

PD-ABH-023

ISN 84977

**SAVE THE CHILDREN/US**

**NEPAL FIELD OFFICE**

**CHILD SURVIVAL VIII  
ANNUAL REPORT FY 93**

Cooperative Agreement No. FAO-O500-A-00-2034-00

**YEAR ONE**

***Empowering Families to Promote Child Survival  
Nuwakot District***

**Save the Children  
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Submitted 10/28/93

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## INTRODUCTION

The project is located in Nuwakot District, in the Central Development Region, covering ilakas 1, 12 and 13. The total potential beneficiary population of the projected area is 38,098. Of these, 7,620 are women aged 15-45 years and 6,096 are children under 5 years.

The goal of this Child Survival VIII project is to reduce infant, child and maternal mortality and morbidity by empowering families to address their own health, education and developmental needs and by creating an increased demand for improved government health services.

## I. OVERVIEW OF YEAR-I ACHIEVEMENT

### [A] Annual Objectives and Accomplishments:

The following are the annual objectives and accomplishments of first year:

SR/#	OBJECTIVES	ACCOMPLISHMENTS												
1	To make literate 2,080 adults by initiating 104 Non-Formal Education (NFE) Centers	<ul style="list-style-type: none"> <li>● 90 out of 104 NFE centers established; 6 months of NFE classes completed</li> <li>● 1,322 adults passed the literacy test in 77 literacy classes, (Result from 13 centers is yet to come).</li> <li>● 57% of CHVs/TBAs are literate in one of the ilakas.</li> </ul>												
2	To conduct 70 Maternal Child Health (MCH) Mobile Clinics	<ul style="list-style-type: none"> <li>● 76 MCH mobile clinics were conducted in coordination with District Public Health Office (DPHO) and Health Posts in 28 sites of 14 Village Development Committees (VDCs).</li> <li>● A total number of 1,986 children under 5 and 475 pregnant and lactating mothers benefited from these clinics.</li> </ul>												
3	To revitalize 30 mothers' groups	<ul style="list-style-type: none"> <li>● 37 mothers' groups were re-vitalized during this reporting period.</li> <li>● They are holding monthly meetings to discuss various issues like immunization, Oral Dehydration Therapy (ORT), AIDS, Sanitation, etc. Community Health Volunteers (CHVs) from respective wards facilitate discussions.</li> <li>● The number of sessions held for discussing specific topics are as follow:               <table style="margin-left: 40px; margin-top: 10px;"> <tr> <td>Immunization</td> <td style="text-align: right;">=</td> <td style="text-align: right;">29</td> </tr> <tr> <td>ORT</td> <td style="text-align: right;">=</td> <td style="text-align: right;">20</td> </tr> <tr> <td>AIDS</td> <td style="text-align: right;">=</td> <td style="text-align: right;">19</td> </tr> <tr> <td>Family Planning (FP)</td> <td style="text-align: right;">=</td> <td style="text-align: right;">20</td> </tr> </table> </li> </ul>	Immunization	=	29	ORT	=	20	AIDS	=	19	Family Planning (FP)	=	20
Immunization	=	29												
ORT	=	20												
AIDS	=	19												
Family Planning (FP)	=	20												

SR/#	OBJECTIVES	ACCOMPLISHMENTS
4	<p>To conduct various trainings based on need and requirement of project to enhance capability of health personnel and volunteers</p> <ul style="list-style-type: none"> <li>● 10 day training for 42 Traditional Birth Attendants (TBAs)</li> <li>● 2 trainings for 14 Village Health Workers (VHWs)</li> <li>● 3 trainings for 5 Health Post Incharges (HPIs)</li> <li>● Quarterly trainings for 126 Community Health Volunteers (CHVs)</li> <li>● AIDS/STDs trainings for teachers at primary, lower secondary and secondary schools.</li> <li>● 13 Traditional Healers (THs) trained on AIDS/STD</li> </ul>	<ul style="list-style-type: none"> <li>● 40 TBAs received a 10 day training.</li> <li>● 6 VHWs received a 3 day training on Mobile Clinic management and 9 received a 4 day training on AIDS/STDs (<i>see Appendix A.1</i>).</li> <li>● 2 HPIs received 5 days training on AIDS/STDs and 5 days on Vitamin A.</li> <li>● CHVs received trainings on mobile clinic, Oral Rehydration Therapy (ORT) and AIDS (2 days each) (<i>see Appendix A.2</i>). In addition, 35 CHVs received a 2 day training on Acute Respiratory Infection) (ARI).</li> <li>● 72 school teachers received 4 days training on AIDS/STD.</li> <li>● 23 THs received 2 days training on AIDS/STD (<i>see Appendix A.3</i>).</li> <li>● 77 peer counselors received 2 days training on AIDS/STD</li> </ul>
5	<p>10% of women between 14-45 years will receive 2+ doses of TT.</p>	<ul style="list-style-type: none"> <li>● 13.28% of women 14-45 years received 2nd doses of TT</li> </ul> <p><i>Note:</i></p> <ul style="list-style-type: none"> <li>● Coverage based on one Health Post (HP) record and TT camp in one ilaka.</li> <li>● Population estimates based on 1991 census.</li> </ul>
6	<p>To organize Vitamin A distribution camp in 14 VDCs.</p>	<ul style="list-style-type: none"> <li>● Done in 14 VDCs. A total number of 1,683 children (6 months to 6 years) received Vitamin A supplementation. 30% 6 months to 6 years children received Vitamin A.</li> </ul>
7	<p>To initiate 6 Home Based Children Care Centers (HBCCCs)</p>	<ul style="list-style-type: none"> <li>● 3 HBCCCs are initiated</li> <li>● 2 HBCCCs will be receiving training in 3rd week of September 1993.</li> </ul>
8	<p>To form 18 Parenting Education (PE) (18 fathers and 18 mothers) groups</p>	<ul style="list-style-type: none"> <li>● 36 PE groups (18 father and 18 mothers) have been formed.</li> <li>● They have received monthly classes on diarrhea, sanitation, worms and nutrition. Between 2 and 4 classes have been held for each group.</li> </ul>
9	<p>To form 18 NFE women's groups</p>	<ul style="list-style-type: none"> <li>● 13 NFE women's groups have been formed.</li> <li>● 12 out of 13 such groups have received trainings on leadership and management.</li> <li>● Over Rs.13,000/- have been raised as group fund.</li> <li>● These groups are involved in one or the other social welfare activities viz.; cleaning drinking water sources, improving trials, community plantation, repairing NFE centers etc.</li> </ul>

SR/#	OBJECTIVES	ACCOMPLISHMENTS
10	To form 3 child to child groups	<ul style="list-style-type: none"> <li>7 child to child groups have been formed and are receiving monthly classes on hygiene, sanitation and worms infestation.</li> <li>The purpose of this program is to have peer groups of children, teaching their peers.</li> </ul>
11	To orient school teachers on Early Childhood Education (ECE)	<ul style="list-style-type: none"> <li>Over 60 teachers from all ilakas received a 2 days training on Early Childhood Education.</li> <li>This training mainly focused on shifting from "Traditional Banking Approach" to "Psychological awareness approach".</li> </ul>

**[B] Training and Conferences:**

The majority of the staff were hired at the beginning of project implementation. Thus various trainings, conferences, workshops were organized to enhance the professional capabilities of the staff. These include the following:

SR/#	TOPIC	DURATION	PARTICIPANTS
1	International AIDS Conference DELHI, INDIA	5 days	- Public Health Coordinator
2	AIDS Prevention Strategy Training THAILAND	10 days	- Dy. Public Health Coordinator - Project Coordinator CS-VIII
3	TOT for NFE KATHMANDU	10 days	- 3 NFE Coordinators
4	TOT and Leadership Training KATHMANDU	7 days	- 3 Women Development Coordinators
5	Focus Group Discuss' on Research KATHMANDU	9 days	- 3 Staff Nurse - 1 Auxiliary Nurse Midwife (ANM)
6	Cluster Sample Survey NUWAKOT	5 days	- All Project Staff
7	Early Childhood Development, Observation LAMJUNG	5 days	- 4 Women Development Coordinators
8	Asia Pacific Regional Health Workshop KATHMANDU	4 days	- Project Coordinator CS-VIII
9	NFE Observation Tour GORKHA	10 days	- 3 NFE Coordinators - 9 NFE Supervisors
10	Early Childhood Development, TOT	6 days	- 3 Women Development Coordinators
11	Semi-Annual Meeting KATHMANDU	2 days	- Project Coordinator CS-VIII - 3 Field Coordinators
12	TOT on Communication Skills KATHMANDU	10 days	- 1 NFE Coordinator - 3 Staff Nurse - 2 Comm. Medicine Auxiliaries (CMAs)

SR/#	TOPIC	DURATION	PARTICIPANTS
13	Health Meeting GORKHA	2 days	- Project Coordinator CS-VIII - 1 Staff Nurse
14	AIDS Conference BERLIN	5 days	- Public Health Coordinator - Country Director
15	NFE Center Supervision GORKHA	5 days	- 10 NFE Supervisors
16	Gender Analysis Workshop KATHMANDU	4 days	- 1 Field Coordinator
17	Legal Rights Workshop GORKHA	3 days	- 1 Field Coordinator
18	Training of Trainers KATHMANDU	5 days	- 3 Women Development Coordinators - 1 Field Coordinator - 2 NFE Coordinators - 1 Information Education Communication Coordinator - Health Research and Training Officer - Dy. Public Health Coordinator
19	Focus Group Discussion (FGD) Research on AIDS NUWAKOT	7 days	- 4 Women Development Coordinators - 1 Field Coordinator - 3 Community AIDS Educators - 1 Information Education Communication (IEC) Coordinator - Accountant
20	Early Childhood Development Conference SINGAPORE	7 days	1 Women Development Program Officer
21	Early Childhood Development Training KATHMANDU	3 weeks	2 Women Development Coordinators
22	Leadership Training BANGLORE	4 weeks	- 1 Field Coordinator - 1 ANM
23	Vitamin-A Training <i>(see Appendix-B)</i> NUWAKOT	5 days	- 3 NFE Coordinators - 2 Field Coordinators - 3 Staff Nurses - 2 CMAs - 1 ANM - 1 Information Education Communication Coordinator - 1 Women Development Coordinator
24	AIDS Training NUWAKOT	5 days	- 3 NFE Coordinators - 3 AIDS Motivators - 3 Staff Nurses - 4 Women Development Coordinators - 2 Field Coordinators

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## **[C] Technical Support:**

Continuing technical assistance was made available at the programme site during the first year to help strengthen program planning, management implementation and monitoring. The following technical support was obtained:

- MS. DONNA SILLAN, Regional Health Consultant for SC/US, facilitated for the preparation of DIP for CS-VIII in January 1993, in Nuwakot district.
- MS. DALE DAVIES from HKI provided technical support for a 5 day training on Vitamin A for CS-VIII staff in Nuwakot (*see Appendix B: Vitamin A Training Report*).
- SEXUALLY TRANSMITTED DISEASES (STDs) camps in 4 sites of 3 ilakas were organized with technical support from 2 doctors from Nepal National AIDS Control Project, Tribhuvan University Teaching Hospital (TUTH), and Women's Rehabilitation Center (WOREC).
- Two TRADITIONAL BIRTH ATTENDANT (TBA) TRAINERS from District Public Health Office (DPHO), Nuwakot, provided technical support for a 10 day TBA training program.
- A week long training on HOME BASED CHILD CARE CENTERS (HBCCC) was organized with the help of Ms. Karuna Yonjon from Seto Gurans.

## **[D] Community Health Committees:**

Mothers' groups, one per ward, as a health education forum, are supposed to meet every month so that Community Health Volunteers (CHVs) can provide health education and motivate them. But not all of them have been functioning because of dropouts and the passiveness of CHVs. The CHVs were not involved with some significant activities. During the last year, they were only involved in motivating and educating women for immunization. To date, 37 such groups have been re-vitalized. They met at least three times during the past 90 days and discussed various issues as follows:

### ***Subjects***

*Immunization*

*Oral Rehydration Therapy*

*AIDS/STDs*

*Acute Respiratory Infection (ARI)*

*Family Planning (FP)*

*Sanitation*

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The project supports increased access to improve maternal and child health care through technical training, logistic support to Health Posts (HPs) and Maternal Child Health (MCH) mobile clinics. The project health team has been facilitating MCH mobile clinics. To increase the management and effectiveness of the clinics, more than 10 MCH mobile clinic management committees were formed.

**[E] Linkages Made:**

Linkage is the key to the project implementation process. Linkages were made at different levels.

**1. National**

- During this reporting period, a formal agreement has been made between the Ministry of Health (MOH) and Save the Children US (SC/US).
- A formal inauguration of the CS-VIII project, Nuwakot, has been inaugurated by the Honorable Vice President of the National Planning Commission, Dr. Ram Sharan Mahat.

**2. District**

- Two formal Co-ordination meetings were organized among the officials from Nuwakot District Headquarters. The participants were the Chief District Officer (CDO), District Development Committee (DDC) Chairman, District Public Health Officer (DPHO), District Education Officer (DEO), District Forestry Officer (DFO), District Medical Officer (DMO) and representatives from Agriculture Development Bank (ADB) and District Agriculture Officer (DAO).
- Frequent correspondence and meetings were made with DPHO, DEO and DFO.

