGM/PWG meeting, less counseling
16	M1 & M2	Increased drink during a diarrhea Episode	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more drink / fluid during the illness	93	6.86	44	11.09	No regular and effective MGM/PWG meeting, less counseling
17	M1 & M2	Increased food during a diarrhea Episode	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	95	6.00	39	10.89	No regular and effective MGM/PWG meeting, less counseling
18	M1 & M2	Care–seeking for Diarrhea	Percent of Children aged 0-23 months with diarrhea in the last two weeks whose mothers Sought outside advice or treatment for the illness	91	7.60	71	10.09	Absenteeism of health workers.

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
19	M2	Maternal Competency in ORS Preparation	Percent of mothers who can correctly prepare ORS	84	6.20	61	8.29	Less functional ORT corners
20	M2	Maternal Hand Washing before Food Preparation	Percent of mothers who usually wash their hands with soap or ash before food preparation.	92	4.68	67	8.00	No regular and effective MGM/PWG meeting, less counseling
21	M2	Maternal Hand Washing before Food Preparation before feeding /after attending to a child who has defecated	Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	78	7.02	31	7.85	No regular and effective MGM/PWG meeting, less counseling
			ARI IDICATOR					
22	M1 & M2	ARI Care –seeking	Percent of Children aged 0-23 months with cough and fast / difficult breathing in the last two weeks who were taken to a health facility or received treatment.	80	14.31	61	9.63	No regular and effective MGM/PWG meeting, less counseling
			PRENATAL CARE INDICATORS					
23	M1	Maternal Health Card Presentation	Percent of mothers with a maternal card (Card-confirmed) for the youngest child less than 12 months of age	65	8.12	17	6.31	Loss of card and giving less importance on card holding

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
24	M1	Tetanus Toxoid Coverage	Percent of mothers who received at least TWO tetanus toxoid injections (Card confirmed) before the birth of the youngest child less than 12 months of age.	63	8.20	14	5.95	Loss of card and giving less importance on card holding
25	M1	Prenatal Care Coverage	Percent of mothers who had at least ONE prenatal visit prior to the birth of her youngest child less than 12 months of age	78	7.02	40	8.32	Less functional of PHC ORC
26	M1	Iron Supplementation Coverage	Percent of mothers who received /brought iron supplements while pregnant with the youngest child less than 12 months of age.	93	4.27	86	5.95	Iron supply shortage for 4 months
			PLACE OF DELIVERY AND DELIVERY ATTENDED					
27	M1	Delivery by skilled Health Personnel	Percent of children aged 0-11 months whose delivery was attended by a skilled health personal upto TBA level	77	7.19	54	8.47	TBA program has been stopped
28	M1	Delivery by skilled Health Personnel	Percent of children aged 0-11 months whose delivery was attended by a skilled health personal upto MCHW level	42	8.39	46	8.47	
29	M1	Clean Cord Care	Percent of children aged 0-11 months whose delivery involved use of a clean birth kit or whose cord was cut with a new razor			98	2.07	Dissemination of five key newborn messages through FM in local dialect

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
30	M1	Clean Cord Care	Percent of children aged 0-11 months whose delivery involved use of a clean birth kit	75	7.34	45	8.46	Diverse practices of clean cord care
31	M1	Immediate Breast Feeding	Percent of children aged 0-11 months who were immediately breastfed with the mother immediately after birth.			41	8.35	
32	M1	Placement at Birth	Percent of children aged 0-11 months who were placed with the mother immediately after birth	82	6.54	75	7.34	
			POSTPARTUM CARE					
33	M1	Postpartum Contact	Percent of mother who had at least ONE postpartum check-up	63	8.20	33	8.00	Less functional ANC/PNC clinics and some cultural barriers
34	M1	Knowledge of maternal Danger Signs	Percent of mothers able to report at least TWO known maternal danger signs during the postpartum period			77	7.10	
35	M1	Knowledge of Neonatal Danger Signs	Percent of mothers able to report at least THREE known neonatal danger signs	98	2.07	77	7.19	

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
36	M1	Knowledge of Neonatal Danger Signs	Percent of mothers able to report at least TWO known neonatal danger signs	98	2.07	92	4.68	
37	M1	Maternal Vitamin A supplementation	Percent of mothers who received a Vitamin A dose during the first six weeks after delivery	80	6.74	67	8.00	Less supply of vitamin A for post partum dosing
38	M1	Maternal iron supplementation	Percent of mothers who received at least 1 month iron tablets during the first two months after delivery	75	7.34	49	8.50	Less supply of iron due to stop of CDP and introduction of free essential health service
			CHILD SPACING					
39	M3	Contraceptive Use Among Mothers Who Want to limit or space births	Percent of non pregnant mothers who desire no more children in the next two years or are not sure, who are using a modern method of child spacing	66	8.04	41	8.37	Less practice of quality counseling by health provider
40	M3	Knowledge of source of Child spacing methods	Percent of mothers who report at least one place where she can obtain a method of child spacing	100		97	2.90	
41	M3	Adequate birth interval between surviving children	Percent of children aged 0-23 months who were born at least 24 months after the previous surviving child	69	12.90	63	12.68	

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
42	M3	Adequate Birth interval Between youngest Surviving Children (Less Stringent Criteria)	Percent of children aged 0-23 months who were born at least 36 months after the previous surviving child	14	9.80	20	10.41	
			KNOWLEDGE OF DANGER SIGNS DURING PREGNANCY, POSTNATAL AND NEW BORN CHILD					
43	M1	Danger signs/ symptoms during pregnancy	Percent of mothers (15-49 years) who know at least TWO danger signs/symptoms during pregnancy	100		78	7.02	Less participation of Pregnant women in MG meeting.
44	M1	Danger signs/ symptoms during pregnancy	Percent of mothers (15-49 years) who know at least THREE danger signs/symptoms during pregnancy	99	1.47	60	8.32	Less participation of Pregnant women in MG meeting.
45	M1	Danger signs after delivery	Percent of mothers who knows at least TWO danger signs/ symptoms of after delivery	98	2.07	77	7.10	Do
46	M1	Danger signs after delivery	Percent of mothers who knows at least THREE danger signs/ symptoms of after delivery	95	3.80	53	8.48	Do

SN	Mod#	Indicator	Indicator/ Definition	LQAS Jun'06	Confidence Interval ± CI	LQAS Dec'09	Confidence Interval ± CI	Explanation of progress
47	M1	Danger signs of new born	Percent of mothers who know at least TWO danger sign of new born	98	2.07	92	4.68	
48	M1	Danger signs of new born	Percent of mothers who know at least THREE danger sign of new born	98	2.07	77	7.19	No proper counseling during ANC/PNC check-up
			DANGER SIGNS OF PNEUMONIA AND DIARRHEA					
49	M2	Danger signs/ symptoms of pneumonia	Percent of mothers who know at least THREE danger signs/ symptoms of pneumonia	98	2.52	68	7.90	Less participation of Pregnant women in MG meeting.
50	M2	Danger signs / symptoms of diarrhea/ dysentery	Percent of mothers who know at least THREE danger sign of diarrhea / dysentery	92	4.48	44	8.43	Do
			KNOWLEDGE ON HIV/AIDS/STD					
51	M3	Knowledge about HIV/AIDS and STD transmission	Percent of mothers who knows at least ONE HIV/AIDS and STD transmission (MOT)	68	7.95	40	8.32	Do
52	M3	Knowledge about HIV/AIDS and STD Prevention	Percent of mothers who knows at least ONE HIV/AIDS and STD prevention (MOT)	69	7.85	40	8.32	Do

ANNEX-7: CHW TRAINING MATRIX

	Project Area (Name of district or community)	Type of Training	Duration	Official Government, CHW and Partner	Paid or Volunteer	Planning Scheduled Date	Number of Trained	Focus of Training	Status
1	Kathmandu district	National Level Master Training of Trainers (MTOT) on CB-NCP	7 days	Government	Paid	Aug 08	25	Training on technical skill of newborn care & management of danger signs and recording reporting, for: ▪ Infection ▪ Hypothermia ▪ Birth asphyxia ▪ Low birth weight	▪ Completed ▪ The training was funded by UNICEF Nepal with coordination with CHD, SC, Plan, Care etc
2	Sunsari and Parsa districts	Planning meeting at district level/program orientation for CB-NCP	2 days	Government	Paid	Sept 08	77	CB-NCP administrative orientation	▪ Completed
3	Sunsari and Parsa districts	District Training of Trainers (DTOT) on CB-NCP	7 days	Government	Paid	Sept 08	39	Training on technical skill of newborn care & management of danger signs and recording	▪ Completed

	Project Area (Name of district or community)	Type of Training	Duration	Official Government, CHW and Partner	Paid or Volunteer	Planning Scheduled Date	Number of Trained	Focus of Training	Status
								reporting, for: ▪ Infection ▪ Hypothermia ▪ Birth asphyxia ▪ Low birth weight	
4	Sunsari and Parsa districts	Health Facility (HF) Ilaka level training on CB-NCP	7 days	Government	Paid	Oct 08 – Jan 09, Oct-Dec 09	335	Training on technical skill of newborn care & management of danger signs and recording reporting, for: ▪ Infection ▪ Hypothermia ▪ Birth asphyxia ▪ Low birth weight	▪ Completed
5	Sunsari and Parsa districts	VHW/MCHW – SHP level training on CB-NCP	6 days	Government	Paid	Apr-Jun 09 Jan-Mar 10	235	Training on technical skill of newborn care & management of danger signs and recording reporting, for: ▪ Infection ▪ Hypothermia	▪ Completed