Major outputs of these linkages are:

- Avoiding duplication by agreeing on the numbers of NFE Centers and locations to be run by SC/US with Basic Primary Education Project (BPEP) and Small Farmer Development Project (SFDP) in 3 of the Village Development Committees (VDCs) in SC/US working areas. A verbal negotiation has been made to deliver Child Survival and AIDS/STDs messages in those centers run by BPEP, SFDP in SC/US working areas.
- Involvement of Health Post Incharges (HPIs) in mobile clinics in all the ilakas.

- Agreement with DPHO to maintain and support cold chain system following a cold chain protocol (*see Appendix-C: A Protocol on Cold Chain*)
- Provision of over 10,000 saplings by DFO and local nurseries for NFE and women's groups.
- ADB is willing to provide skills trainings to women's groups.

### 3. Local

Three quarterly meetings with VDC representatives were organized. These meetings focused on the discussions and feedback on activities performed during the past quarter and the activities planned for the following quarter.

#### [F] Staffing:

- Professional staff who joined SC/US after the preparation of DIP are as follows:

<i>Name</i>	<i>Designation</i>	<i>Date of Appointment</i>
Moti Bishwokarma	CMA	February 1, 1993
Shova Lama	Women Development Coordinator	July 23, 1993 (See appendix-D: Names and Resumes of Staff)

- The following staff members are being shifted from other areas to work for the USAID funded 3½ year project, "Basic Education for the Least Educated", effective August 15, 1993.

<i>Name</i>	<i>Previous Designation</i>
Meera Rana	Women Development Coordinator
Rajeshwor Devkota	IEC Coordinator

*Reasons for shifting these people are as follows:*

**Mr. Rajeshwor Devkota** has wide experience in NFE with SC/US. Education is a major component of Basic Education for the Least Educated project. Focusing on its requirements and priority need, Mr. Rajeshwor was assigned to this new project. Thus, hiring for a new IEC Coordinator is under way.

**Ms. Meera Rana** has worked in USAID funded CS-III with SC/US, where she gained a good experience in coordinating with other line agencies. Since Basic Education for the Least Educated Project has a similar nature, i.e., partnering, coordinating etc., she has been transferred to work with that project. Ms. Shova Lama was hired to replace her post.

## II. Changes Made in Project Design

### [A] Comparison of Present Objectives to Those Given in Proposal and DIP

	Proposal	DIP	Current
<b>Immunization</b>	75% of children 12-23 months will be fully immunized against BCG, DPT, polio, and measles	40% of children 12 to 23 months will be fully immunized against BCG, DPT, polio, and measles	SAME
	50% of women between 15 and 45 years will be immunized against tetanus, by MOH norms	25% of women between 15 and 45 years will be immunized against tetanus, by MOH norms	SAME
<b>Control of Diarrheal Diseases</b>	At least one member in 50% of families with under-5 children will prepare ORS correctly	SAME	SAME
	25% of children with diarrhea in the last two weeks will be treated with ORT (Jeevan Jal)	SAME	SAME
<b>Female Literacy</b>	Female literacy rate increased to 35% of 15-45 year population, including 80% of CHVs and trained TBAs	Female literacy rate increased to 30% of 15-45 year population	SAME
<b>HIV/AIDS Prevention</b>	50% of men and women will be knowledgeable about three main modes of AIDS/HIV transmission and three protective behaviors.	SAME	SAME

	Proposal	DIP	Current
<b>Nutrition</b>	75% of under three children attending health posts and assembly points will be weighed at least quarterly and 75% of at-risk children will receive follow-up visits	70% of mothers will know to give supplementary foods at four to six months	SAME
	75% of mothers will be knowledgeable about the benefits of exclusive breastfeeding through six months and one member in 60% of families will be competent in the preparation and feeding of weaning foods at an appropriate age	SAME	SAME
			60% of mothers will introduce supplementary weaning foods to their children between the age of 4 and 6 months (NEW)
			60% of mothers will mix additional fat into their children's food (NEW)
			60% of mothers will know that they should NOT actively reduce their children's food intake during illness and that they should INCREASE their children's food intake during convalescence from illness (NEW)
			50% of mothers will NOT actively reduce their children's food intake during illness and will increase their children's food intake during convalescence (NEW)
<b>Vitamin A</b>	85% of children attending health posts and assembly points will receive Vitamin A supplementation by MOH norms	40% of under-five children will receive Vitamin A supplementation every 6 months	40% of children between 6 and 60 months will receive Vitamin A supplementation every 6 months (Revised according to MOH policy)
<b>ARI</b>	90% of VHWs, 80% of CHVs, 60% of TBAs and 25 % of families will be competent at early detection of ARI and referral of cases to health posts for treatment	25% of families will be competent at early detection of ARI and referral of cases to health posts for treatment	25% of mothers will know the danger signs for ARI and where to seek treatment

	Proposal	DIP	Current
<b>Maternal Health</b>		40% of mothers will know the three clean birth principles (NEW)	SAME
	50% of births will be attended by trained TBAs or medical professionals	DROPPED	DROPPED
	50% of pregnant women will receive at least two antenatal check-ups at MCH clinics		20% of mothers who will have delivered in the last year will have attended at least one prenatal care session (NEW)
<b>Family Planning</b>	10% of eligible couples will be using temporary methods of contraception	15% of eligible couples will use any method of contraception	SAME
<b>Early Childhood Development</b>		20% of families will be trained in healthy and stimulating child care practices (NEW)	SAME
<b>Sustainability</b>		30% of community groups formed will be operating independently (NEW)	SAME

**[B] Section 5-d-11:**

After negotiation with DPHO, it was concluded that because of the restructuring in the number of TBAs based on geographic conditions, micro planning is necessary to fix the number of TBAs in CS-VIII working areas.

**[C] Section 5-a-4:**

TT camps had been planned in the DIP to improve access and coverage. A decision has been made to promote TT in the regular immunization (EPI) clinics: lessons learned from TT camps suggest that the Regular Clinic approach is more sustainable.

**[D] Revised Sections:**

The sections 5-g-4, technical assistance on Vitamin A intervention, immunization, nutrition, ARI, maternal care are revised and elaborated (*see Appendix E*).

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### **III. Constraints, Unexpected Benefits and Lessons Learned**

#### **[A] and [B] Constraints/Alternative Strategies to Overcome Constraints:**

- The major constraint is the recent reorganization in Government structure, i.e., MOH. The EPI section has been dissolved; therefore there is no specific focal point to contact for the EPI program. Further, more, many of the sanctioned positions are not filled: this leads to difficulties in carrying out coordinated activities. The reorganization in DPHO has been a major one which clearly affects coordination and programmatic functions.
- In remote Tamang villages, it was difficult to find NFE facilitators: Tamang villagers are poorly educated and NFE facilitators need to be educated. The strategy for overcoming this problem was to identify a group of people who have completed four to six years of schooling and then give them a three week long TOT based on the NFE curriculum so as to make them capable of conducting NFE classes. Another approach was to involve local school teachers (who are usually outsiders). To do so, an agreement with DEO has been made.
- Seasonal migration of highland residents and their cultural beliefs in some areas were barriers against the contribution of HBCCC. For this, an alternative strategy has been planned, Family Based Child Care Cooperatives in those areas instead of HBCCC.
- Nuwakot is a politically sensitive area: at the beginning of the program, local politics affected project implementation, especially NFE. Some of the NFE centers dropped because of this reason. Frequent meetings and correspondence with district officials and formal as well as informal meetings with VDC representatives and other key persons reduced such problems.
- The policy on per diem for Government staff during trainings and other assignments affected the implementation of some activities, especially in Health and NFE sectors. It created some confusion between Government and SC/US staff. Correspondence was made with District Public Health Officer to eliminate the confusion. Now the problem is resolved.
- Having only one ilaka office in each ilaka (four to five VDCs) makes it difficult for project staff to go back and forth between offices because of distances and difficult geographical terrain. Thus one sub-office in each ilaka has been planned where staff can stay overnight after they visit distant areas.

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### **[C] Circumstances Facilitated Implementations/Unexpected Benefits:**

- Regular meetings with district officials and VDC representatives have positively affected implementation of project activities.
- NFE groups and saving groups have demonstrated an inclination towards social/community welfare. These groups have planted about 10,000 saplings al over three ilakas. Some of the women groups became involved in trial improvements. One of the women groups has established a shop to increase their group fund. A disabled person looks after the shop and gets a certain amount of the profit.
- A group of teachers in one of the ilakas, after receiving a training on AIDS, have planned to organize a workshop on "AIDS Control" on their own in the coming year.
- Apart from providing services, MCH mobile clinics have led to increase in health service utilization. According to a Health Post Incharge, patient flow in Health Posts has increased since SC/US MCH Mobile Clinic establishment. This has also led to the regularity of EPI clinics. Working with HP staff has made positive effects in maximizing their services.
- The project staff were trained in Child Survival Baseline Survey techniques and AIDS/STDs. They played the role of survey supervisors, which was more cost effective and reliable.

### **[D] Lessons Learned:**

- Though trafficking of girls for the sex industry in India is widespread, it remains a sensitive issue. The issue of AIDS/STDs was not discussed freely in the trainings for ex-prostitutes. They were very sensitive about issues related to AIDS/STDS. To facilitate more openness in these discussions, discussions were initiated with the topics of birth spacing and condoms, and then proceeded to the topic of AIDS/STDS.
- During Vitamin A camps and MCH Clinics, some of the CHVs administered Vitamin A capsules under supervision of clinic staff. If they are given trainings on Vitamin A administration, they can conduct Vitamin-A camps.

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## IV. Health Information System:

### [A] Characteristics and Effectiveness of the Project HIS:

- CS-VIII aims to adopt the nationally standardized forms and procedures developed by MOH and strengthen utilization of the government HIS. DPHO in Nuwakot has recently completed the census with the standardized forms and procedures. A training/workshop will be held among DPHO/HP staff at the start of FY93/94 to strengthen utilization of data collected in the census.
- Indicators for CS-VIII interventions have already been developed (*see Appendix-F*).

### [B] Data Collection and Utilization

- Data about routine check ups and referrals for children <5 years and pregnant mothers are being collected from MCH mobile clinic service sheets. Special camp records provide data on services provided through camps, viz.; Vitamin A, TT and STD camps. EPI coverage by antigen are collected from the VHW registers.
- As stated in DIP, a survey to assess the changes in KAP status was planned in March 1993.

### [C] Needs for Further Refinement of the System.

- Supports will be provided to CHVs/VHWs in updating data.

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## V. Budget and Expenditure

[A] Not Applicable.

[B] See Attached Pipeline Analysis

[C] Not Applicable.

[D] Not Applicable.

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## VI. Follow up of DIP Review

Responses to Detailed Implementation Plan (DIP) review comments responses are attached in *Appendix E*.

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## VII. Others

### [A] IEC:

The IEC component is directed mostly towards AIDS/STDs. The activities done to date are as follows:

- Twelve signboards on AIDS/HIV transmission and protective behaviors have been prepared and posted in Health Posts, schools, offices and other public gathering places.
- A pretest based on information presented in the AIDS/HIV flip chart has been recently completed and is on its way to press.
- Six local AIDS/STDs "Hotlines" have recently been prepared: these consist of one letter box and one bulletin board posted near the box. Every week the letters will be collected from the box and answers will be posted on the bulletin board. Identity will be kept confidential (the sender doesn't need to identify himself/herself).
- A street drama has been planned, which will be done in co-ordination with ABC Nepal, a Nepali NGO.

### [B] Research:

A focus group discussion and in-depth interviews on AIDS/STD has been done in three ilakas (*see Appendix H*).

<b>A REPORT ON AIDS TRAINING FOR VHWS</b>
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**INTRODUCTION**

A four day long AIDS training session was organized for village health workers (VHWs) at Sallemaidan health post on August 23 - 26, 1993. The goal of this training was to raise awareness among VHWs about transmission and prevention of HIV/AIDS and sexually transmitted diseases (STDs). There were 9 VHWs who participated actively in the training program; 4 VHWs could not participate because of heavy rains and personal problems.

**THE OBJECTIVES OF THE TRAINING PROGRAM**

The objectives of the training program were as follows:

- \* To update and upgrade the level of knowledge, attitude and practice on transmission and prevention of HIV/AIDS and STDs.
- \* To decrease fear about unsubstantiated modes of transmission of HIV/AIDS.
- \* To share ideas on mode of transmission and prevention of AIDS and management of STDs at community level.

**ACTIVITIES OF THE TRAINING PROGRAM**

The training was started with welcome speech by Ms Neena Gauchan, a Field Coordinator of Save the Children US (SC/US) ilaka number 1, to all the participants. Next the training proceeded to introductions among participants and facilitators through name cards, songs etc. to build trust and create a comfortable environment. Management and review committees were formed to run the training program smoothly. Each committee consisted of two participants on rotation basis. The committee members performed their job very well.

The major topics of the training program included: definition of HIV/AIDS and STDs, HIV/AIDS situation in Nepal; mode of HIV transmission; high risk behavior; signs and symptoms of AIDS; key interventions for preventing HIV infection; ethics issues associated with AIDS; management of STDs; role of condoms in preventing HIV infection and STDs; special issues concerning women and AIDS; counseling; sterilization and disinfection techniques.

## **METHODS AND MATERIALS**

Various teaching and learning methods and materials were used to make the sessions interesting and effective. These included group work, role-plays, quizzes, posters, pamphlets, cut outs, newsprint , marker pens etc.

## **EVALUATION**

Pre and post tests were performed to determine the participants' level of knowledge on HIV/AIDS and STDs. The post tests demonstrated that knowledge levels increased about 40 % through this training program.

The training was facilitated by following staff:

- ✦ Moti Bishwokarma
- ✦ Maya Gole
- ✦ Manoj Babu Dhakal

## **CLOSING**

At the end of the program, all the participants were thanked for their active participation and effort and certificates were distributed. Members of the group which won the quiz contest were awarded simple prizes..

## **CONCLUSION**

VHWs who took part in the program were very happy with their exposure to various training activities. They requested that other training sessions be organized as soon as possible.

**A Report of AIDS training  
for CHVs**

**INTRODUCTION:**

A two day AIDS training for the Community Health Volunteers (CHVs) was held at ilaka no. 12 at three different venue and time. It was conducted on August 19 to 20, 23 to 24 and 29 to 30 at Shikharbesi Health post, Samundratar office and Kharanitar Health post respectively. There were altogether 38 CHVs who actively participated in the training.

**OBJECTIVE:**

The objectives of the training are as follows:

- \* to update and upgrade the level of knowledge, attitude and practice on HIV/AIDS and STDs transmission.
- \* To decrease the fear of HIV/AIDS & STDs.
- \* To share ideas on controlling and preventing HIV/AIDS and STDs transmission in their communities.

The major topics of the training were definitions of HIV/AIDS and STDs; mode of transmission; high risk and low risk behaviors; signs and symptoms of AIDS; prevention of HIV/AIDS and STDs; including condom use; management of STDs; ethical issues on AIDS; and counseling.

**METHODS:**

Various teaching and learning methods were followed: question/answer sessions; discussions; group work; role-play; demonstrations; and story telling.

**MATERIALS:**

The following training materials were used in the training:

- \* Newsprint
- \* Marker pen
- \* Glasses
- \* Plastic pieces
- \* Posters

**CONCLUSION:**

The training was helpful and interesting because of active participation by CHVs and facilitators. It is expected that this training will help to create community awareness about transmission and prevention of HIV/AIDS and STDs.

**A BRIEF REPORT OF TRADITIONAL HEALERS TRAINING**

**INTRODUCTION**

Traditional Healers (THs) play a vital role in the community in provision of health care services. Most of the villagers believe in THs and seek help from them rather than from health personnel when they have health problems. The population in the SC/US impact area is at high risk for AIDS/STDs transmission and has poor access to maternal and child health services. In order to increase the ability of THs to raise village awareness about AIDS/STDs and to improve health services, a 2 day training session was organized from August 19-20, 1993 at Gaunkharka, Ilaka # 13 of Nuwakot district. 23 THs participated in this training program from Gaunkharka, Rautbesi and Betini village development committees (VDCs).

**THE OBJECTIVES OF THE TRAINING ARE AS FOLLOWS:**

- \* To improve knowledge of THs about health services and AIDS/STDs.
- \* To clarify the role of THs in the health delivery system
- \* To motivate THs to refer the clients for the medical help as early as possible to appropriate health care providers.
- \* To improve TH counseling techniques.

**THE TOPICS OF THE TRAINING PROGRAM:**

- Introduction of new health problems into the community; health care seeking behavior of the community people; and management techniques for these health problems.
- Family planning and importance of birth spacing.
- AIDS/STDs - introduction, causes, mode of transmission, sign and symptoms, counseling techniques; and HIV preventive measures.
- The role of THs in the community and coordination with local volunteers/leaders/health post staff.

## **METHODOLOGY OF THE TRAINING**

The following methods were used:

- Questions/answers
- Discussion
- Demonstration
- Role play
- Problem solving
- Story telling
- Listening tape cassette on AIDS

## **FACILITATORS:**

- \* Ravindra Thapa
- \* Tulasi Gurung
- \* Netra Prasad Bhatta
- \* Ranjana Khanal

## **CONCLUSION**

The participants were very interested in learning new things. They realized that other health care providers in addition to THs have a role in treating most diseases. They appreciated the role of THs as well as other health personnel in the health delivery system. They suggested that other trainings be conducted on specific diseases (e.g.) or therapies and that the arrangements of the training hall and sitting place be improved. THs will play an important role in improving health knowledge levels among the people of their communities.

**INTEGRATED  
VITAMIN A AND NUTRITION TRAINING**

***SAMUNDRATAR, NUWAKOT  
AUGUST 13 - 17, 1993***

**GRANT #: FAO-0500-A-00-2034-00**

***SAVE THE CHILDREN US  
MAHARAJGUNJ  
KATHMANDU, NEPAL***

**REPORT PREPARED BY:  
DALE DAVIS  
NAVIN K. PYAKURYAL**

## **TRAINING OBJECTIVES AND APPROACH**

1. **To refresh the technical knowledge and understanding of Vitamin A and nutrition programming for the health, women development, agriculture and non-formal education facilitators.**
2. **To develop a multi sectoral approach to the vitamin**
3. **To develop learner centered trainings for the target groups in each sector.**

### ***Expected Outcomes:***

1. **Increase in the technical knowledge of how and why vitamin A interventions work.**
2. **An action plan developed around lessons learned in capsule distribution/treatment programs nutrition education and food production.**
3. **A learner centered training approach with a multi-sectoral concepts.**

# THE WORKSHOP

## DAY 1

**Facilitators of the day: Ms. Bhim K. Pun and Mr. Jay Shrestha**

**In order to make the training more participatory, participants were requested to volunteer for being facilitators every day. These facilitators were given the complete responsibility of organizing sessions, distributing handouts, conducting games energizers whenever necessary and also overseeing arrangement of tea/snacks.**

### ACTIVITY INTRODUCTION

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**Facilitator:  
Dale Davis**

**A welcome to all ! Over the next few days we will have the opportunity to work together as a team acquire new knowledge and more that knowledge into an effective training plan for the people in your impact areas. You will learn what vitamin A is, how it functions in the body and what happens when there is not enough of it. We will have the time to discuss what is going on both overseas and in Nepal with vitamin A programming so that we can discuss and use the experience of others when preparing your own plans. Then you will have the challenge of creating and preparing a vitamin A package for yourselves.**

**Helen Keller International worked together with SC in Gorkha to assist SC to strengthen their vitamin A programs and to develop strong Training of Trainers capacity. Now with Navin and Ravindra you have excellent trainers and HKI is here as a resource support over the next two days. It is a pleasure for me to be here with you all. The resource table has a selection of books and materials which should be helpful to you.**

#### ***Name Tags***

**All participants made their own name tags. We decided to do them by colour for each ilaka program so that we had integrated teams A drawing of their vitamin A symbol distinguished the groups;**

**Pumpkin, Mango, Spinach and Papaya.**

## **ACTIVITY**

### **Meeting Each Other - Bingo Games\***

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**Facilitators:**  
Navin Pyakuryal, Ravindra Thapa

#### ***Purpose:***

To subtly force newcomers to make new acquaintances in a non-threatening climate, and encourage old acquaintances to learn more about each other.

#### ***Process:***

A bingo card was given to each participant and they were asked to move around the room until they found a person who fit the description shown. That person then signed his or her name in the appropriate box. When the player filled up one row to each participant and they were asked to move around the room until they found a person who fit the description shown. That person then signed his or her name in the appropriate box. When the player filled up one row (horizontal, vertical, or diagonal, they could sit down.

#### ***Results:***

After all the participants had completed a row and were seated, they were told they all had won a prize. The prize was they were honored to be participants in the workshop ! In addition, they may have learned some new things about others, or met some newcomers, and were encouraged to carry on their conversations in their free time.

***Materials:*** Bingo card (in Nepal) and pen (1 for each person)

***Time:*** 20 minutes

#### ***Comments/Assessment:***

Although Bingo was not a familiar game to the Nepal staff, the game was easily understood. The game was effective in stimulating movement and mingling. It may also be useful to have a concrete prize related to the workshop for all the participants at the end of the game, for example, their participant packet, handouts, etc.

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\* Source: "Games Trainers Play" by JW Newstrom and EE Scannell, McGraw Hill Book Co., NY 1980.

## **ACTIVITY**

### **Hopes and Fears\***

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**Facilitators:**  
Navin Pyakuryal, Ravindra Thapa

#### ***Purpose:***

To share hopes and fears about the workshop that can be monitored during the training.

#### ***Purpose:***

Participants were asked to think about their own hopes and fears about the workshop, and list them on a sheet of paper. They were then asked to share these in small groups of about 3-4 persons, and summarize them on newsprint. Each group was asked to share their summary with the whole group, and post it on the wall. These hopes and fears were referred to during the process of the workshop.

The goals and objectives of the workshop (see introductory section), and the expected products were then reviewed by the facilitators, and compared with the hopes of the participants. Due to the limited time for the workshop, all of the hopes could not be fully met. Fears of the participants were also discussed and everybody agreed to respect other people's concern.

#### ***Results:***

##### **Hopes of the participants:**

- ☞ To gain additional knowledge about vitamin A, its source, causes, prevention, treatment of vitamin A deficiency (especially technical knowledge).
- ☞ To discuss implementation of vitamin A related program in the community.
- ☞ To gain proper skills in training the community people regarding vitamin A.
- ☞ To know the effective communication technique for disseminating vitamin A messages.
- ☞ To participate in interesting training games.
- ☞ To exchange idea and knowledge with fellow participants.
- ☞ To acquire the technique to translate people's knowledge into practice.
- ☞ To know how to make available vitamin rich foods in villages.

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\* Source: Tools for Community Participation by Lyra Srinivasan, UNDP, NY, 1990.

### **Fears of the Participants:**

- ⌘ Whether the knowledge acquired in the training can be applied in field or not.
- ⌘ Can we follow all the teachings in the training and grasp it.
- ⌘ How to acquire all knowledge related to vitamin A in such a short duration.
- ⌘ I can not stay full time in the training.
- ⌘ Facilitators may mind when I raise questions frequently.
- ⌘ The sitting arrangement and hot temperature in the hall may not be convenient for effective training,

## **ACTIVITY**

### **The Rupee Exchange/Idea Exchange**

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**Facilitators:**  
**Facilitator: Navin Pyakuryal**

***Purpose:***

To encourage a climate for open exchange of ideas among the participants.

***Process:***

First one volunteer participant was asked to loan a five rupee note to the facilitator. Displaying it properly, then another five rupee, currency was asked from another participant. Then the first loaner was repaid with the first rupee. Then the whole group was asked "Is either of these persons richer than they were before?". The answer was obviously NO. Those two volunteers were requested to write one idea each on a piece of paper and to exchange it with each other. By contrast now the whole group realized the idea sharing has made both the volunteers richer and along with those idea givers all the participants have become richer in experience than they were previously.

***Materials:*** Paper sheets and pens.

***Time:*** 15 minutes

***Comment:*** If worked excellent in making the whole group realize the importance of idea sharing in the training.

## **ACTIVITY**

### **Testing the Vitamin A and Training Related Knowledge**

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**Facilitators:**  
**Ravindra Thapa and Navin Pyakuryal**

***Purpose:***

To formally test the participants' knowledge in vitamin A and training before and after the workshop.

***Process:***

Participants were given approximately 30 minutes to complete a pre-test questionnaire on vitamin A. The questionnaire included questions on vitamin A source and deficiency, capsule dose and training. The questions were explained in Nepal also by the facilitators. Participants did not see any problem in putting their names on the tests and they were collected for grading. The past test was given at the end of the training and both the results were used for the evaluation of the training itself.

***Materials:*** Pre-test questionnaire for each participant.

***Time:*** 30 minutes

***Comments:***

Most of the questions were objective type and as there was no minus system in grading it became very easy to secure high marks. Questionnaire should be better prepared in Nepal language and given for the tests.

**ACTIVITY**  
**PICK AN A ... ANY A !**

**A Nutrition Card Game**

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**Facilitators:**  
**Ravindra Thapa and Dale Davis**

***Purpose:***

**This game is a fun way to learn about the differing vitamin A content in our local foods. The foods chosen are commonly eaten in Nepal and are all part of a balanced diets. The fun is to pick the ones high in A.**

### ***The Rules and Process:***

We placed 48 cards face down on a mat in the middle of the floor. These cards had the name of a common food written on the top side. The participants were divided into four groups of three and stood one group to each side of mat. We then drew a number to see who would go first. The group decided that it would be best to keep the cards together until the selection process was finished and then discuss each card group.

Then moving clockwise each team participant had one selection at a time until all the cards were gone.

The participants then sat in a circle in their groups and one at a time held up their cards and turned them around to show the score. This provided a good opportunity for everyone to discuss and learn together. It gave time to talk about what a particular food contained, if not an A high content, and the availability and regular consumption habits of those that were high in A.

### ***Summary:***

The participants enjoyed this very much. They all agreed that it was a good start to understanding about vitamin A, its sources and what it needs to be properly absorbed in the body. It also clarified some mistaken ideas about food sources i.e.: green beans are high in "A".

### **PICK AN "A" SCORE BOARD**

Remember: Children under 6 years of age need about 900 IU of vitamin A each day ...this means a high scoring food provides enough for one day in a 100 gm serving.

<b><u>POINTS</u></b>	<b><u>VIT. A IU<sub>s</sub> PER 100 GM</u></b>	<b><u>COMMON FOODS</u></b>
0	< 100 IU	Cucumber, water/bitter gourd, okra, bread, banana, cauliflower, potato, cabbage, barley, millet, sugar, limes, eggplant, rice, maize, mustard oil.
5	100-200 IU	Orange, jack fruit, pineapple, guava, red tomato.
25	200-900 IU	Whole cows milk, orange yam, orange papaya.
50	900-5,000 IU	Spinach, radish leaves, Swiss chard, coriander, egg (yolk), yellow/orange pumpkin and leaves, carrot, kakalo, red chili, mustard leaves.
100	> 5,000 IU	Goat/chicken liver, small whole fish (liver), vitamin A capsule.
<b>50 + BONUS</b>		<b>Breast milk.</b>

Team scores were pretty close ! Everyone managed to pick some high scores; team 1: 380 team 2:255 team 3:250 team 4:245.