	Project Area (Name of district or community)	Type of Training	Duration	Official Government, CHW and Partner	Paid or Volunteer	Planning Scheduled Date	Number of Trained	Focus of Training	Status
								▪ Birth asphyxia ▪ Low birth weight	
6	Sunsari and Parsa districts	Basic training to FCHVs on CB-NCP	7 days	CHW	Volunteer	Oct 08 – Jan 09 Oct-Dec10	1,222	Training on technical skill of newborn care & management of danger signs and recording reporting, for: ▪ Infection ▪ Hypothermia ▪ Birth asphyxia ▪ Low birth weight	▪ Completed in Sunsari district and going on in Parsa district
7	Sunsari district	Regional ToT on CB-NCP	7 days	Government and partner	Paid	Feb 2009	24	Training on technical skill of newborn care & management of danger signs and recording reporting, for: ▪ Infection ▪ Hypothermia ▪ Birth asphyxia ▪ Low birth weight	▪ Completed

	Project Area (Name of district or community)	Type of Training	Duration	Official Government, CHW and Partner	Paid or Volunteer	Planning Scheduled Date	Number of Trained	Focus of Training	Status
8	Sunsari and Parsa districts	PWG training	2 days	Government and CHW	Paid and FCHV volunteer	Jul'08 to Jun'09	2,185	Training focus on demand, service and know about danger sign during pregnancy, delivery, postnatal and newborn	▪ Completed
9	Kathmandu district	LQAS training to IOM student, Kathmandu	4 days	Student	Volunteer	Sep & Dec'08	87	Training focus on survey technique; data collection through selection community, household and respondent as well as data hand tabulation and analysis	▪ Completed
10	Kathmandu district	LQAS orientation to IOM faculty member, Kathmandu	4 days	Partner	Paid	Sep'08	17	Training focus on survey technique; data collection through selection community, household and respondent as well as data hand tabulation and analysis	▪ Completed

	Project Area (Name of district or community)	Type of Training	Duration	Official Government, CHW and Partner	Paid or Volunteer	Planning Scheduled Date	Number of Trained	Focus of Training	Status
11	Kathmandu district	LQAS Master TOT	5 days	Government and Partner	Paid	Jan'08	25	Training focus on survey technique; data collection through selection community, household and respondent as well as data hand tabulation and analysis	▪ Completed
12	Bara, Parsa and Sunsari district	LQAS training	4 days	Government and Partner	Paid	Jan'08, Feb'08, Dec'09 to Feb'10	234	Training focus on survey technique; data collection through selection community, household and respondent as well as data hand tabulation and analysis	▪ Completed
13	Bara, Parsa and Sunsari district	CSSA workshop	3 days	Government, stakeholder and Partner	Paid	May'08, Aug'08, Dec'09 to Mar'10	141	Workshop on how to program sustainable after project completion and developed action plan	▪ Completed
14	Sunsari	Rapid Health	9 days	Government,	Paid	Feb'10	21	Training focus on	▪ Completed

	Project Area (Name of district or community)	Type of Training	Duration	Official Government, CHW and Partner	Paid or Volunteer	Planning Scheduled Date	Number of Trained	Focus of Training	Status
	district	Facility Assessment		stakeholder and Partner				survey technique for health facilities assessment	
15	Parsa district	Orientation on Chlorhexidine (CHX)	1 day	Government, stakeholder and Partner	Paid	Oct'09	20	Orientation for use of CHX in umbilical stump of newborn baby	▪ Completed
16	Parsa district	CHX training to Hospital staff	1 day	Government	Paid	Nov'09	92	Training for apply of CHX in umbilical stump of newborn baby within 1 or 2 hours	▪ Completed
17	Parsa district	CHX training to district and HF staff	1 day	Government	Paid	Oct'09 & Jan'10	122	Training for apply of CHX in umbilical stump of newborn baby within 1 or 2 hours	▪ Completed
18	Parsa district	CHX training to VHW/MCHW	1 day	Government	Paid	Nov & Dec'09	132	Training for apply of CHX in umbilical stump of newborn baby within 1 or 2 hours	▪ Completed
19	Parsa district	CHX training to FCHV	1 day	CHW	Volunteer	Jan to Jun'10	223	Training for apply of CHX in umbilical stump of newborn baby within 1 or 2 hours	▪ Going on

ANNEX-8: EVALUATION TEAM MEMBERS AND THEIR TITLES

Rose Schneider – Mid-term Evaluator

Bhagawan Das Shrestha – Field Program Manager – LIBON

Dipak Dahal – Monitoring and +Evaluation Officer – LIBON

Sherbahadur Rana – Health Coordinator – Plan Nepal

Stacy Fehlenberg – Technical Backstop – Plan USA National Office

Justin Fugle – Program Office Backstop -- Plan USA National Office

ANNEX-9A: EVALUATION ASSESSMENT METHODOLOGY

Provide a brief discussion of the assessment methods used by the Mid-Term Evaluation team to assess essential knowledge, skills, practices, and supplies of health workers and facilities associated with the project.

The Mid-term evaluation used a solid qualitative methodology to assess and report on LIBON's progress and for the external evaluator to work closely with the LIBON team and representatives of partners from the MOPH and IOM. This methodology included: the review and use of the key project documents, a local team planning meeting, key informant interviews with LIBON and MOPH staff, development of short data collection instruments for use in field visits in the three districts (Sunsari, Parsa and Bara), key informant interviews with MOH staff at the district and health facilities levels and focus group discussions with FCHVs and members of PWGs.

The initial document reviews provided background and considerable in-depth project information including a recently developed second year annual report. The information and rationale for approaches used by LIBON were explored with staff in a series of in-depth key informant interviews. Graphs of the data were developed from the LQAS and were used as part of the Field Visit key informant interviews with MOPH staff. These LQAS graphs and the data collection instrument were used to focus the information solicited from DHO, hospital, health center, and sub health center staff. These staff provided to the evaluation team their information on their services, skills, training, supplies and equipment to support the program. They also provided their analysis of project progress, rationale, limiting factors and discussed adjustments or needs to help LIBON meet its objectives.

As part of the Field Visits, key informant interviews were also held with FCHV to solicit information on their role, the tasks they carried out, the support from various health workers/facilities, the equipment and supplies provided. They were also asked to discuss why certain LQAS reported project indicators had increased and why certain ones had declined. As a key part of the field visits, a number of PWG were interviewed in focus groups to solicit information on the topics they had been trained/exposed to, the services they received from FCHV, and health staff at several levels and other information. The information from the field visits, although not representative due to time limitations was used to triangulate information from LIBON reports and staff key informant interviews, from LQAS, other reporting, key informant interviews from MOPH, IOM, and other partners.

The intense discussions within the evaluation team also contributed additional data and analysis of the progress of LIBON and especially to solicit their insights for the changes to be made for the second half of the project. The participation of the new director of the CB-IMCI division at the MOPH and the Director of the Community Health Department of the IOM provided much additional information as well as partners' perspectives. The presentation of the MTE finding and conclusions to the expanded stakeholders provided feedback on design, technical and management issues, identified areas to be considered for strengthening and considerations on the conclusions reached. It was also a forum to seek additional interest and collaboration from the MOPH and other stakeholders for the second half of the LIBON project.

ANNEX-9B: EVALUATION ASSESSMENT METHODOLOGY

Lot Quality Assurance Sampling (LQAS) method:

Method and process of LQAS survey training has three stages by time frame. The first stage is the training of enumerators and supervisors which lasts 4 days. Day one covers orientation, clarification and explanation on LQAS-what, why and how to use LQAS. Day two covers how the community, household and respondent selection and how the data hand tabulation and process. Day three covers further in-depth, practical solutions to the problems faced by the participants during field test along with identifying and determining survey locations, communities, households and respondents through random sapling method. Day four covers questionnaire review and role play for further clarification on LQAS survey process as well as preparation for the field data collection.

The Monitoring and Evaluation Officer and the Facilitator team members made efforts to convince and make the participants confident in learning to apply the LQAS tools to collect information during the field survey.

Participants are grouped in two-person teams in a group representation from D(P)HO, partner NGOs and Plan Program Unit offices of Rautahat during Bara; Morang during Sunsari training; and Makwanpur during Parsa districts including LIBON Project field based staff for enumeration and data collection during the survey.

After completion of data collection, survey team members made hand calculation and tabulation of the data, information collected under the guidance of the Facilitators.

Findings and results are shared and discussed in the plenary by each survey team, with open comments and feedback by each Supervision Area (Ilaka) based on the indicators as comparison of baseline threshold, decision rules, program average percentage and monitoring targets to the findings and results of present survey for MTE. During the following 3 days, hand tabulation and analysis are made of the collected field data. In sessions after the field survey, MoHP policy makers, regional and central offices, D(P)HO, partners, Plan Nepal PUs, and LIBON project members participate to discuss the results, health service and status of each Supervision Areas and the districts.

Sample size and sample frame:

Sample size is the number of responses obtained per Supervision Area for a specific indicator. The total sample size for the catchments area is the aggregated sample size from all supervision areas.

For the purpose of MTE data collection, the three districts are divided into existing D(P)HO Supervision Areas (Ilaka) including the municipalities' slums and the periphery where health facilities are still in poor condition to measure the achievements and performance results against indicators based on the decision rules.

Bara district is divided into 7 Supervision Areas (SAs) based on CS-XVII project final evaluation Supervision Area. Sunsari district is divided into 15 SAs (12 Ilakas of Sunsari DHO and 3 municipalities) based on Ilakas of DDCs and DHO and similarly, Parsa district is divided into 13 SAs (12 Ilakas of Parsa DPHO and 1 municipality).

A sample size of 19 households is selected per SA for MTE purpose to minimize α and β errors for the sample size of less than 19 and more work that does not necessarily reduce the margin of error for greater sample size than 19 i.e. less than 10%. In assessing coverage, all the samples taken from each Supervisory Area have been aggregated in order to obtain a large enough sample size as required to estimate the proportion in each population subgroup. Total sample size for Bara is 133 mothers (19 HHs X 7 SAs), for Parsa, 247 mothers (19 HHs X 13 SAs) and for Sunsari, 285 mothers (19 HHs X 15 SAs) for each module.