Source Vitamin A Content:

"A special compilation of Vitamin A + Sieve" by Prevention Magazine, and Rodale Press, Inc., 1986.

Tables of nutrient composition of Bangladesh foods: English version with particular emphasis on vitamin A content, Darton-Hill, I., Hassan N, Karim, R, and Dunthie, MR, Published by Helen Keller International, Voluntary Health Services Bangladesh, 1989  
Facilitator: Dale.

## **ACTIVITY**

### **INTERNATIONAL OVERVIEW AND FACTS**

---

**Facilitator:**  
**Dale Davis**

#### ***Purpose:***

**This session aimed to give the participants a good understanding of the development of vitamin A as an internationally recognized public health problem, particularly in the developing world.**

#### ***Method:***

**We followed the vitamin A course through the body learning about its function in normal healthy growth, how it is absorbed and what happens in the different parts of the body when there is insufficient stored in the liver or available in the bloodstream.**

**We traced its history from early discovery through to the research which proved its connection to xerophthalmia, nutritional blindness, particularly in young children and then on to the discovery of the link to mortality and morbidity in children with measles, diarrhea and malnutrition.**

**We discussed the WHO/VACG/UNICEF guidelines for treatment and prevention and then went on to discuss what happens when the body ingests too much vitamin A, what to do if it occurs and how to avoid it through effective planning and adequate understanding.**

**To correlate all this information we then look at the holistic approach to vitamin A in family health and how it involves the different sectors and strategies.**

#### ***Comments:***

**Before this session I had received earnest requests from the group to give them technical information about vitamin A.**

**The participants found this session very informative. They asked lots of excellent questions in an effort to understand vitamin A as thoroughly as possible as a base for their planning.**

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***Handouts:***

**\*Bellagio Brief - Vitamin A Deficiency & Childhood Mortality  
(Helen Keller International, 1992)**

**\*"Physiological Consequences of Vitamin A Deficiency", Whitney, EN,& Hamilton,  
ER, Understanding Nutrition, West Publishing Co, St. Paul, 1984**

**\*Combating Vitamin A Deficiency, (WHO, 92703)**

**\*"Q & A ON VITAMIN A", How much is too much? by Helen Keller International and  
Johns Hopkins University**

**Facilitator: Dale**

## **DAY 2**

**Facilitators of the day: Bed B. Lama and Moti Bisham**

### **ACTIVITY ESTABLISHING TEAM IDENTITY**

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**Facilitators:  
Dale Davis, Navin Pyakurel and Ravindra Thapa**

***Purpose:***

To allow the newly formed integrated planning teams an opportunity to establish a team identity through a fun and creative process.

***Process:***

As an introduction to team building process the facilitator initiated discussion on the difference between working as a group versus working as a team, a team being united with a specific goal or purpose.

Next the participants were divided into mixed sector ilaka groups and asked to develop as a team a creative poster that included:

<b>TEAM NAME</b>
<b>LOGO</b>
<b>MOTTO OR SONG</b>
<b>TEAM MEMBERS NAME</b>

***Results:***

The team were very excited about the activity. Likening it to a competition, they wanted to make their products the best. They had long serious discussion in their team before reaching to a decision.

Two of the three teams could also make a song with their motto which they presented with great enthusiasm. The team name and motto prepared by the participants:

- |    |   |
|----|---|
| 1. | Rural Health Servant:<br>Ilaka No. 1<br>"Produce Green Leaves, save your life".   |
| 2. | Human Resource Center:<br>Ilaka No.2<br>"Healthy life, green vegetables".   |
| 3. | Balanced Diet Academy:<br>Ilaka No.3<br>"Feed green leafy vegetables and yellow fruits, save future stars, the children". |

**Materials:** Coloured card boards  
Colour marking pens  
Tapes.

**Time:** 1 hour 30 minutes.

**Comment:**

This was a very valuable activity in establishing communication bonds in the integrated groups. Which helped later in the difficult process of program planning. The exercise was fun and creative.

## **ACTIVITY UPDATE ON VITAMIN A IN NEPAL**

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**Facilitator:  
Dale Davis**

### ***Purpose:***

To assist the field trainers to prepare an effective training and implementation strategy for their field work within the national framework and according to the national vitamin A Guidelines.

### ***Process:***

Participants were given an overview of the specific vitamin A deficiency research findings in Nepal and where the greatest vitamin A deficiency areas were located.

We then outlined the strategy of the National Vitamin A Program, where the priority areas are and discussed reasons for their prioritized selection.

We then described the actual vitamin A campaign plan and compared it with the vitamin A distribution program which was conducted by the SC team in Nuwakot in May (capsule supply through the ministry of Health /Technical assistance group). We then talked about what happened and ways of improving the distribution campaign to have greater coverage and nutritional impact.

### ***Summary:***

The participants found it useful to understand the national concept. They felt that a brief assessment of their distribution campaign had pointed to the need for a stronger training program and the need to develop a curriculum. With their improved knowledge they felt more equipped to undertake this task.

### ***Handout:***

NGO Guidelines to the National Vitamin A Program, June 1993

Diagram of distribution point:      Map of priority areas

**ACTIVITY**  
**LESSONS LEARNED IN VITAMIN A PROGRAMMING**

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Facilitator:  
Dale Davis

***Purpose:***

Assist participants to gain a understanding of what works best and situations to avoid when they develop their programs in Nuwakot.

***Process:***

Now that the group had a sound knowledge of what vitamin A means to the health of a population and the approach to the problem in Nepal it is time to look at what the experience of others has been in the different aspects of vitamin A programming in other countries.

The lessons learned were divided into three main categories; capsule distribution, nutrition education and kitchen gardening as these correlate closely with the objectives of Nepal's national program priorities.

**CAPSULE DISTRIBUTION:** The experience of others pointed to 4 major areas of concern;

- (1) establishing a reliable source for vitamin A capsules
- (2) establishing a reliable recording and reporting system
- (3) accurately assessing coverage
- (4) developing a simple system for follow-up dosing.

Participants noted these points and felt that they could cover them quite effectively within their own impact areas.

We then discussed lessons learned from Nuwakot;

- (1) advertise 10 days before distribution dates
- (2) have more distribution points so that access is easier in remote areas.
- (3) more intensive and improved training program for CHVs and include more nutrition education.

**NUTRITION EDUCATION:** We first need to do an assessment of our impact areas to discover the reasons for the food problem:

- not grown so not available
- available but not sold in the market
- available in the market but too expensive
- available but not fed to the small children
- women and children not getting the best foods
- children not breast fed

**Points to remember;**

- \* education does not change everything
- \* education must reach the decision makers
- \* education must incorporate a holistic view to health
- \* messages must be clear and simple
- \* messages should focus on positive
- \* behavior change takes time
- \* community-identified solutions work best
- \* income generation is an important component of improved health

### **KITCHEN GARDENING**

- consider water availability and how to solve access
- start small and grow
- consider off-season growing and food preservation
- improved distribution and access is as important as production
- start with locally grown foods first
- involve women in the planning and development of all projects

**Nutrition/health should be the major focus of gardening benefits.**

We need to assess dietary habits, promote vitamin A enriched foods, and promote consumption in those who need it most through cooking classes, easy recipes, feeding behavior problem solving.

### ***Summary:***

Although this was a lot to digest the information was useful to the participants. It gave them a more comprehensive view of vitamin A programming, where the emphasis should be in each sector and a holistic concept of health and well being. It also helped them to learn from the experience of others, which is often not far from there own program experiences.

## **ACTIVITY BREAST FEEDING**

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**Facilitator:  
Navin Pyakuryal**

### ***Purpose:***

**This exercise is designed to develop a clear understanding of the importance of breast feeding for normal healthy growth so that the field trainers are able to encourage correct concepts in their mothers.**

### ***Process:***

**Key points were written on separate pieces of paper and given to each of the participants. Each person was asked at random to read out their "key point" and explain what subject it was related and why it was important. The points were related either to breast feeding or bottle feeding.**

**Then, the handout showing a mother of twins, one male and one female were distributed. The mother breast feeds her son and bottle feeds the daughter because her mother-in-law told her she would not have enough milk for both. The difference in size and health status is incredible and the tragedy is that the baby girl died the following day. The group then opened for discussion.**

### ***Summary:***

**Participants were able to talk about the power of cultural beliefs, which are not always true. At first they thought that this type of situation would not happen in Nepal, however further discussion began to reveal favoring of the boy child. Although it was agreed that in the village environment most women breast feed as long as possible, it was clear that these trends are beginning to change in the towns and cities where "modern" Nepali mums are more likely to choose bottle feeding for convenience. In the towns the women are more influenced by advertising and new ways.**

**Handout: From Helen Keller International - pre-testing material for the vitamin A training manual;**

**Photograph courtesy of Children's Hospital, Islamabad.**

### **KEY POINTS**

- 1. As babies have low levels of vit.A stores, breastmilk is an important source of the vit. for them.**
- 2. There is only bad substitutes for breastmilk; these substitutes lead to serious illness and poor growth of babies.**
- 3. Breastmilk alone is a sufficient diet for babies until the age of 4 - 6 months.**
- 4. The more breastmilk consumed, the more produced.**
- 5. Mothers should use both breasts equally.**
- 6. Almost all mothers can produced enough breastmilk for infants up to the age of 6 months. If not, the mothers diet should be improved or she should be referred for check up.**
- 7. Breastfeeding is the best and safest way of keeping your baby healthy and helping him or her grow during first 6 months.**
- 8. Substitutes or supplemental foods may cause diarrhea if given to babies before 6 months of age.**

## **DAY 3**

**Facilitators of the day: Netra Bhatta and Maya Gole**

### ***ACTIVITY*** **THE 16 QUESTIONS**

---

**Facilitator:**  
**Navin Pyakuryal**

***Purpose:***

Just to sensitize the group on the issues relating to effective technique of information collection as part of monitoring and evaluation.

***Process:***

3 volunteer were invited to participate in this exercise. One played the role of community people and other two were the investigators. The community person was asked to think a word relating to vitamin A, which was told secretly to the facilitator. The investigators were allowed to ask 16 questions only to find out what he was thinking. After the exercise the whole group discussed on what went wrong in the questioning.

This game was very successful in its purpose.

***Results:***

The investigators failed to detect the word even after 16 questions. First they were not expert in the art of questioning and next the community person confused them by thinking "Liver". The participant playing the role of the community people was a non vegetarian so the investigators only could suggest vitamin A rich vegetables and fruits.

***Materials:*** Done

***Comment:***

The investigators could not fully grasp the instructions. So clear instructions should be developed and explained to them in a more understandable way.

***Source:***

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Developed by Navin Pyakuryal on the basis of T.V. program.

## **ACTIVITY**

### **Monitoring and Evaluating Vitamin A Programs**

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**Facilitators:**  
Navin Pyakuryal and Ravindra Thapa

#### ***Purpose:***

To briefly review the need for and methods of monitoring and evaluation of programs and review the suggested indicators as well as develop a monitoring/evaluation plan.

#### ***Process:***

First there was brainstorming on need to evaluate followed by a brief lecture on type of indicators. Then the groups were divided according to Ilaka to identify the relevant indicators and develop a monitoring evaluation plan.

#### ***Results:***

Three types of indicators were discussed:

- 1) **Impact Indicators:** true impact or results of a program showing change. e.g. prevalence rate of night blindness, child mortality rate.
- 2) **Output Indicators:** It simply reflects the output produced by program efforts e.g. rate of under five children covered by capsule distribution, immunization coverage.
- 3) **Process Indicators:** It measures whether the program actually took place a planned e.g. number of trainings held.

Then the each group developed monitoring/evaluation plan which includes type of indicators, technique and source of getting information on that and the time for these activities. Based on these sample plans, each team will prepare a final plan after more serious work on it.

***Time:*** 1 hour 20 minutes

#### ***Comment:***

This session, specially the discussion on type of indicators and method of data/information collection was felt very useful by the participants.

## **ACTIVITY WHO SHOULD GET THE EGG**

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**Facilitator:  
Navin Pyakuryal**

### ***Purpose:***

**This exercise was developed to highlight nutritional and including the vitamin A needs of the family members of different age groups. In Nepali society the extended family living situation is the norm hence the emphasis on being able to appreciate the differing needs.**

### ***Process:***

**We placed the figures of grandmother, father, mother, daughter and son on a black flannel board.**

**Our little girl is 6 years old, going to school and helps around the house with daily chores. She is taking care of her little brother is almost two years old when she finds an egg in the field next to the house. She takes it to mother explaining that the hen has laid an egg...good for a snack!**

**Ah, but who should get this egg?**

**We know now that it is a good source of vitamin A, protein and vitamins. In Nepal it is appreciated as a good food to eat and to offer to guests.**

The participants were divided into five small groups. Each group was randomly assigned a family member. They were given 15 minutes to prepare their substantial argument and reasons why their family member should get the egg. With each presentation the points were recorded on newsprint and summarized when all presentation were completed.

***Summary:***

This exercise proved useful for the participants to think about the nutritional needs of each age group through the life span; to think about the vitamin A specific needs in each age group; and to examine how and why families make their decisions of who should get the better food in the family, particularly when food is limited.

Source: Adapted from  
"Who should get the egg?"  
a film strip by World Neighbors.

***Results:***

The following list of arguments was generated by the participants on why their assigned family member should get the egg. These points were presented by the participants in a very colourful way either in the form of skit or story telling with the help of cut out figures on flannel board.

**Father:**

- I am responsible for supporting the whole family.
- I need nutritious food to get energy for hard labour.
- All the family members respect me.
- My family loves me so much.
- I am the ultimate decision maker so I can decide on my favour.

**Mother:**

- I should be well nourished for breast feeding.
- I have to look after and take care of everybody.
- I need energy to work over whole day.
- I am weak.
- I should be strong to hold the pregnancy.
- If I wish my daughter, Suntali will give the egg secretly to me.

**Grandmother:**

- As I am getting old, I am as weak as a child.
- I have already developed cataract.
- I am the sun above the mountain so do not have much time left to eat, others can eat later.
- I am the household head.
- I have no teeth left and the egg is soft to eat.

**Suntali:**

- I need the egg as I am still growing.
- I need energy to help me learn in school.
- The mother loves me.
- My little brother takes breast milk but I stopped years back.
- I am weak.

### **Pre School Boy:**

- **Parents love me more.**
- **Being a son I have to support the family in future.**
- **If I do not survive there will be no one to continue the family in future.**
- **Son preference.**
- **I can not eat other hard food.**

**Materials:** Flannel board, cut out characters of family members, hen and egg.

**Time:** 1 hour.

**Comment:**

**In case of pre school boy the argument completely shifted from nutritional needs to son preference. Participants became more involved in the sex bias issue rather than nutrition. Hence in the cultural context of Nepal it will be better to make either both the child characters female or both male.**

**DAY 4**

**Facilitators of the day: Durga Regmi and Ranjana Khanal**

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## **ACTIVITY**

### **Action Plan for Vit. A Programming**

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**Facilitators:**  
**Navin Pyakuryal and Ravindra Thapa**

#### ***Purpose:***

**Provide a frame work for integrated program planning in vitamin A and develop a draft action plan for each ilaka.**

#### ***Process:***

**First participants were briefed on the framework for developing action plan. They first discussed these issues in main group:**

- **Goal**
- **Objectives**
- **Existing problem**
- **Target group**
- **Community resources**
- **Activities**
- **Time frame for each activities.**

**Then participants were divided into three previously decided integrated teams to develop the action plan. Next morning they worked in group and prepared a presentation on that.**

#### ***Results:***

**The group task was very challenging for the team. As it was multisectoral effort so everybody had different perception to the problem. However after lot of arguments and discussion gradually they learned to settle the issue and produced three action plans for each ilaka.**

***Material:*** Newsprint, markers.

***Time:*** Total 3 hours 15 minutes.

## **ACTIVITY CHILD EATING BEHAVIORS**

---

**Facilitator:  
Navin Pyakuryal**

***Purpose:***

To provide a relaxed and fun situation to open discussion on the childhood feeding problems and frustrations faced by mothers, not only in Nepal but the world over. In a Nepali village environment mothers have very little choice of child foods...there are no supermarkets filled with 57 varieties of tastes. This hopes to provide some ideas on how we can deal with these conditions. Often when infants take a new food they reject it but with gentle persuasion and some taste disguise they can change their minds.

***Process:***

Three participants were selected as infants, blindfolded and seated ready for feeding. Mother has four different types of foods to offer, bitter & salty, soft & sweet, slimy & hot, soft & spicy. She fed each child a different food and others observed the child's reaction.

***Material:*** 3 blind folds

4 types of food, plates and spoons for 3 persons.

**Result:**

The actors were very enthusiastic in their role playing. The mothers role was much difficult as she was not allowed to speak in Nepali but only in artificial language so that the children would not understand. All the participants realized this can be a very interesting exercise for the training of community people also.

## **ACTIVITY**

### **Training Need Assessment with Local Community Groups**

---

**Facilitator:**

***Purpose:***

To meet various community groups and begin to assess their training needs, problems, constraints and interest in vitamin A and nutrition.

***Process:***

Three community groups were invited to take part in the discussion one day earlier. They were the CHVs (Community Health Volunteers), the non formal education facilitators and the home based child care group mothers. Participants were divided into three groups on the basis of their interest for assessing the needs and later for developing the trainings. When the community people arrived the participant's team sat with them and discussed elaborately their needs and concern.

***Results:***

About 20 community people attended the need assessment meeting. Discussion were rich and helped the team assess the interest and baseline knowledge of the community people. Participants felt this exercise to be really useful to look at the problem from villagers perspective and develop empathy.

***Materials:*** Refreshment for community people.

***Time:*** 1 hour 30 minutes.

## **ACTIVITY**

### **Problem Posing Pictures**

---

**Facilitator:**  
**Navin Pyakuryal**

#### ***Purpose:***

To provide simple but creative problem posing tool which can be used to facilitate discussions around nutritional gardening and can be applied also for a wide range of community activities.

#### ***Process:***

This exercise used an innovative tool called problem posing pictures to help community members identify and discuss realistic constraints to gardening for improved family nutrition. These pictures are simple drawings which depicts local scenes of real life difficulties. In this exercise a set of 5 posters were given to the four groups of participants. As there were unrealized sets the groups were free to order it any way and present a story, highlighting not the ideal situations or solutions but rather present the real situation. They were given 20 minutes to develop a story and told to be creative and that there is no right or wrong way story.

#### ***Results:***

Each group presented the story in a very entertaining way and the pictures order varied. After the presentation there followed discussion regarding:

- ⊕ Why some stories were different than others?
- ⊕ What are the pertinent issues raised by the stories?
- ⊕ How they feel using this material?
- ⊕ Can it be helpful in the discussion with the community people?

***Materials:*** Set of 5 problem posing pictures for each group.

***Time:*** 1 hour 15 minutes.

## DAY 5

**Facilitators of the day: Rajendra Lama and Manoj Dhakal**

### **ACTIVITY** **Perception Game**

---

**Facilitator:**  
**Ravindra Thapa**

***Purpose:***

To make the participants realize that people have different perception based on their past experience, knowledge and background.

***Process:***

Three participants were invited to play the role of leaders and others were divided in three groups under them. The leaders talked with either group members for five minutes on three separate issues; bamboo, ladder and ropes. When everybody was back in the room one illustration was presented and asked what it is? The groups answered as they were told before by their leaders. Actually only one group was correct and the picture was that of two bamboos. After that discussion followed why the answers varied.

***Results:***

Participant found this game quite interesting and they were very much excited in the process. They blamed their leaders for conditioning them to an answer.

***Comment:***

This was the first time the game was presented so the instruction were not clear enough. The leaders could not play their role efficiently and hence tried to persuade an answer. However it was found to be a very valuable experience and later improvement will certainly make it a useful training game.

***Materials:*** Illustration of two bamboos.

***Time:*** 40 minutes.

## **ACTIVITY**

### **Curriculum Development**

---

**Facilitator:**  
**Navin Pyakuryal**

***Purpose:***

To review the steps in curriculum development as a tool for designing effective trainings.

***Process:***

The session was earlier designed to be a simple discussion on lesson planning. However, participants were interested more on designing the whole curriculum and they wanted to discuss at length on it. The logical steps in curriculum development was presented as follows:

---

**Identification of Problem**

***Task Analysis***  
***K.A.S. Required***

***Trainee Analysis***  
***Existing K.A.S.***

**Assess Training Needs**

***Set Training Objectives***

***List Training Content***

**Analyze the Training Content  
and Sequence it**

**Select Appropriate  
Methods/Materials**

**Divide Training into  
Session and Units**

**Divide Training into  
Session and Units**

**Set Overall Evaluation  
Method**

---

---

Then participants were told for each individual session or unit separate, elaborate lesson plan should be prepared.

After that participants were divided in three earlier decided groups; CHV, NFE and HBCC. They worked hard in groups to develop the curriculum.

***Results:***

Participants were very enthusiastic and involved in their work of curriculum development. However in a limited time they could not complete the whole process. After presentation/discussion they decided to improve and complete the curriculum later in their work area.

***Comment:***

It was not possible to complete the task of curriculum development in a short training period. However the participants were acquired and could practice the process themselves which made them confident to develop it later.

***Materials:*** Poster with steps of curriculum development.

***Time:*** Total 3 hours 30 minutes  
(30 minutes for review, 2 hours for group work and 1 hour for presentation).

**SAVE THE CHILDREN US  
HEALTH SECTOR  
NUWAKOT**

**Immunization Programme  
A Protocol on the Cold Chain**

**A COLD CHAIN:**

A cold chain is a system of people, equipment and procedures that transports safely vaccines from the manufacturer through various stages of storage to the person who is vaccinated. The chain is composed of many links, each of them critical, because vaccines are heat sensitive.

**KEEPING VACCINES COLD:**

Vaccines must be kept in a freeze at the correct temperature the whole time, until they are taken out to use in clinics. For mobile clinics a cold box is essential.

**HOW TO MAINTAIN:**

- \* When vaccines are on the way, they must be in thermostat-flask with ice or cold packs in special cold boxes.
- \* Keep vaccines at correct cold temperature. The correct temperature to store vaccines at health centre is between 0°C to 8°C. Temperatures which are too cold or too warm damage vaccines.
- \* Keep the diluent cold by keeping it together with vaccines in cold box.
- \* Keep cold chain monitor card up to date. Record the temperature at 10 am and 4 pm daily, using temperature ledger.
- \* A fully frozen solid ice pack is to be used.
- \* Change the ice packs every or alternate day.
- \* Use luxumberg at health post during sessions.
- \* Ice packs from luxumberg need not be used for vaccine carrier - VHWs (village health workers).
- \* Maintain kerosene or gas powered refrigerators properly.
- \* Keep spare parts (e.g. thermometer).
- \* Keep good records of the supplies of vaccines and proper storage of all supplies.

### **MAINTENANCE DURING ADMINISTRATION PROCEDURE:**

- \* Always keep ice and vaccine/cold box in a cool and shady place
- \* Stand vaccine ampules on ice pack.
- \* Keep the vaccine out of sunlight.
- \* Clean injection area with boiled water with cotton. **DO NOT** use spirit or chemicals.
- \* Use reconstituted vaccine for only one session, throw away any vaccine that remains. **DO NOT** keep partly used vaccine in cold box.
- \* **DO NOT** use frozen and thawed vaccine. Frozen and thawed vaccines sediment even after shaking.

### **DAMAGE OF VACCINE:**

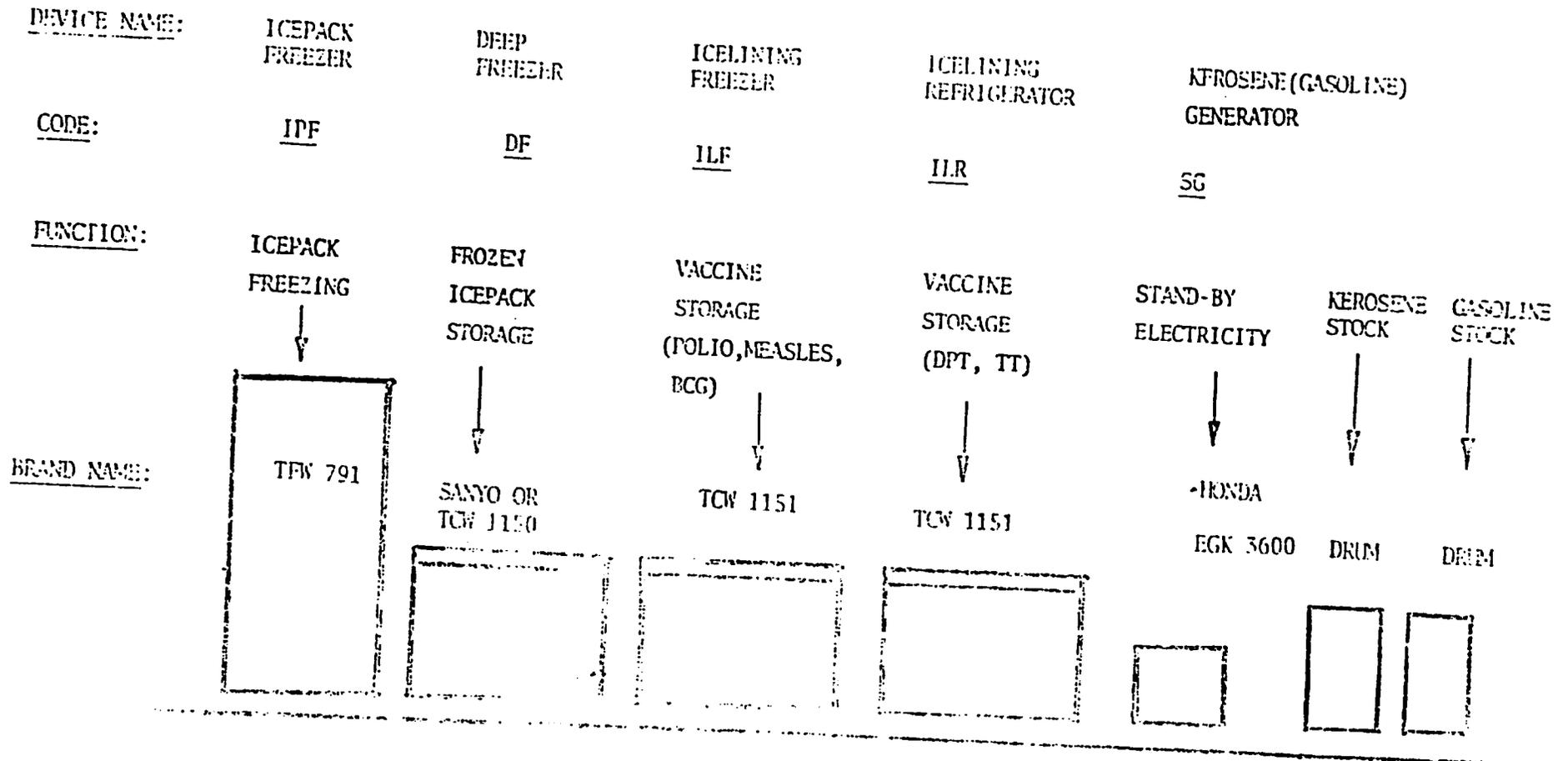
Vaccines are very delicate. They can easily be damaged if they are not kept at the right temperature the whole time. Following conditions damage the vaccines:

- Heat/sunlight/light damages all vaccines but especially polio, measles and BCG.
- Chemicals such as antiseptics, disinfectants. e.g. spirit, soap, savlon etc.
- Vaccines lose their potency after the date of expiration.
- Freezing - too much e.g. DPT and TT are easily damaged by freezing. DPT and TT must never be frozen.
- Shaking vigorously.