Questionnaire

Translated copies of different questionnaire modules developed during the baseline survey of Sunsari and Parsa in year 2008 and indicators of final evaluation of CS-XVII Project Bara year 2006 corresponding to various groups of target beneficiaries of three districts have been discussed and shared among the participants and stakeholders openly for thorough common understating to collect information for MTE. Different sets of questionnaires were prepared for Bara district as per the indicators set for final evaluation of CS-XVII Project. For Sunsari and Parsa, module 1 is set for mothers of children 0-5 months old, to collect information on mothers' knowledge of neonatal indicators and module 2 questionnaires for mothers of children 0-23 months for Rapid Catch Indicators to assess immunization coverage and breastfeeding status.

Team Composition and Field Plan:

The team composition is made from two to three persons representing each organization e.g. D(P)HO, municipality, stakeholders, partner NGOs, Plan Nepal PUs (Rautahat and Morang, Makwanpur) and LIBON Project to join the adjoining districts Bara, Sunsari and Parsa and LIBON field based staff in each district depending upon the number of participants in the training. After training, field plan is scheduled for 7 or 8 days to collect information during the survey. Groups are formed according to the number of SAs per district.

2) CHILD SURVIVAL SUSTAINABILITY ASSESSMENT (CSSA) WORKSHOP:

Methodology:

Introduction to CSSA and Child Survival Projects

Facilitators' team clarified the objectives of the CSSA – Workshop as an assessment tool for MTE of LIBON Project Districts.

- *To define sustainability within the context of health programs.*
- *To assess the sustainability of LIBON Project in Sunsari and Parsa and develop a Plan of action.*
- *To assist local partner organizations to assess their own sustainability.*

Evolution of Sustainability:

Stage 1: Since 1985 to 1995, Plan Nepal has challenges of performing its results in small manageable, sizeable and controllable atmosphere.

Stage 2: Since 1995, it has challenges of expanding, scaling up of its services to the un-reached children, mothers and communities of Nepal beyond its control, resources and management in open social laboratories with joint collaboration with cooperation and participation of various relevant actors, stakeholders and the communities.

Some of the pertinent challenges are as below.

The three mores that are being demanded of Private Volunteer Organization (PVOs)/NGOs:

1. More reduction in mortality, fertility, and everything else – through greater equity, quality etc.
2. More people reached: Scale
3. More lasting impact: Sustainability;

Challenges in producing further reductions in mortality

- Increase equity: Reach the poorest and those farthest away
- Increase quality of implementation
- Address other causes of mortality that are more difficult to decrease e.g. neonatal mortality

Facilitator was focus and describe on 6 components of 3 dimensions as follows:

Dimension 1: Health and health Services
Component 1: Health Outcomes
Component 2: Health Services

Dimension 2: Organizational
Component 1: Local Organizational Capacity
Component 2: Local Organizational Viability

Dimension 3: Community and social Ecological
Component 1: Community competence and capacity
Component 2: Ecological, human, economic political and policy environment

The participants were divided into three group for the exercise on outcomes of each elements including baseline indicators indicating the health and health service, organizational capacity and viability and community competency and socio political, ecological environment. All groups presented their result and finally, the group finalized common elements and indicators of each component. The sources are identified and consensus on the indicator settings is made. The sources of indicators are HMIS, LQAS and other information from DHO, District Education Office (DEO), Women Development Organization (WDO), health facility information and external reports.

The same groups were prepared the action plan and discussed about the ownership of the future health of community along with influence on health program, roles and responsibilities and relationships among various factors in the communities.

All the three workshops were held as scheduled in the three districts. Participation of representatives from relevant stakeholders, actors and partners like central and regional divisional heads, chiefs of child and maternal health, CB-NCP, CB-IMCI of MoHP, D(P)HO, DDC, municipalities, FPAN field office, WDO, DEO and local partner NGOs was quite lively and inquisitive regarding the results from the Black Box to know the formula of interpretation of data by the participants. As per set objectives, the workshop followed all the six steps for sustainability assessment as a self-discovery tool to know, to realize and to improve the situation of child and maternal health condition through follow-up action plan for the coming year. Facilitator team members from central to field office made hard efforts as usual for data exploration, analysis and to make the stakeholders actors and partners realize their ownership and responsibility for informed planning and management. Findings of results and workshop are presented systematically in step wise below and proceeding including list of participants are annexed under respective district headings.

ANNEX-10: LIST OF PERSONS INTERVIEWED AND CONTACTED DURING THE MID-TERM EVALUATION

Interviewees of CARE Nepal and HRI in NCO, Kathmandu on 23 Mar 2010

MTE team:

	Name	Position	Organization
1	Ms. Rose Schneider	MTE Team Leader	
2	Ms. Stacy Fehlenberg	HIV & Health Advisor	Plan US
3	Mr. Sher Bahadur Rana	Health Coordinator (HC)	Plan Nepal
4	Mr. Bhagawan Das Shrestha	Project Coordinator (PC)-LIBON	Plan Nepal
5	Mr. Dipak Dahal	M&E Officer	Plan Nepal
6	Ms. Nirmala Sharma	Health Program Coordinator	Care Nepal
7	Ms. Chandra Rai	Project Director/ Country Representative	Health Right International (HRI)
8	Mr. Hari Bahadur Rana	Training & Operation Officer	HRI
9	Mr. Bijaya Bharati	Project Coordinator	HRI

Interviewees of PWG/MG in Sapahi VDC, ward -5, Bara district on 24 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Parashuram Shrestha	CB-IMCI Chief
3	Mr. Sher Bahadur Rana	Health Coordinator
4	Mr. Dipak Dahal	M&E Officer
5	Mr. Diwakar Mishra	Assistant District LIBON Coordinator (ADLC) - Bara
6	Mr. Amleshwor Mishra	CB-IMCI focal person
7	Ms. Meena K Singh	Admin & Finance Assistant (AFA)
8	Mr. Raj Kishor Chaudhary	LIBON Facilitator (LF)

PWG/MG:

	Name	Type
1	Ms. Ranti Chaudhary	PWG member
2	Ms. Rukmili Chaudhary	PWG member
3	Ms. Rajmani Chaudhary	PWG member
4	Ms. Nilu Chaudhary	PWG member
5	Ms. Jamuna Chaudhary	PWG member
6	Ms. Jagiya Chaudhary	PWG member
7	Ms. Kaushila Chaudhary	FCHV
8	Ms. Surendri Devi Chaudhary	FCHV
9	Ms. Bal Kumari Chaudhary	FCHV
10	Ms. Bhageshwari Chaudhary	FCHV
11	Ms. Sabita Keshari	FCHV

Interviewees of Sapahi SHP team, Bara district on 24 Mar 2010

MTE team:

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Mr. Chitra Kumar Gurung	Prof. IOM
3	Mr. Bhagawan Das Shrestha	PC-LIBON
4	Mr. Deo Ratna Chaudhary	District LIBON Coordinator (DLC)
5	Ms. Shanta Rajaure	Sponsorship Program Manager (SPM)

SHP team:

	Name	Position
1	Mr. Parash Nath Chaudhary	SHP In-charge
2	Ms. Sarad Devi Karna	MCHW
3	Mr. Uttam Kumar	VHW

Interviewees of Narayani Sub-Regional Hospital team, Birgunj, Parsa district on 25 Mar 2010

MTE team:

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Ms. Stacy Fehlenberg	HIV & Health Advisor
3	Mr. Parashuram Shrestha	CB-IMCI Chief
4	Mr. Chitra Kumar Gurung	Prof. IOM
5	Mr. Sher Bahadur Rana	HC
6	Mr. Bhagawan Das Shrestha	PC-LIBON
7	Mr. Deo Ratna Chaudhary	DLC
8	Mr. Krishna Bahadur Achhami	ADLC – Parsa
9	Ms. Meena K Singh	AFA
10	Mr. Dipak Dahal	M&E Officer

Hospital team:

	Name	Type
1	Dr. Lal Babu Gupta	Hospital In-charge
2	Dr Arun Kumar Singh	Head of Nutrition & Rehabilitation
3	Ms. Bishakha Chaudhary	Gyno In-charge
4	Ms. Sarita Yadav	Nutrition & Rehabilitation section In-charge

Interviewees of PWG/MG in Mahuwan VDC, ward-2, Parsa district on 25 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Chitra Kumar Gurung	Prof. IOM
3	Mr. Deo Ratna Chaudhary	DLC
4	Mr. Dipak Dahal	M&E Officer

5	Ms. Saraswoti Kharel	LF
6	Mr. Mr. Ejaz Ansari	LF

PWG/MG:

	Name	Type
1	Ms. Mishri Devi Pandit	PWG member
2	Ms. Shakuntala Devi Kalwar	PWG member
3	Ms. Phulmati Devi Yadav	MG member
4	Ms. Shila Devi Patel	PWG member
5	Ms. Samjana Devi Patel	PWG member
6	Ms. Indu Devi Jaiswal	PWG member
7	Ms. Prabha Devi	PWG member
8	Ms. Bishnu Devi Thakuri	PWG member
9	Ms. Phulmati Devi Thakur	MG member
10	Ms. Aaila Kurmi	MG member
11	Ms. Mina Giri	MG member
12	Ms. Laxmi Kurmi	MG member
13	Ms. Ranju Devi Kurmi	MG member
14	Ms. Kanti Devi Dhobi	MG member
15	Ms. Champa Devi Kurmi	MG member
16	Ms. Phuljhari Goad	MG member
17	Ms. Shanti Majhi	MG member
18	Ms. Kalawati Devi	MG member
19	Ms. Rani Majhi	MG member
20	Ms. Babita Giri	MG member
21	Ms. Rajmati Devi Kalwar	MG member
22	Ms. Suman Devi	PWG member
23	Ms. Punita Devi Giri	PWG member
24	Ms. Umrawati Devi	PWG member
25	Ms. Chhathiya Devi	PWG member

Interviewees of in Mahuwan SHP, Parsa district on 25 Mar 2010

MTE team:

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Mr. Parashuram Shrestha	CB-IMCI chief
3	Mr. Sher Bahadur Rana	HC
4	Mr. Bhagawan Das Shrestha	PC-LIBON
5	Mr. Krishna Bahadur Achhami	ADLC
6	Ms. Meena K Singh	AFA

SHP team:

	Name	Type
1	Mr. Sroj Giri	AHW
2	Mr. Nageshowr Mishra	VHW
3	Ms. Sita Giri	MCHW
4	Ms. Sushum Kumari Devi	FCHV

5	Ms. Gangajali Devi	FCHV
6	Ms. Tetari Devi	FCHV
7	Ms. Lalmati Devi	FCHV
8	Ms. Maya Devi	FCHV
9	Ms. Sunari Devi	FCHV

Interviewees of Pokhariya Hospital team, Parsa district on 25 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Chitra Kumar Gurung	Prof. IOM
3	Mr. Deo Ratna Chaudhary	DLC
4	Mr. Dipak Dahal	M&E OFFICER
5	Mr. Jay Mangal Thakur	LF

Pokhariya hospital team:

	Name	Position
1	Dr. Jhari Lal Jayswal	Chief of Hospital
2	Ms. Subhadra Thapa	ANM
3	Mr. Lal Babu Sah	AHW
4	Mr. Raghusir Prasad	AHW
5	Mr. Lilam Kumar	AHW
6	Mr. Brijesh Dubedi	AHW
7	Mr. Rajindar Prasad	AHW
8	Mr. Rajindar Mahato	Lab Assistant

Interviewees of LIBON and PU team at Hotel Makalu, Parsa district on 25 Mar 2010

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Ms. Stacy Fehlenberg	HIV & Health Advisor
3	Mr. Sher Bahadur Rana	HC
4	Mr. Prabhakar KC	Program Manager (PM)
5	Mr. Bhagawan Das Shrestha	PC LIBON
6	Mr. Bharat Tamang	Development Coordinator (DC)
7	Mr. Deo Ratna Chaudhary	DLC
8	Mr. Krishna Bahadur Achhami	ADLC – Parsa
9	Mr. Diwakar Mishra	ADLC - Bara
10	Mr. Raj Kishor Chaudhary	LF
11	Ms. Saraswoti Kharel	LF
12	Mr. Ejaz Ansari	LF
13	Mr. Sajit Kumar Adhikari	LF
14	Mr. Jay Mangal Thakur	LF
15	Ms. Srijana Rai	Office Assistant (OA)
16	Ms. Meena K Singh	AFA
17	Mr. Dipak Dahal	M&E OFFICER

Interviewees of Parsa DPHO team at Hotel Makalu, Parsa district on 26 Mar 2010

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Ms. Stacy Fehlenberg	HIV & Health Advisor
3	Mr. Parashuram Shrestha	CB-IMCI Chief
4	Mr. Chitra Kumar Gurung	Prof. IOM
5	Mr. Sher Bahadur Rana	HC
6	Mr. Bhagawan Das Shrestha	PC LIBON
7	Mr. Deo Ratna Chaudhary	DLC
8	Mr. Krishna Bahadur Achhami	ADLC – Parsa
9	Mr. Diwakar Mishra	ADLC – Bara
10	Mr. Dipak Dahal	M&E Officer
11	Mr. Arun Kumar Mahato	Public Health Administrator (PHA), DPHO-Parsa
12	Mr. Prem Chandra Jaiswal	CB-NCP-Focal Person, DPHO-Parsa

Interviewees of Harinagara PHC team, Sunsari district on 27 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Dipak Dahal	M&E Officer
3	Ms. Indira Phuyal	Gender & CEDC Program Coordinator
4	Mr. Chitra Kumar Gurung	Prof IOM
5	Mr. Hari Dev Shah	ADLC
6	Mr. Yam Bahadur Thapa	LF
7	Mr. Rajendra Prasad Sah	LF

PHC team:

	Name	Position
1	Mr. Madhav Lal Dev	PHC In-charge
2	Mr. Birendra Deo	AHW
3	Mr. Dev Narayan Sah	In-charge Basantapur SHP
4	Mr. Birendra Yadav	In-charge Rashi SHP
5	Ms. Pinky Bhagat	ANM
6	Ms. Sanita Sah	ANM

Interviewees of PWG/MG, Lauki VDC, ward – 3, Sunsari district on 27 Mar 2010

MTE team:

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Mr. Parashuram Shrestha	CB-IMCI chief
3	Ms. Chhing Lamu Sherpa	Program Unit Manager (PUM)
4	Mr. Sher Bahadur Rana	HC
5	Mr. Bhagawan Das Shrestha	PC-LIBON

6	Ms. Kalawati Changbang	Health Program Coordinator (HPC)
7	Ms. Shova Thakali	Inclusion Manager
8	Mr. Bijaya Kumar Sah	LF

PWG/MG:

	Name	Type
1	Ms. Kamala Raut	PWG member
2	Ms. Phulmanti Raut	PWG member
3	Ms. Babita Mandal	PWG member
4	Ms. Teju Devi Urau	FCHV
5	Ms. Shanti Subba	FCHV
6	Ms. Lalita Urau	MG member
7	Ms. Sunita Devi Urau	MG member
8	Ms. Laxmi Devi Urau	MG member
9	Ms. Gita Phaudhar	MG member
10	Ms. Babita Phaudhar	MG member
11	Ms. Meena Urau	MG member
12	Ms. Parbati Mandal	MG member
13	Ms. Rita Urau	MG member
14	Ms. Kalmi Devi Urau	MG member
15	Ms. Dev Kala Mandal	MG member
16	Ms. Kamala Subba	MG member
17	Ms. Namrata Urau	MG member
18	Ms. Binita Devi Mandal	MG member
19	Ms. Amrita Urau	MG member

Interviewees of PWG/MG in Harinagara VDC, ward-2, Sunsari district on 27 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Dipak Dahal	M&E Officer
3	Ms. Indira Phuyal	Gender & CEDC Program Coordinator
4	Mr. Chitra Kumar Gurung	Prof IOM
5	Mr. Rajendra Prasad Sah	LF

PWG/MG:

	Name	Type
1	Ms. Rawati Devi Mandal	PWG member
2	Ms. Budhani Devi Mandal	PWG member
3	Ms. Rekha Devi Ram	PWG member
4	Ms. Babita Devi Mandal	PWG member
5	Ms. Bimala Devi Ram	Postnatal mother
6	Ms. Anita Devi Ram	Postnatal mother
7	Ms. Ritu Devi Ram	Postnatal mother
8	Ms. Sanechari Devi Ram	Postnatal mother

9	Ms. Shusila Devi Ram	Postnatal mother
10	Ms. Phulkumari Mandal	Postnatal mother
11	Ms. Buchiya Devi Mandal	Postnatal mother
12	Ms. Samrita devi Mandal	Postnatal mother
13	Ms. Rambha Devi Ram	MG member
14	Ms. Rambha Devi Mehta	MG member
15	Ms. Rajiya devi Ram	MG member
16	Ms. Sita Devi Ram	MG member
17	Ms. Phekali Devi Mahato	MG member
18	Ms. Dewaki Devi Ram	MG member
19	Ms. Malati Devi Mahato	MG member
20	Ms. Sharda Devi Ram	MG member
21	Ms. Khatari devi Mahato	MG member
22	Ms. Rekha Devi Ram	MG member
23	Ms. Phulo Devi Sah	MG member

Interviewees of DHO team, Sunsari district on 28 Mar 2010

MTE team:

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Mr. Parashuram Shrestha	CB-IMCI chief
3	Ms. Chhing Lamu Sherpa	PUM
4	Mr. Sher Bahadur Rana	HC
5	Mr. Bhagawan Das Shrestha	PC-LIBON
6	Mr. Hari Dev Shah	ADLC – Sunsari
7	Ms. Chandra Subba	Awashar Project Coordinator

DHO team:

	Name	Position
1	Dr. Daya Shankar Lal Karna	District Health Officer
2	Mr. Shiv Narayan Yadav	CB-IMCI focal person
3	Mr. Ram Charitra Mehta	Health Assistant

Interviewees of PWG/MG in Bhaluwa VDC, ward-3, Sunsari district on 28 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Dipak Dahal	M&E Officer
3	Ms. Kalawati Changbang	HPC
4	Mr. Chitra Kumar Gurung	Prof IOM
5	Mr. Yogendra Giri	LF

PWG/MG:

	Name	Type
1	Ms. Soni Devi Kha	Postnatal mother
2	Ms. Babita Thakur	PWG member

3	Ms. Kabita Paswan	PWG member
4	Ms. Sulekha Paswan	PWG member
5	Ms. Chanara Paswan	Postnatal mother
6	Ms. Sabitri Kha	Postnatal mother
7	Ms. Dashanwati Chaudhary	PWG member
8	Ms. Patri Devi Chaudhary	PWG member
9	Ms. Phul Kumari Sardar	Postnatal mother
10	Ms. Lagiya Chaudhary	FCHV
11	Ms. Ratan Chaudhary	FCHV
12	Ms. Mahawati Biswash	FCHV
13	Ms. Tara Chaudhary	FCHV
14	Ms. Sena Paswan	Postnatal mother
15	Ms. Rina Rishidev	PWG member
16	Ms. Punam Paswan	MG member
17	Ms. Radha Paswan	MG member
18	Ms. Kaari Chaudhary	MG member
19	Ms. Aasha Chaudhary	Postnatal mother
20	Ms. Sunita Risidev	PWG member
21	Ms. Sita Sah	Partner