If vaccine is damaged by heat, sunlight or freezing, you **CAN NOT** make it potent again. Throw away.

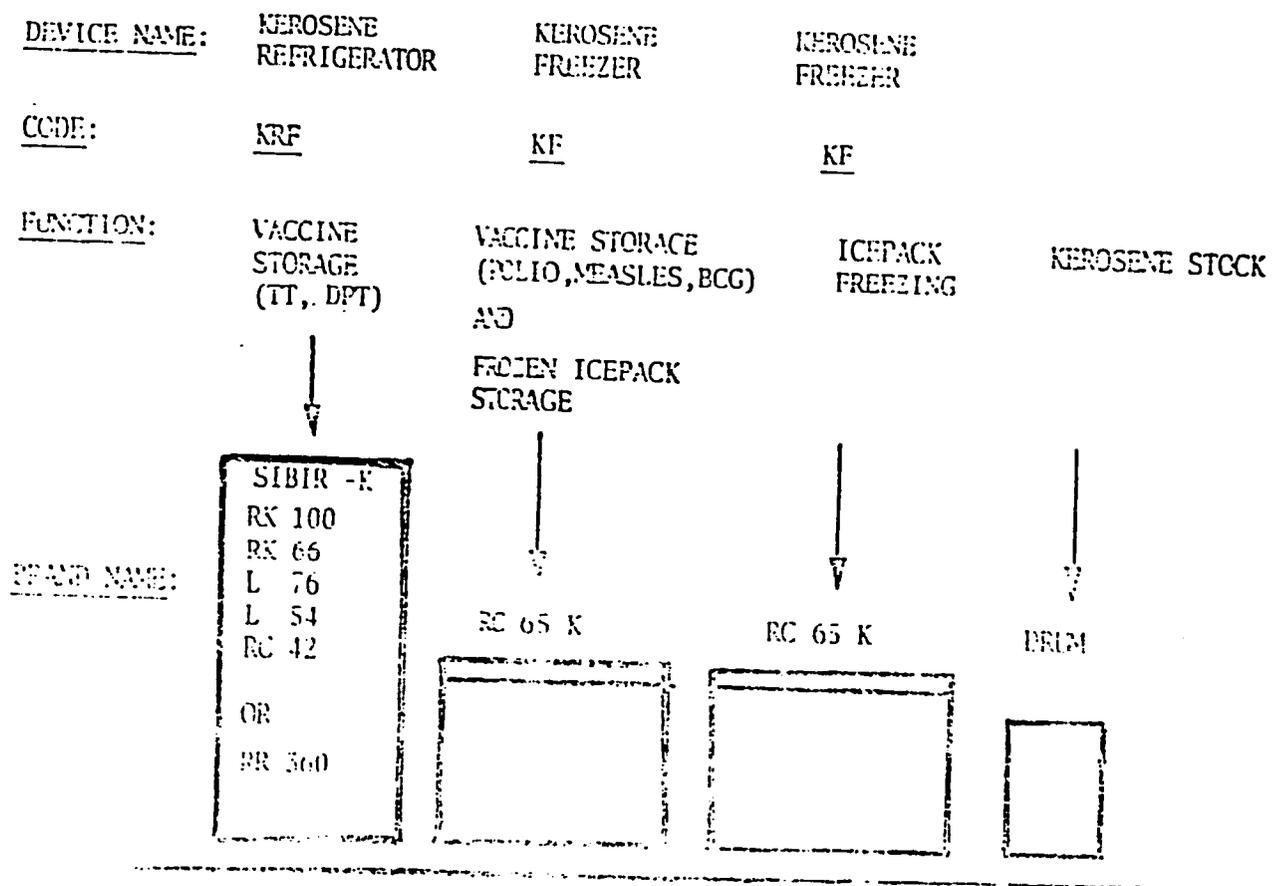
To sterilize immunization equipment, you must use heat, steam or boiling.

A PACKAGED SET OF DISTRICT COLD STORE (WITH ELECTRICITY SUPPLY)

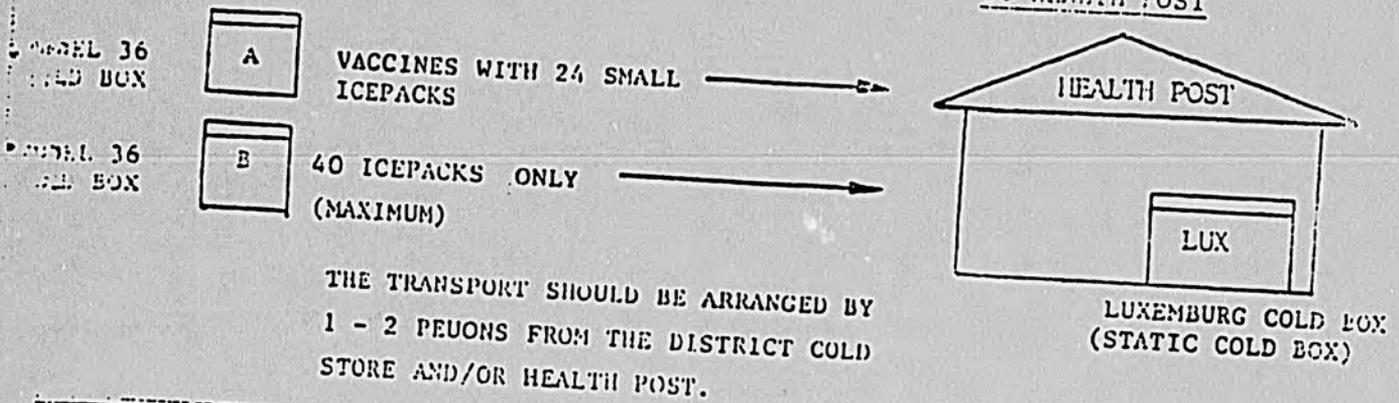


52

A PACKAGED SET OF DISTRICT COLD STORE (WITHOUT ELECTRICITY)

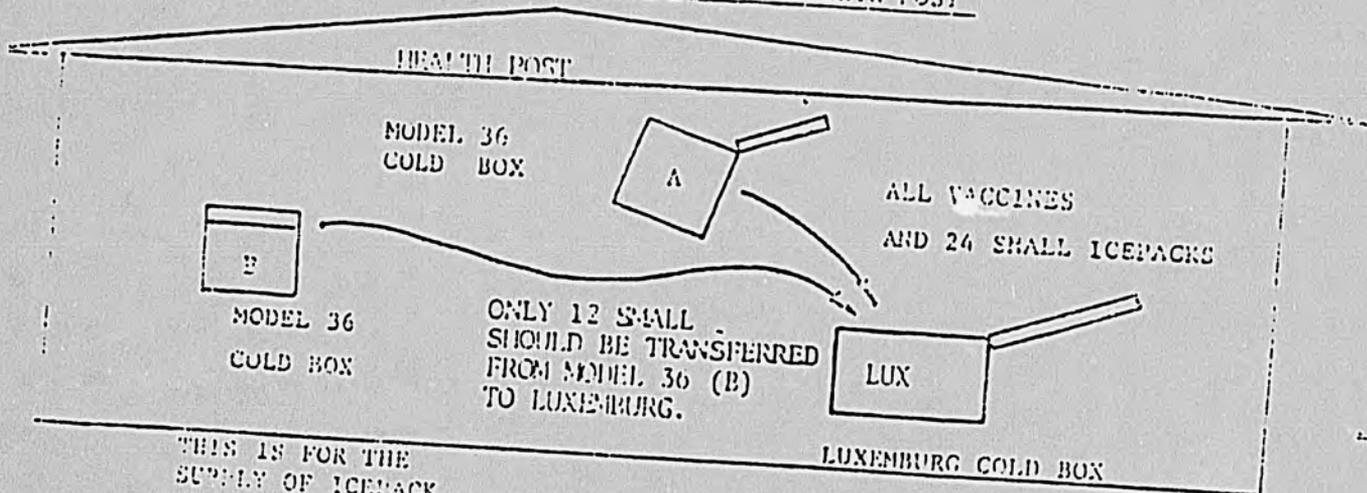


STEP 1 (1 DAY BEFORE THE EPI OPERATION WEEK STARTS.)  
DISTRICT COLD STORE



STEP 2 (1 DAY BEFORE THE EPI OPERATION WEEK STARTS.)

CONVERTING VACCINES AND ICEPACKS AT HEALTH POST



THIS IS FOR THE SUPPLY OF ICEPACK FOR VACCINATOR'S VACCINE CARRIERS.

(VACCINES CAN BE KEPT FOR 6-7 DAYS WITHOUT REPLACING THE ICEPACKS IN TEMPERATURE. NO ICEPACK IS ALLOWED TO BE TAKEN AWAY FROM THIS COLD BOX UNTIL THE END OF 5 DAYS OPERATION)

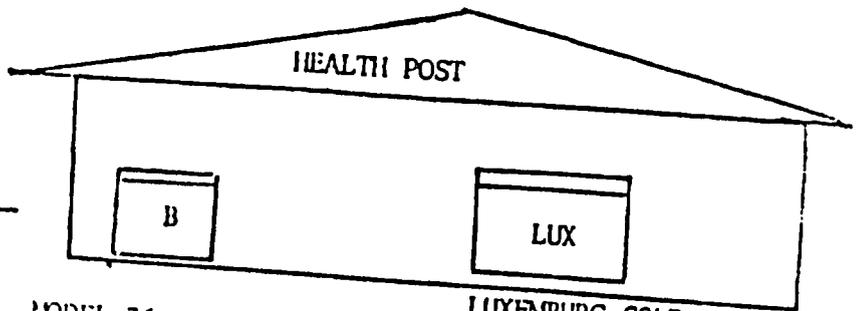
STEP 3

( THE 1ST DAY OF THE EPI OPERATION WEEK.)

IMMEDIATELY SENT BACK  
DISTRICT COLD STORE  
(NEW ICEPACKS.  
& REPLENISHMENT)



MODEL 36  
COLD BOX  
(EMPTY)



MODEL 36  
COLD BOX  
FOR ICEPACK  
DISTRIBUTION

LUXEMBURG COLD BOX  
ONLY VACCINES ARE TO  
BE TAKEN FROM THIS  
COLD BOX TO THE VACCINE  
CARRIERS.

new icepacks

vaccines

VACCINE CARRIER

VACCINE CARRIER

VACCINE CARRIER

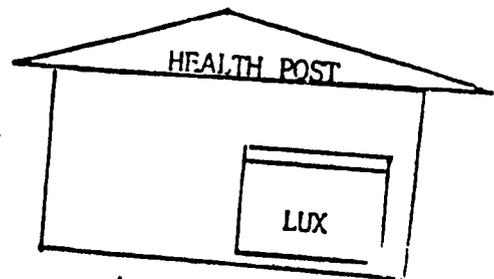
STEP 4.

( THE 2ND DAY OF THE EPI OPERATION WEEK.)