Interviewees of Bhaluwa SHP team, Sunsari district on 28 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Dipak Dahal	M&E Officer
3	Ms. Kalawati Changbang	HPC
4	Mr. Chitra Kumar Gurung	Prof IOM
5	Mr. Yogendra Giri	LF

Health Facility team:

	Name	Position
1	Mr. Pramod Chaudhary	SHP In-charge
2	Ms. Lila Chaudhary	ANM
3	Mr. Gajadhar Dahal	VHW

Interviewees of Baklauri HP team, Sunsari district on 28 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Dipak Dahal	M&E Officer
3	Ms. Kalawati Changbang	HPC
4	Mr. Chitra Kumar Gurung	Prof IOM
5	Mr. Yam Bahadur Thapa	LF
6	Mr. Rajendra Prasad Sah	LF

Health Facility Team

	Name	Type
1	Mr. Hari Dev Thakur	HP In-charge
2	Mr. Rohit Timilshina	AHW
3	Mr. Kedar Nepal	VHW
4	Ms. Anita Shrestha	ANM
5	Mr. Lagan K Singh	Lab Assistant
6	Ms. Puspa Magar	ANM
7	Ms. Ranjita Shrestha	ANM

Interviewees of PWG/MG, Baklauri VDC, ward-6, Sunsari district on 28 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Dipak Dahal	M&E Officer
3	Ms. Kalawati Changbang	HPC
4	Mr. Chitra Kumar Gurung	Prof IOM
5	Mr. Yam Bahadur Thapa	LF
6	Mr. Rajendra Prasad Sah	LF

PWG/MG:

	Name	Type
1	Ms. Sabitri Kunwar	PWG member
2	Ms. Sita Kunwar	PWG member
3	Ms. Meena Sadha	PWG member
4	Ms. Inje Chaudhary	Postnatal mother
5	Ms. Rekha Ray Dhami	Postnatal mother
6	Ms. Gandhari Chaudhary	Postnatal mother
7	Ms. Manju Kunwar	Postnatal mother
8	Ms. Champa Chaudhary	MG member
9	Ms. Rekha Chaudhary	MG member
10	Ms. Subhagi Chaudhary	MG member
11	Ms. Rukmani Chaudhary	FCHV
12	Ms. Sarsawoti Chaudhary	FCHV
13	Ms. Subiya Chaudhary	FCHV

Interviewees of PWG/MG, Chandbela VDC, Ward-6, Sunsari district on 28 Mar 2010

MTE team:

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Mr. Parashuram Shrestha	CB-IMCI Chief
3	Mr. Sher Bahadur Rana	HC
4	Mr. Bhagawan Das Shrestha	PC-LIBON
5	Mr. Hari Dev Shah	ADLC
6	Mr. Bijaya Kumar Sah	LF
7	Ms. Chandra Subba	Awashar Project Coordinator

PWG/MG:

	Name	Type
1	Ms. Shusila Singh	FCHV
2	Ms. Ashiya Singh	FCHV
3	Ms. Sita Singh	PWG member
4	Ms. Sabita Singh	PWG member
5	Ms. Radha Rishidev	PWG member
6	Ms. Bishumani Singh	MG member
7	Ms. Punam Devi Singh	MG member
8	Ms. Rajendra Kala Singh	MG member
9	Ms. Radhawati Singh	MG member
10	Ms. Rita Shardar	MG member
11	Ms. Rabita Singh	MG member
12	Ms. Shanta Shardar	MG member
13	Ms. Chandra Kala Singh	MG member
14	Ms. Niru Shardar	MG member
15	Ms. Chandra Kala Singh	MG member
16	Ms. Neena Singh (A)	MG member
17	Ms. Neena Singh (B)	MG member
18	Ms. Jeewan Shardar	MG member
19	Ms. Bilama Shardar	MG member
20	Ms. Mamata Singh	MG member
21	Ms. Pramila Shardar	MG member

Interviewees of LIBON team at Sunsari PU, Sunsari district on 28 Mar 2010

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Ms. Stacy Fehlenberg	HIV & Health Advisor
3	Mr. Sher Bahadur Rana	HC
5	Mr. Bhagawan Das Shrestha	PC LIBON
7	Ms. Kalawati Changbang	HPC
8	Mr. Hari Dev Shah	ADLC - Sunsari
9	Mr. Yam Bahadur Thapa	LF
10	Mr. Rajendra Prasad Sah	LF
11	Mr. Yogendra Giri	LF
12	Mr. Bijay Kumar Sah	LF
13	Ms. Muiya Rai	OA
14	Mr. Dipak Dahal	M&E Officer

Interviewees of NFHP team, Kathmandu on 29 Mar 2010

MTE team:

	Name	Position
1	Ms. Stacy Fehlenberg	HIV & Health Advisor
2	Mr. Bhagawan Das Shrestha	PC-LIBON

NFHP team:

	Name	Position
1	Ms. Penny Dawson	Resource Person

2	Mr. Dirgha Raj Shrestha	RH Specialist
3	Ms. Leela Khanal	Senior Program Officer

Interviewees of USAID team, Kathmandu on 30 Mar 2010

MTE team:

	Name	Position
1	Ms. Rose Schneider	MTE Team Leader
2	Mr. Justin Fugle	Program Manager
3	Ms. Stacy Fehlenberg	HIV & Health Advisor
4	Mr. Sher Bahadur Rana	HC
5	Mr. Bhagawan Das Shrestha	PC-LIBON

USAID Nepal team:

	Name	Position
1	Ms. Ann P. McCauley	Senior Public Advisor
2	Mr. Sita Ram Devkota	Program Specialist (Family Planning and Reproductive Health)
3	Mr. Deepak Paudel	Program Specialist (Maternal & Newborn Health)

MTE findings sharing workshop of LIBON project on 2 Apr 2010, Kathmandu

	Name	Position	Organization
1	Ms. Rose Schneider	MTE Team Leader	
2	Mr. Justin Fugle	Program Manager	Plan US
3	Ms. Stacy Fehlenberg	HIV & Health Advisor	Plan US
4	Dr. Y. V. Pradhan	Director General	DoHS
5	Parashu Ram Shrestha	Chief IMCI	CHD/DoHS
6	Donal Keane	Country Director	Plan Nepal
7	Subhakar Baidya	Program Support Manager	Plan Nepal
8	Krishna Ghimire	Sponsorship & Grant Support Manager	Plan Nepal
9	Kamalesh K. Lal	People & Culture Manager	Plan Nepal
10	Dr. Daya Shankar Lal Karna	District Health Officer	DHO, Sunsari
11	Shiv Narayan Yadav	Public Health Inspector	DHO, Sunsari
12	Mohammad Sabir	Public Health Officer	DHO, Bara
13	Amaleshwor Mishra	Public Health Inspector	DHO, Bara
14	Prof. Chitra Kumar Gurung	Head	IOM
15	CITT Lubz		USAID Nepal
16	Deepak Paudel	Program Specialist	USAID Nepal
17	Dr. Amit Bhandari	TL	Save the Children
18	Dr. Ashish KC	PM	Save the Children
19	Bhim Kumari Pun	PC	Save the Children
20	Nirmala Sharma	HC	Care Nepal
21	Sangita Budhathoki	Program Coordinator	HKI
22	Chandra Rai	Project Director	HRI
23	Badri Shrestha	Program Unit Manager	Plan Nepal
24	Chhing Lamu Sherpa	Program Unit Manager	Plan Nepal

25	Mr. Sher Bahadur Rana	HC	Plan Nepal
26	Mr. Bhagawan Das Shrestha	PC-LIBON	Plan Nepal
27	Shusil Joshi	CPME Coordinator	Plan Nepal
28	Deo Ratna Chaudhary	District LIBON Coordinator	Plan Nepal
29	Kalawati Changbang	Health Program Coordinator	Plan Nepal
30	Krishna Bahadur Achhami	ADLC	Plan Nepal
31	Diwakar Mishra	ADLC	Plan Nepal
32	Dipak Dahal	M&E Officer	Plan Nepal

ANNEX 11: PROJECT DATA FORM

Child Survival and Health Grants Program Project Summary
April 2010
PLAN International (Nepal)

General Project Information
Cooperative Agreement Number: GHN-A-00-07-00006
Project Grant Cycle: 23
Project Dates: (10/1/2007 - 9/30/2011)
Project Type: Standard

PLAN Headquarters Technical Backstop: Stacy Fehlenberg
Field Program Manager: Bhagawan Das Shrestha
Midterm Evaluator: RoseSchneider
Final Evaluator
USAID Mission Contact: Dipak Paudel

Field Program Manager Information
Name: Bhagawan Das Shrestha
Address:C/O Plan Nepal Country Office Lalitpur
Phone: +977 11 490 469; +977-1-5535580
Fax: +977-1-5536431
E-mail: bhagawan_das_shrestha@plan-international.org

Alternate Field Contact
Name: Sher Bahadur Rana
Address: Plan Nepal Country Office, Lalitpur
Phone: +977-1-5535580
Fax: +977-1-5536431
E-mail: Sherbahadur.Rana@plan-international.org

Funding Information:
USAID Funding:(US $): $1,494,337 **PVO match:(US $)** $543,737

Project Information:
Description: In order to reach its overall goal to Sustainably Reduce Neonatal Mortality in Nepal, the LIBON project has three impact-oriented and innovative sub-goals:

Sub-Goal 1: Reduced neonatal mortality in the districts of Sunsari and Parsa through the application of an integrated, community-based package of interventions and service delivery strategies that include the MINI and the chlorhexidine field trials

Sub-Goal 2: Increased social inclusion and improved quality of child, maternal, and neonatal health through a fact-based decision making process for the planning and resource allocation of district-based programs.