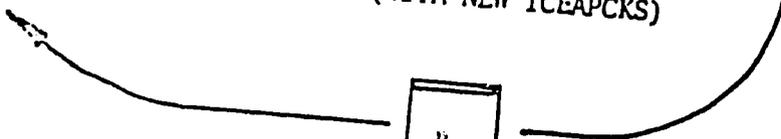
DISTRICT COLD STORE



MODEL 36  
COLD BOX  
(WITH NEW ICEPACKS)

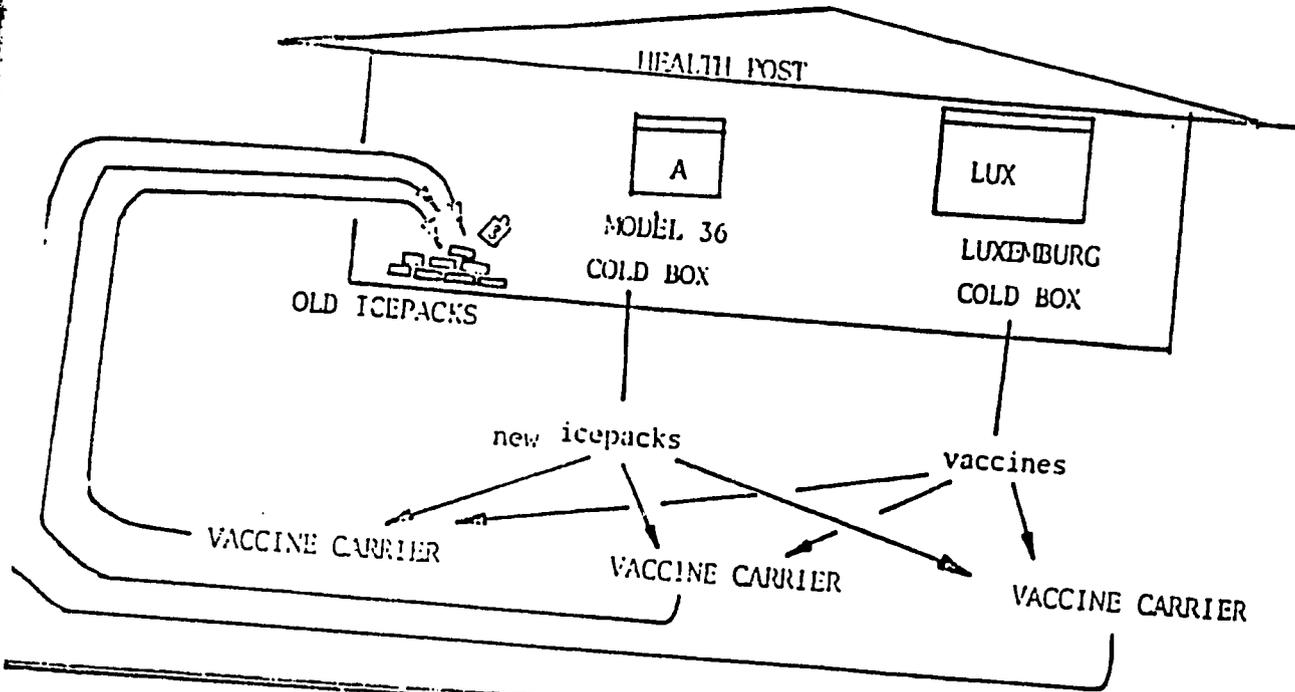


NO TOUCH ON  
LUXEMBURG COLD BOX

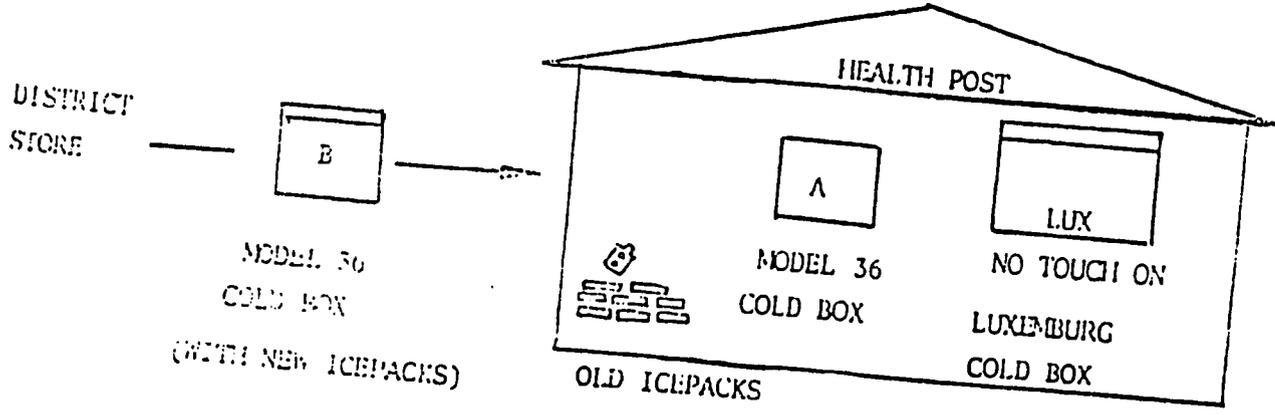


MODEL 36  
COLD BOX  
(EMPTY)

STEP 5 (THE 3RD DAY OF THE EPI OPERATION WEEK.)

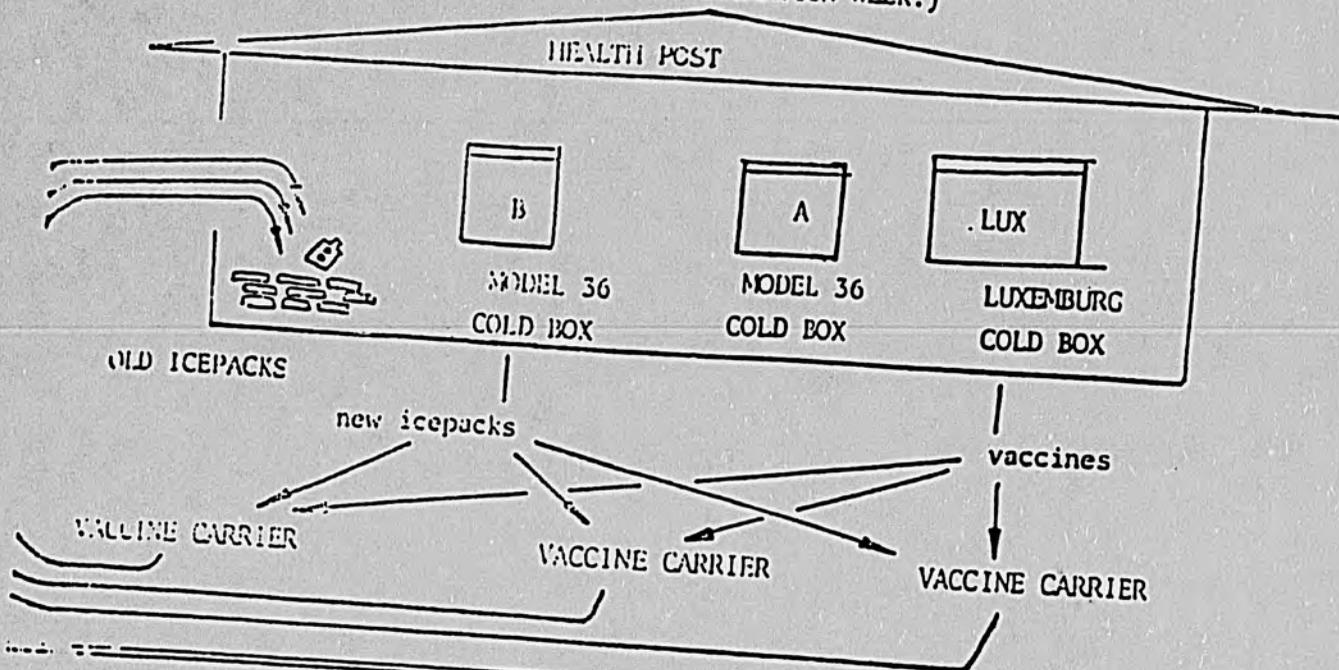


STEP 6 (THE 4TH DAY OF THE EPI OPERATION WEEK.)



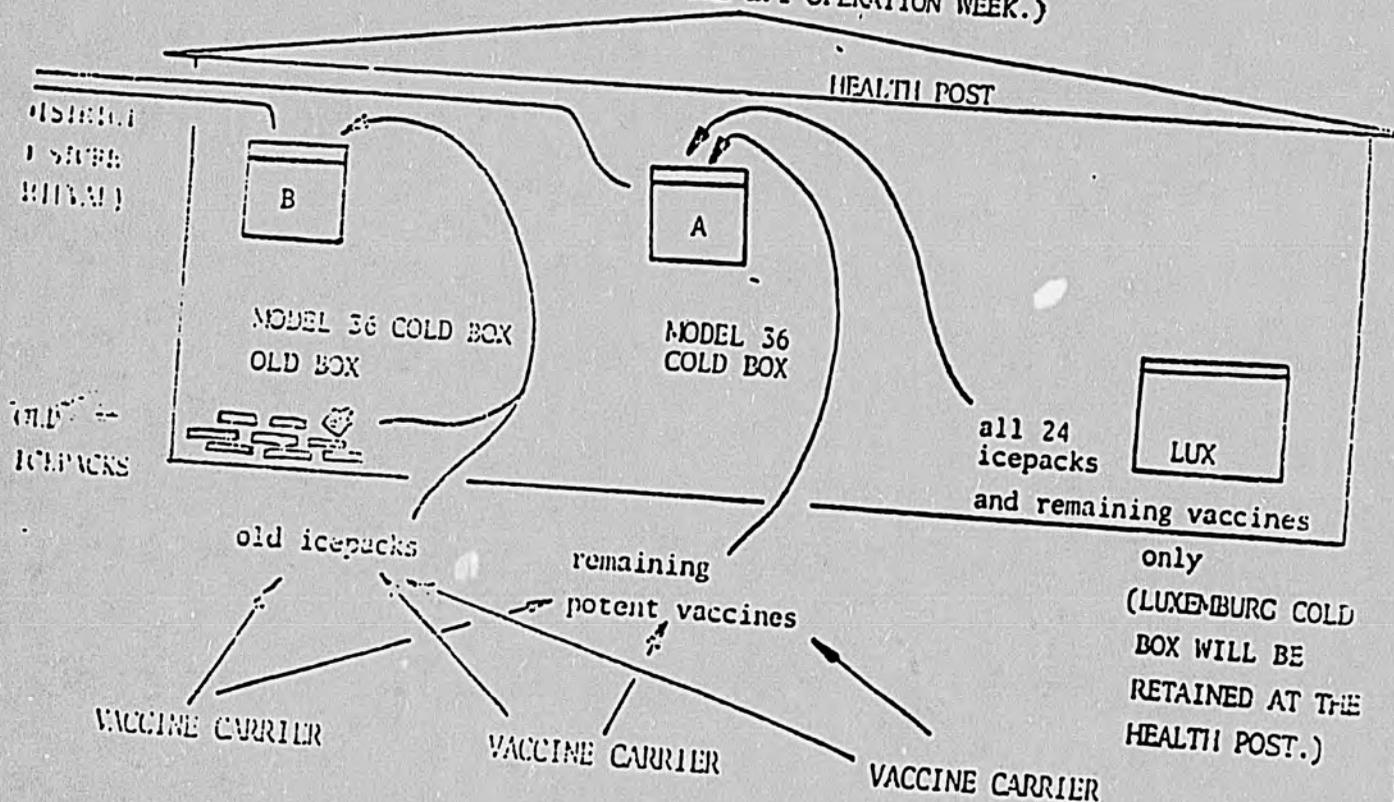
STEP 7

(THE 5TH DAY OF THE EPI OPERATION WEEK.)



STEP 8

(THE 6TH DAY OF THE EPI OPERATION WEEK.)



**THE NAMES AND RESUMES OF STAFF****BIO-DATA**

**Name** : Moti Lal Biswakarma

**Date of Birth** : 2025-3-20

**Place of Birth** : Amppipal-8, Gorkha

**Father's Name** : Nanda Lal Bishwokarma (Dead)

**Address** : Amp Pipal-8, Gorkha

**Academic Qualification** : SLC (2043) (63.28%)  
C.M.A. from C.M.A. Campus, Palpa (79.33%)

**Experience** : Medical Shop (since 8 months)  
Working continuously since 6 month in Thalajung Health Post  
at Gorkha District

**Marital Status** : Single

**Language** : Nepali, English

**Contract** : Padam Biswokarma  
Nepal Red Cross Society  
Phone #: 270-761, 272-761

## **BIO-DATA**

### **1. Personal Information:**

**Name** : Shova Lama  
**Date of Birth** : 29th April, 1964  
**Citizenship** : Nepali  
**Marital Status** : Unmarried  
**Phone No.** : 417-785  
**Language** : English, Newari, Tamang and Hindi

### **2. Academic Qualification:**

1992 M.A. Tribhuvan University  
1988 B.A. Padma Kanya Campus  
1984 I.A. Padma Kanya Campus

### **3. Training Experience:**

English Typing Training in 2039 B.S.  
Nepali Typing Training 2039 B.S.  
Basic English Course from The American English Language Institute in July 1st 1988.  
Word Perfect 5.1 from Sigma Computer Institute in 1992

### **4. Professional Experience:**

Research Assistant to Technical Co-operation Assessment and Co-ordination a Thematic Study 1992.

Translator and Research Assistant to "Eastern Region Water Supplies Project - Review. A multidimensional study by ODA Evaluation Team November 1992.

Researcher to Preliminary Research on Children at Risk in Narayanghat, April 1993.

### **5. At Present:**

**The Chief Editor of Quarterly paper "Damphu La Sher"**  
**and**  
**the Member of "Nepal Damphu Samuha"**

**6. *Extra Curriculum Activities:***

**Dissertation and Reports**

**Lama, Shova "Women in the farming system:**

**A case study of Tamang Women"**

**M.A. Dissertation**

**Village profile of Manmiju village, Part-I**

**National Development Service,**

**Tribhuvan university, 1992**

**The role of women in agriculture in Manmajju VDC, Part-II**

**Tribhuvan University, 1992.**

**Translator and Research Assistant to "Eastern Region Water Supplies Project - Review. A multidimensional study by ODA Evaluation Team November 1992.**

## Appendix E

### Responses to concerns of CSVIII DIP Technical Reviewers

Following are the responses to comments on CS8 DIP Technical Reviewers:

#### 1. Immunization

- a. The evaluation of this objective will be in terms of 12 through 23 month olds.
- b. NFO project staff have developed a checklist for monitoring the cold chain; it is included as an appendix D to this report.