Sub-Goal 3: Increased capacity of the MOHP and other constituencies in policy formulation and implementation of programs that will accelerate the reduction of neonatal mortality in Nepal

To meet these goals, the project will:
1. Integrate innovative strategies for reducing neonatal infection with interventions in the MOHP's service delivery strategy and those that have proven successful in previous Child Survival projects.
2. Build requisite capacity at the central, district and village levels to make data driven decisions using information collected from the KPC, CSSA, and Integrated Health Facility Assessment methodologies.
3. Stimulate national level policy dialogue on nation-wide implementation of LIBON's innovative interventions.

Location:
Bara, Sunsari, and Parsa Districts of Nepal.

Project Partners:
Project Sub Areas:
Sunsari District
Parsa District
Bara District

General Strategies Planned:
Strengthen Decentralized Health System

M&E Assessment Strategies:
KPC Survey
Health Facility Assessment
Lot Quality Assurance Sampling
Community-based Monitoring Techniques

Behavior Change & Communication (BCC) Strategies:
Peer Communication
Support Groups

Groups targeted for Capacity Building:
PVO Non-Govt Partners
Other Private Sector Govt Community
CS Project Team
Health Facility Staff
National Ministry Health, CBOs, CHWs

Interventions/Program Components:
Maternal & Newborn Care (100 %)

Target Beneficiaries:

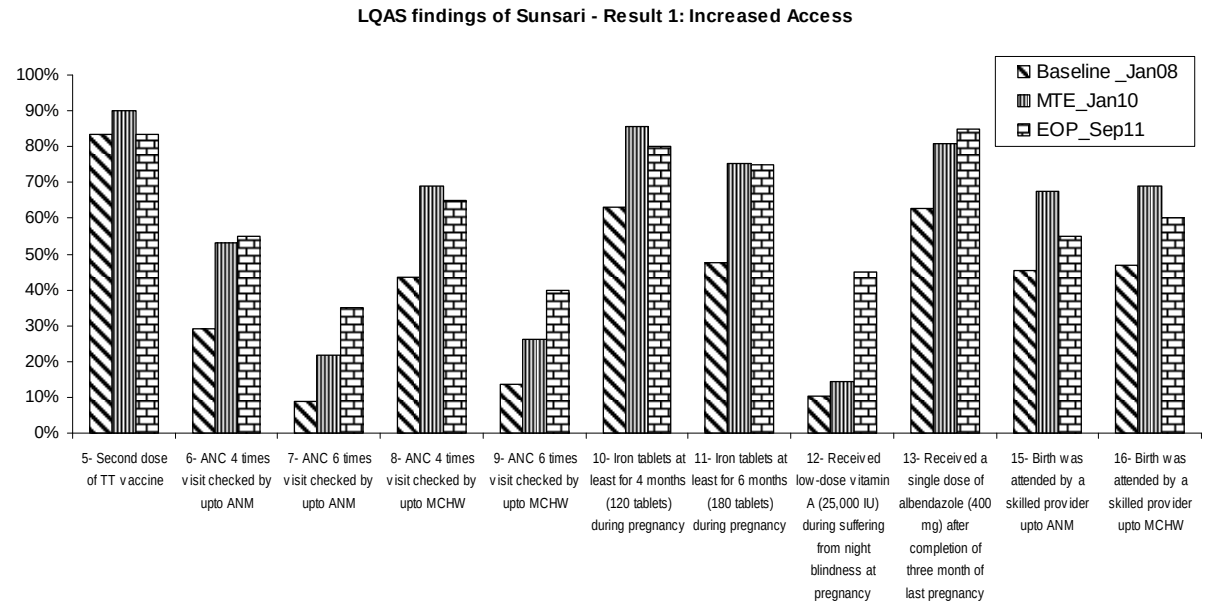
	Sunsari District	Parsa District	Bara District	Total Beneficiaries
Infants < 12 months	18,837	15,697	17,680	52,214
Children 12-23 months	19,286	16,617	18,616	54,519
Children 0-23 months	38,123	32,314	36,296	106,733
Children 24-59 months	56,785	49,533	55,291	161,609
Children 0-59 months	94,908	81,847	91,587	268,342
Women 15-49 years	139,344	110,422	125,053	374,819
Population of Target Area	733,919	580,572	652,286	1,966,777
Rapid Catch Indicators	LQAS sampling methodology was used for this survey			

ANNEX 12: LOT QUALITY ASSURANCE SAMPLING (LQAS) SURVEY FINDINGS

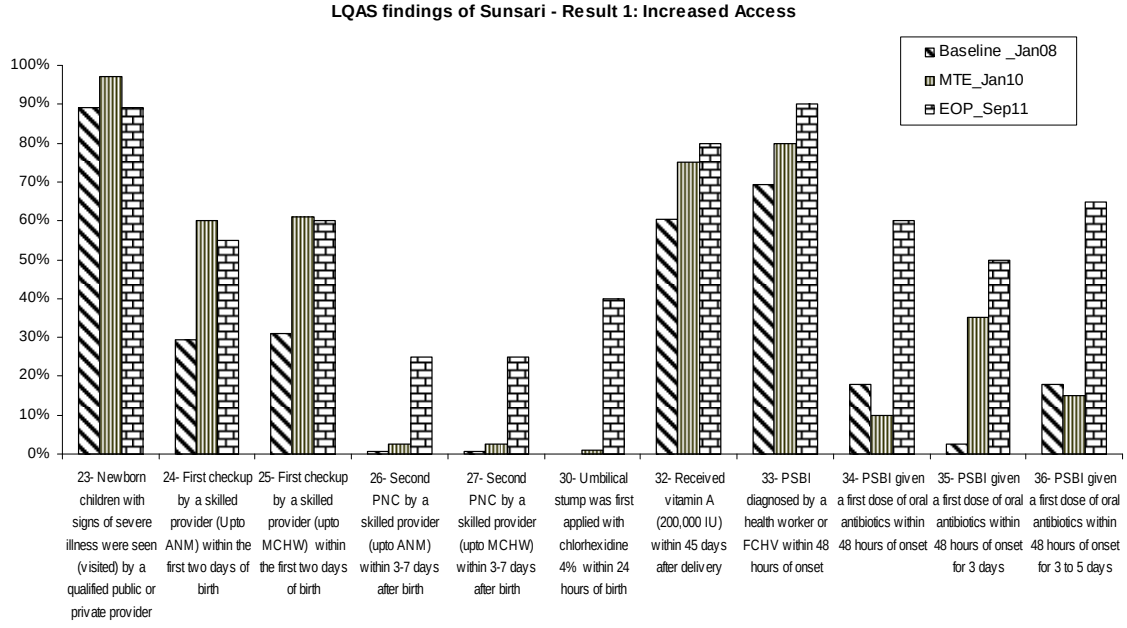
Sunsari, Parsa and Bara districts
(Dec 2009 to Feb 2010)

Sunsari District:

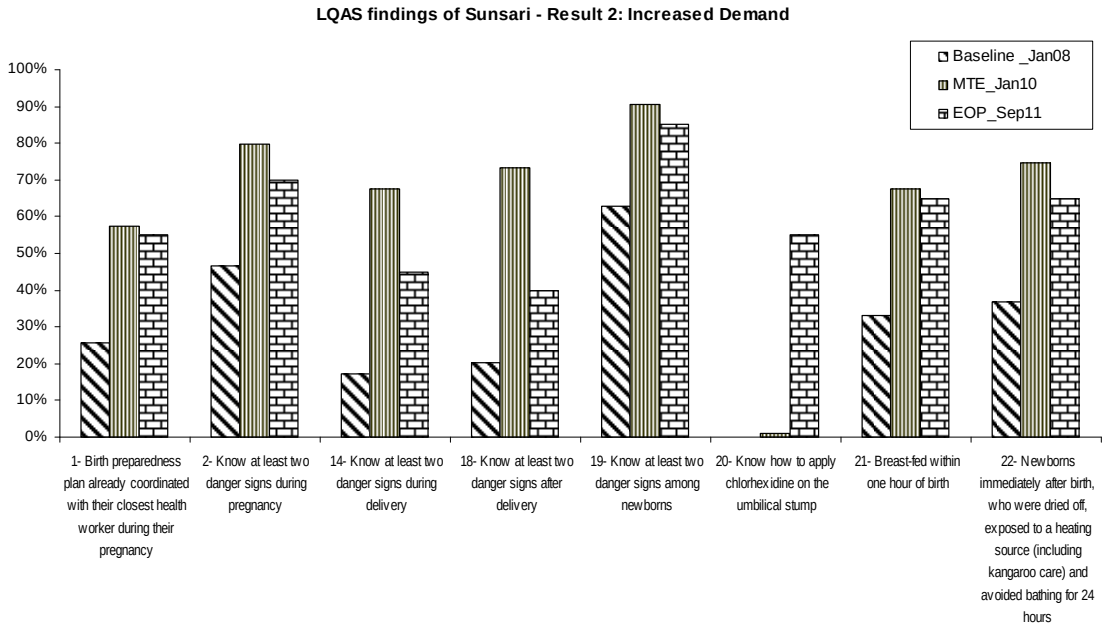
Result 1: Increased access



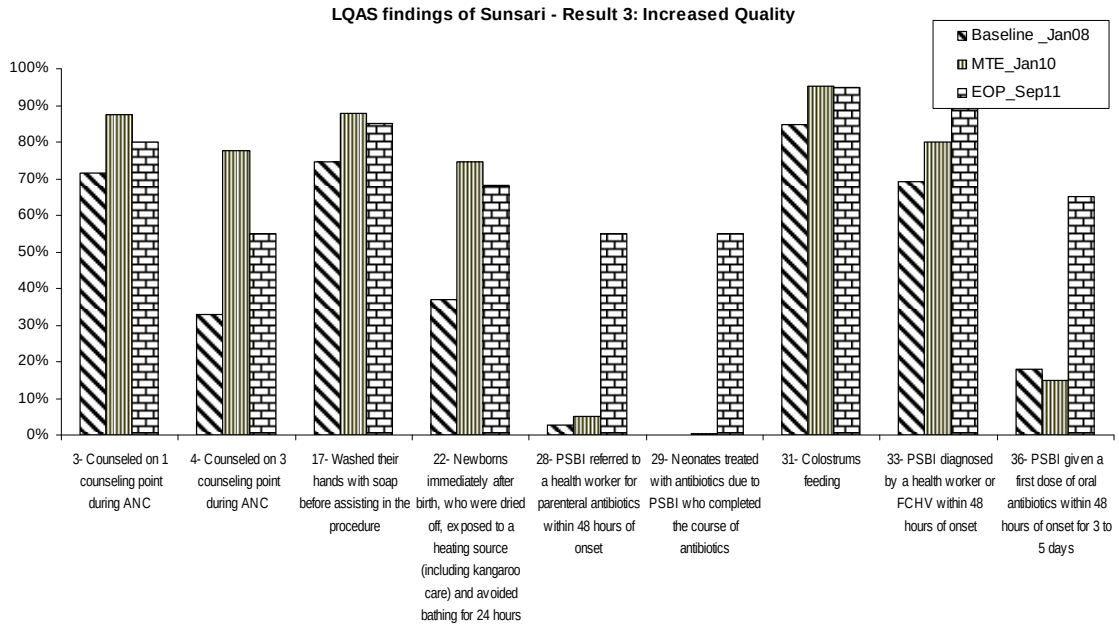
Result 1: Increased access (Cont.)



Result 2: Increased Demand

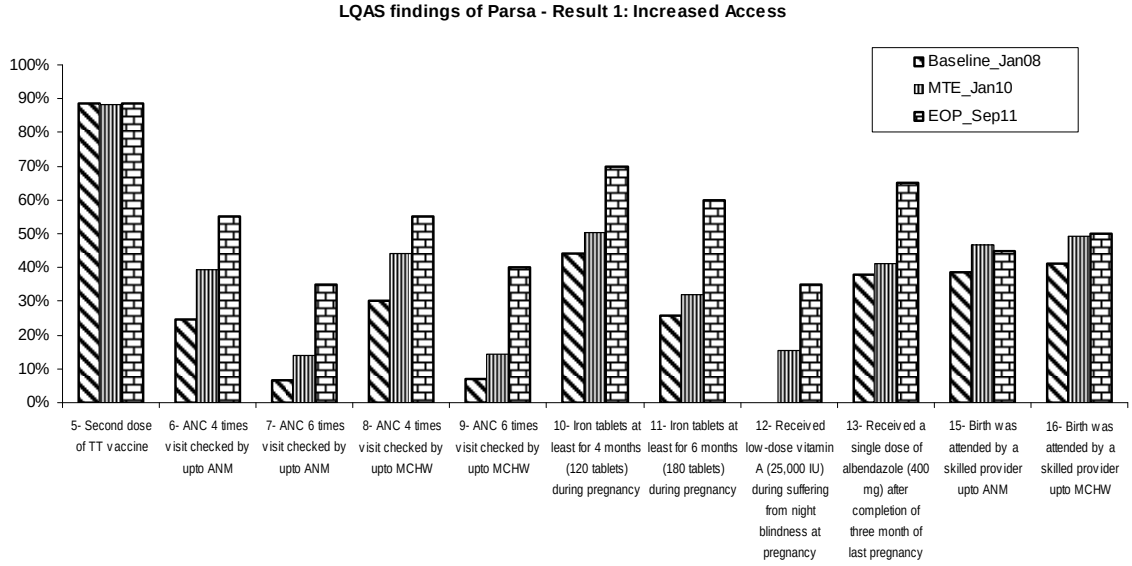


Result 3: Increased Quality

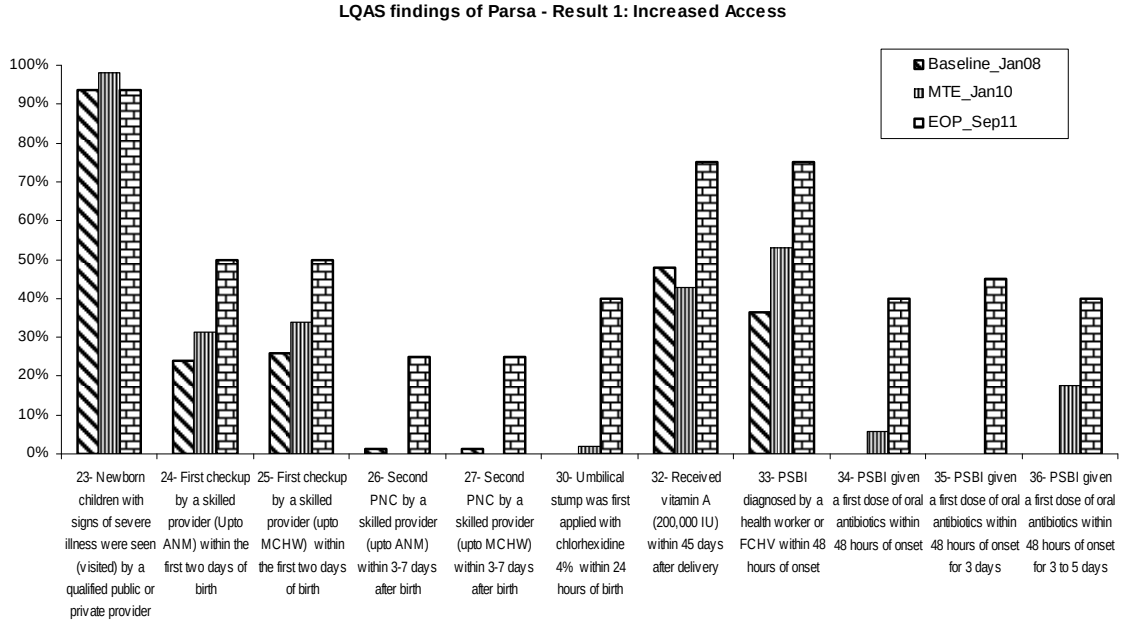


Parsa district:

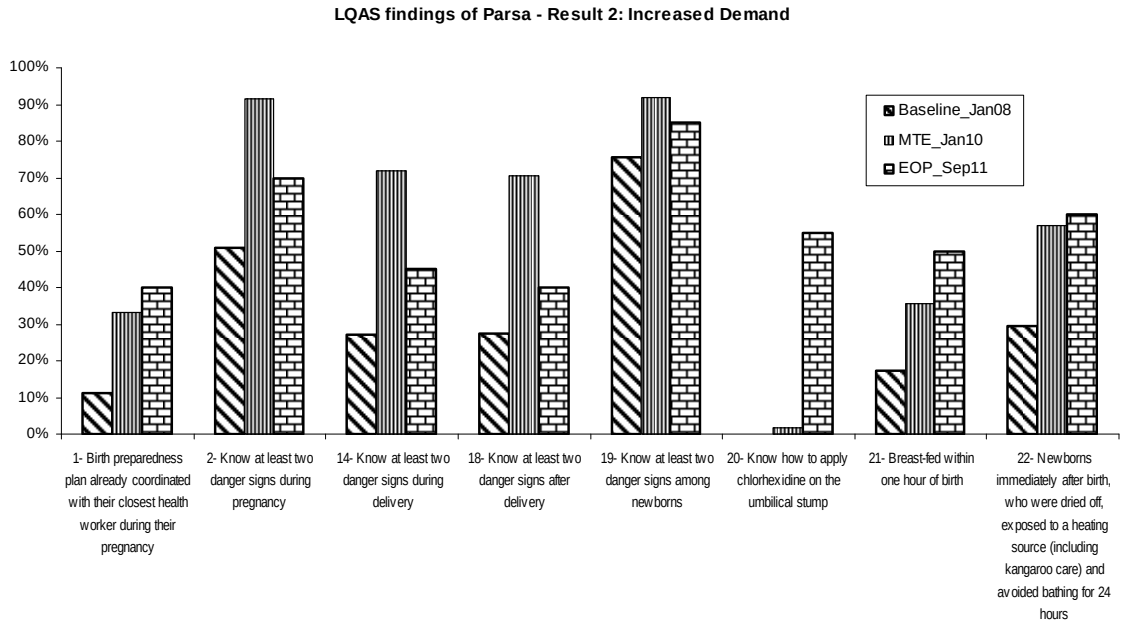
Result 1: Increased access (Cont..)



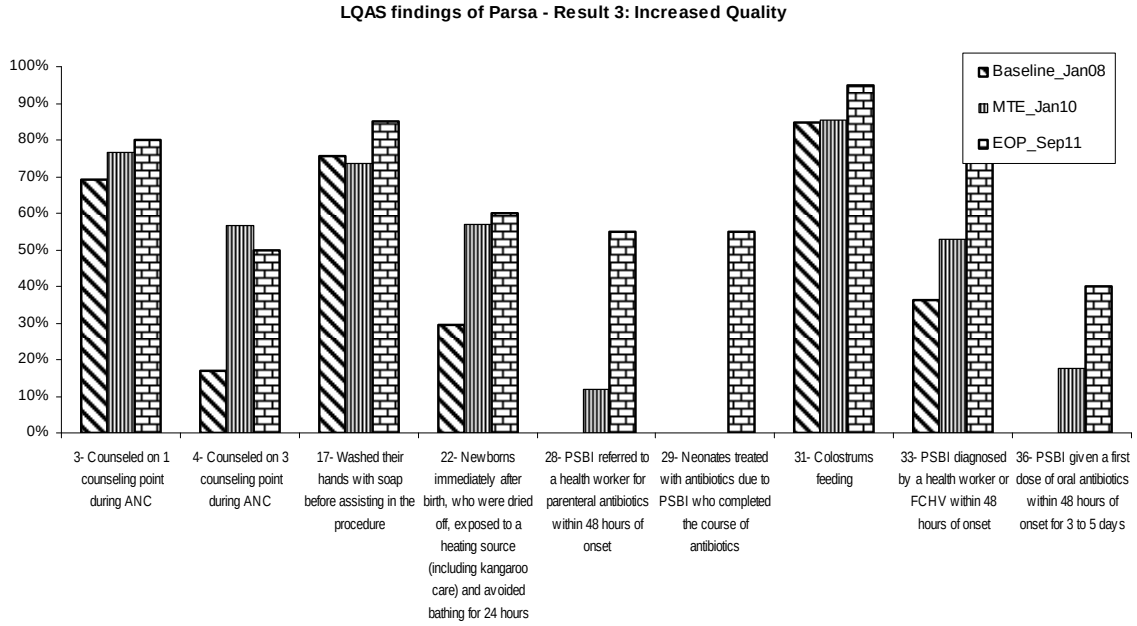
Result 1: Increased access



Result 1: Increased Demand

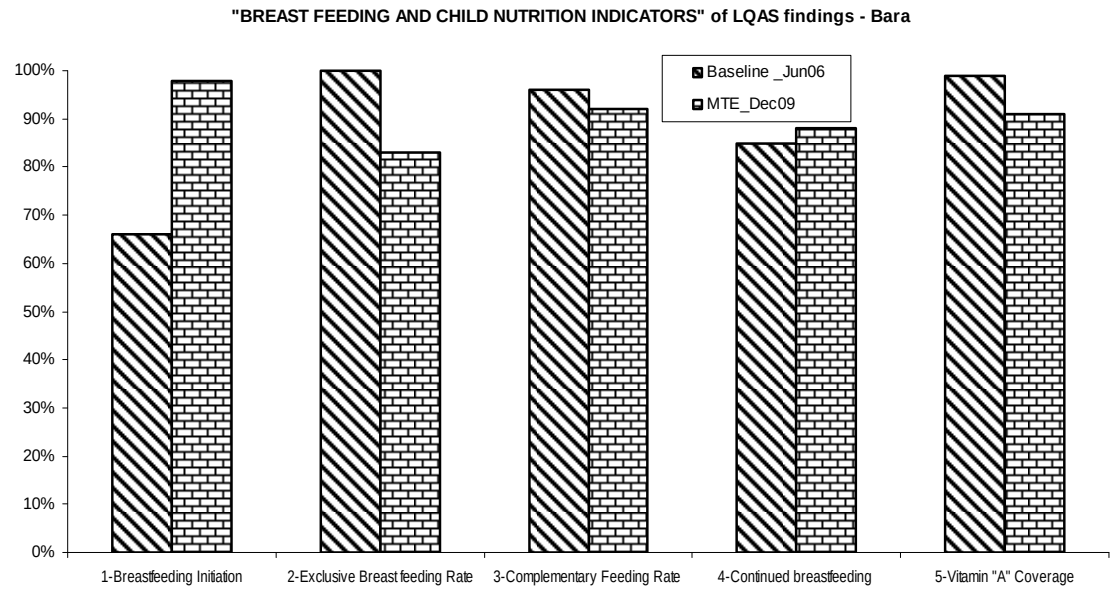


Result 1: Increased Quality

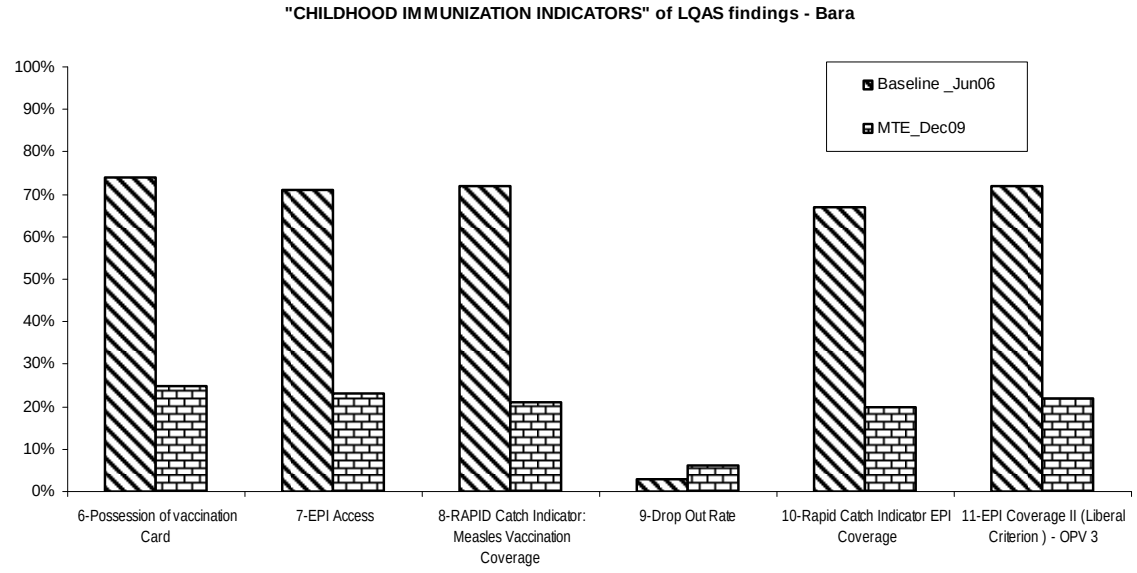


Bara district:

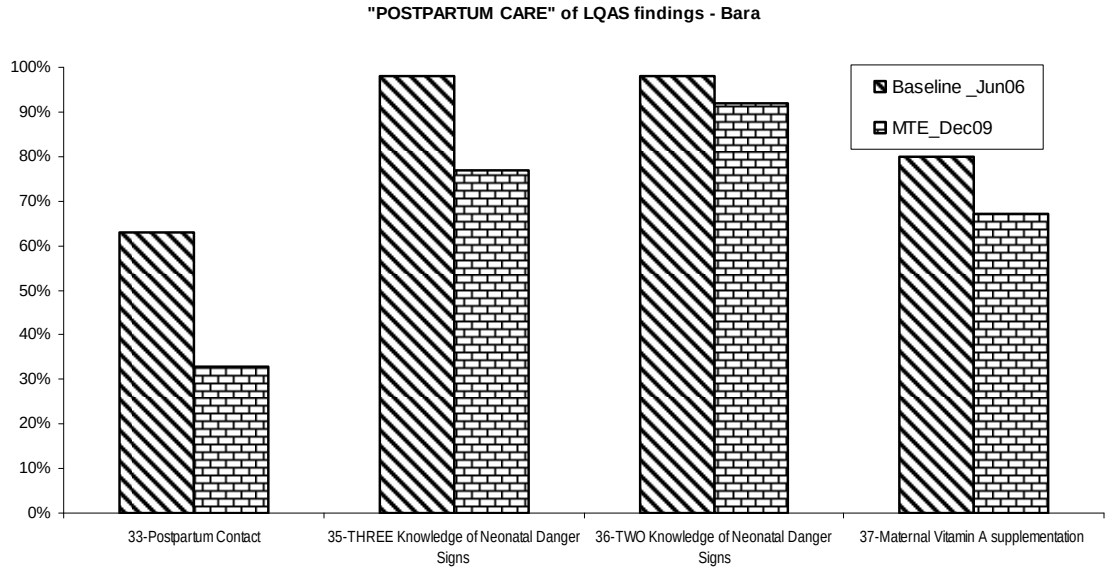
Breastfeeding and child nutrition



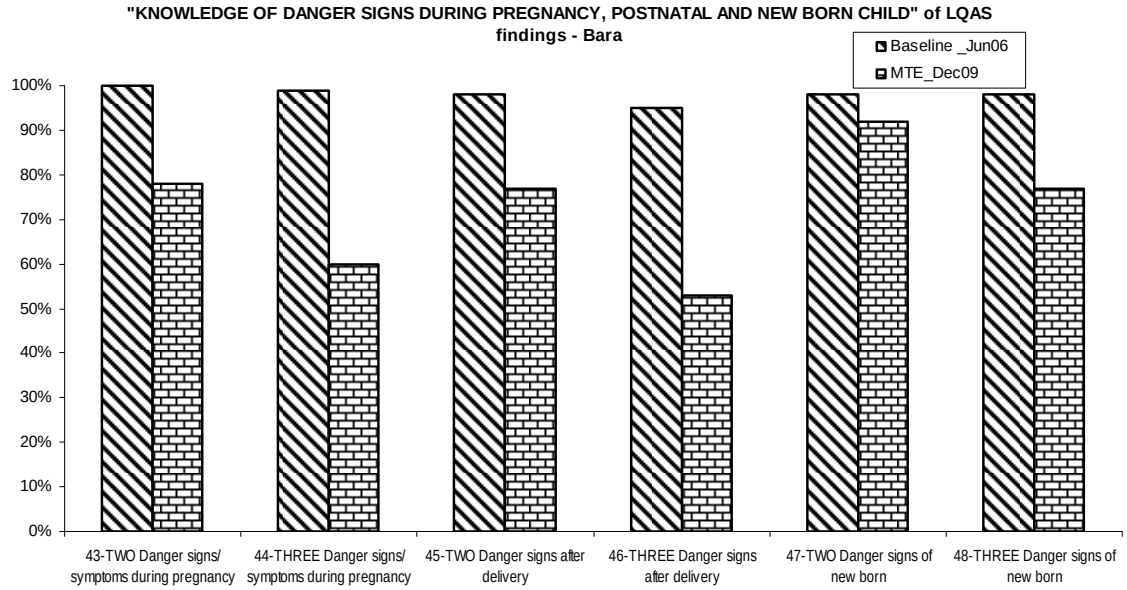
Childhood immunization



Postpartum care



Knowledge of danger signs during pregnancy, postnatal and newborn care



ANNEX-13: HMIS MONITORING

Excel Document – Attached Separately