#### 2. Nutrition

- a. As indicated in earlier NFO comments on Vitamin A interventions, objectives on mothers' knowledge about and use of vitamin A rich foods to prepare weaning foods will be developed at the time of the midterm evaluation: the NFO is now in the process of studying current patterns of use of vitamin A rich foods and is assessing Vitamin A rich kitchen gardens which have been implemented through Women's Groups.
- b. In addition to the current DIP objective that "70% of mothers will know supplementary foods should be given at 4-6 months", the following two objectives on weaning practices will be included:
  - \* 60% of mothers will introduce supplementary weaning foods to their children between the age of 4 and 6 months.
  - \* 60% of mothers will mix additional fat into their children's food.

Because of the baseline survey finding that most mothers tend to reduce children's food intake during illness, the following two knowledge/practice objectives were added:

- \* 60% of mothers will know that they should NOT actively reduce their children's food intake during illness and that they should INCREASE their children's food intake during convalescence from illness.

- **50% of mothers will NOT actively reduce their children's food intake during illness and will increase their children's food intake during convalescence.**

**Regarding objectives on increasing maternal food intake during pregnancy and lactation, the NFO is now in the process of conducting focus groups to explore eating practices during these periods: objectives on knowledge and practice regarding food intake during pregnancy and lactation will be drafted at the time of the midterm evaluation.**

### **3. Case management of ARI**

- a. **The objective for ARI is as follows: By the end of the project, 25% of mothers will know the danger signs for ARI and where to seek referral. Mothers will be trained in recognizing symptoms of pneumonia according recommendations of WHO ("Supervisory Skills: Management of the Young Child with an Acute Respiratory Infection", Chapter 1) and the Nepal MOH.**
- b. **Regarding case management of ARI and sources of appropriate care, project staff met with Dr. Penny Dawson (JSI) to review MOH-approved treatment protocols and to discuss current MOH policy on training VHWs to treat ARI. Case management of ARI using cotrimoxazole and alternative first line drugs (amoxicillin, ampicillin and procaine penicillin) are based on WHO protocols; oral chloramphenicol is the second line drug of choice for cases which are referred to Health Posts and hospitals and which were previously treated unsuccessfully with cotrimoxazole.**

**Given the weakening of health posts in the new MOH restructuring, VHWs appear more and more to be the most logical source of curative care: Dr. Dawson informed SC staff that the MOH is now piloting a program to train VHWs in ARI treatment in two central regions of Nepal. SC project staff will remain informed about MOH and USAID Mission policy regarding ARI treatment by VHWs; if and when such a strategy is approved, SC project health staff will assist in training and supervising ARI management by VHWs.**

**Project staff also explored with Dr. Dawson the possibility of conducting a Focused Ethnographic Study on community ARI recognition and treatment in the CSVIII project area: Dr. Dawson will inform staff of the costs of such a study, and**

if CSVIII budget is adequate, the study will be undertaken. As ARI has become the leading cause of child mortality in Nepal, it is becoming increasingly important to understand community practices regarding ARI recognition and management.

#### **4. Maternal Care**

- a. With respect to women's health services, the recent reorganization of the MOH has weakened SC's strategy to increase access to prenatal care: the health post may no longer be able to provide an assistant nurse midwife (ANM) to work at government outreach clinics. Thus, SC's mobile clinics have become a more important (though less sustainable) source of prenatal care: for each village development committee (population=approximately 2721), there are two mobile clinic sites, served in alternate months by an SC team consisting of one staff nurse, a community medicine assistant (who is often trained as an ANM), and an ANM. A prenatal care quality assurance workshop for SC mobile clinic staff will occur in October, 1993.**
  
- b. The project's objective with respect to prenatal care is as follows: By the end of the project, 20 % of mothers who delivered in the last year will have attended at least one prenatal care session. (It is important to realize that, because mothers can receive TT immunization during mass campaigns, the objective for maternal TT immunization may differ from that for prenatal care.) As the MOH does not have a maternal health card, the project has not designed an objective for mothers having such cards.**
  
- c. The project's objective with respect to care during delivery is that 40% of mothers will know the "three cleans" for safe delivery. As the government is committed to providing only one trained TBA per ward, it is not practical to have an objective for the percentage of mothers delivered by a trained TBA. The SC staff nurse and AMN have quarterly contact with TBAs and CHVs during meetings: this provides an opportunity for informal supervision and training of TBAs, and problem-solving sessions. It should be noted, however, that the absence of an ANM within health posts means that no government health worker is designated to provide on-going supervision of TBAs.**

- d. **The likelihood that CHVs will identify all pregnant women and encourage them to attend PNC sessions will increase as they will be attending mothers' group sessions and other community meetings. CHVs will also be encouraged to sweep through their communities at least four times a year to identify pregnant women, report them to VHWs, and encourage them to attend PNC.**
- e. **Information on family planning objectives was included in the response to comments on HIV/AIDS: the project has as its objective for family planning that 15% of eligible couples will use any method of contraception. VHWs in the project area may soon be trained in injection of depo provera, as they have in other CS projects in Nepal.**

## **5. Literacy Activities**

**SC's experience in other project areas suggests that community residents do place a high priority on literacy skills: in fact, within the CS VIII project area, it has been difficult for staff to meet community demand for places in literacy classes. There are no cultural barriers to enrollment.**

## **6. Human Resources**

1. **As a result of the recent MOH re-structuring, it is unfortunately less likely that community residents will be able to depend on government to provide basic preventive primary and public health services: it is a key strategy of this project to strengthen the government primary health care infrastructure. The only volunteers in this project, the CHVs, are included in the government primary health care plan. Project staff will make an effort to improve the practices of "private providers" and traditional practitioners, but such providers are sought mainly for curative care.**
2. **SC already has an IEC coordinator based in Katmandu: the project manager is now trying to hire an appropriate IEC coordinator to be based in Nuwakot.**
3. **The project relies on needs assessments, pre/post training tests and on-going supervision to improve the knowledge and practice of CHVs and TBAs. While SC project staff cannot directly supervise VHWs (who are part of the government system), staff do participate in quarterly EPI training sessions for VHWs and assist VHWs in improving their problem-solving skills.**

## **Responses to Comments in Technical Review of CSVIII Dip: HIV/AIDS and Vitamin A**

### ***1. Revised Sectioned.5g: DIP for HIV /AIDS interventions***

Sections 5g1-3 and 7 remain unchanged: presented in these sections were findings from baseline survey, estimated size of beneficiary population, objectives, numbers of workers to be trained, and person responsible for this intervention. Here we elaborate on section 5g4, the strategy for this intervention, taking into account points made by the technical reviewers. Part of the CSVIII project area is included in a program funded by the WHO Global Program on AIDS ("AIDS Education and Prevention Project Among Tamang and Lower Caste Communities in Nuwakot District of Central Nepal"), and some of the interventions presented below were developed as part of that program.

In order to explore the attitudes towards sex and disease which shape community response towards the HIV/AIDS epidemic and towards HIV-infected persons, a series of focus groups and in-depth interviews has already been undertaken. (Findings from these interviews and focus groups are appended to the annual report, "Appendix I"). Interviews were conducted with school teachers, village political and social leaders, community health volunteers (CHVs), priests, peddlers, and members of a minority caste group. Separate focus groups were conducted with members of four caste groups: Brahmin, Chetri and Newar (who are relatively advantaged), and Tamangs (who are disadvantaged). The groups were stratified according to sex and age: age groups among women were 14-17 years, 18-30 years and >30 years; age groups among men were 16-30 years and >30 years.

Regarding in the DIP reviewers' concerns about the project's strategies for involving men in HIV/AIDS interventions: As focus group discussions included men as well as women, project staff will gain a better understanding about men's attitudes towards HIV infection and high risk activities, as well as potential strategies for intervention. Male migrant laborers have been identified as a potential high risk group: peer counselors will be trained to reach this group.

Concerning the ability of project staff to gain a better understanding of patterns of prostitution. Even in well-conducted focus groups, this remains a sensitive topic; it is likely that the problem remains under-reported, and that women may leave the area to work as prostitutes at ages as young as 11 or 12 years.

**Recruitment of returning commercial sex workers as peer counselors will provide more information about risk factors in sexual practices.**

**Three locally hired AIDS educators will assist with the following HIV/AIDS intervention activities:**

- 1. Training of peer counselors (among women, some sex workers returning from India have already been identified and trained as peer counselors; among men, some migrant laborers will be identified and trained during the course of the project as peer counselors). Peer counselors are expected to run 500 counseling sessions with members of high risk groups (commercial sex workers, migrant laborers) during the course of the project.**
- 2. Establishment of an AIDS hotline, in the form of information boards on to which questions about AIDS (posed mainly by students) can be anonymously placed; staff will collect the questions and post answers on the boards. Fifty information boards will be established. Twelve are established already.**
- 3. Holding essay competitions and dramas (focusing on HIV/AIDS issues) among high school students. HIV/AIDS information classes have already been held in all of the five high schools in the project area.**
- 4. Organizing information sessions for the following groups according to the indicated schedules:**
  - a. School teachers (bi-annually; 72 primary and secondary school teachers have already been trained)**
  - b. Peer counselors (four times a year)**
  - c. Local DPHO and NGO staff (November 4-5, 1994)**
  - d. High school and primary school students (annually; 348 school students have already participated in classes).**
  - e. Community health volunteers (four times a year); CHVs will in turn deliver HIV/AIDS messages to mothers' groups, according to schedules which they establish.**
  - f. Non-formal education groups (approximately monthly, during regular sessions, Nov-June)**
  - g. Village health workers (annually)**
  - h. Village political and social leaders (four times a year)**

- i. **Parents' groups (mothers and fathers) who meet because of Early Child Development Activities (180 sessions--ten with each of 18 groups--have been scheduled)**
5. **Organizing annual STD camps, in partnership with staffs at government health posts, the National Aids Control Project and other NGOs . The first STD camp was held in March, 1993: Save the Children (SC) organized the camp, along with the Institute of Community Medicine and a local NGO (the Women's Rehabilitation Center) and District Public Health Office (DPHO), Nuwakot and NACP and delivered education; the NACP conducted HIV surveillance. Follow up curative care for STDs will be available from SC's mobile clinics.**

**DIP reviewers expressed justifiable concern about the availability of condoms within the project area. Project staff intend to distribute condoms during STD camps and at all of the information sessions described above: it is uncertain, however, whether condom supplies from UNFPA and government will be adequate to meet increased demand; in the past, family planning commodities have only been sporadically delivered to District Public Health Offices. Unfortunately, the Contraceptive Retail Sales Project has stopped its social marketing activities in rural areas; SC project staff believe that establishment of a social marketing infrastructure for family planning commodities is beyond the scope of this CS project.**

**Project staff agree with DIP reviewers that it will be important to integrate messages on HIV/AIDS into any activities designed to promote family planning. In the baseline survey, a great gap was documented between knowledge of/demand for contraceptive methods, and access to such methods; prevalence of contraception among eligible couples was extremely low: consequently, the objective for family planning is expressed in terms of use rather than knowledge: 15% of eligible couples will use any method of contraception. The problem is not so much one of resistance to use of modern contraceptives as it is one of access to adequate services and supplies. The recent re-organization of Nepal's Ministry of Health imposes great constraints on reaching project objectives, especially with regard to maternal health and family planning: many health posts will no longer be staffed and the only health service providers based in the field are the Village Health Workers. SC will distribute family planning commodities which it obtains from government through mobile clinics; with written permission from MOH, SC staff will also be training VHWs to administer depo-provera. It is recognized that distribution of commodities through mobile clinics is not a sustainable approach, but in the absence of supplies and personnel at**

health posts, this approach is viewed as the only means to achieve prevalence of contraception.

## **2. Vitamin A**

SC project staff have been obtaining technical assistance on Vitamin A interventions from Dale Davis at HKI; Ms. Davis will be hired as a consultant to the CSVIII project . A report on the recent training of project staff in Vit A interventions is appended to the Annual Report " Appendix B", as the newly developed Vit A curriculum.

At present, the only objective on Vit A is that 40% of children aged 6-60 months will receive Vitamin A tablets every 6 months. Lessons learned from the first Vit A rallies will facilitate the meeting of this objective: rallies should be advertised at least ten days before the date they are held; more distribution points are needed; and CHVs need better training in promoting Vit A.

Project staff are now assessing current patterns of use of Vitamin A rich foods. At the time of the Midterm Evaluation, project staff should be able to develop objectives on mothers' knowledge and practices regarding Vit A rich foods.

Although project staff understand the advisability of supplementing lactating mothers, both the Nepal MOH and the local USAID Mission think that current services are inadequate to reach mothers within one month postpartum. The only viable strategy for supplementing postpartum mothers is to supply TBAs with Vitamin A capsules and train them in use of the tablets: SC staff are discussing with DPHO staff how such training might be offered to TBAs, but the recent re-structuring of the MOH (which resulted in the elimination of the nutrition and nursing divisions and absence of ANMs at DPHO) will make it difficult to expand/improve TBA training in the near future.

# *Health Indicators*

INDICATOR	DATA SOURCE	PERIOD
<b>[A] IMMUNIZATION:</b>		
<input type="checkbox"/> % of children under one year who received vaccination by each antigen dose	HP/VHW/ORC record of immunization by age	Quarterly
<input type="checkbox"/> % of children 12-13 months who have completed dose of immunization by age one	Survey data	Baseline Midterm Final
<input type="checkbox"/> % of women 15-45 years who received at least 2 doses of TT	HP/VHW/ORC record of TT by age of women	Quarterly
<b>[B] DIARRHEAL DISEASE MANAGEMENT:</b>		
<input type="checkbox"/> % of mothers of children with diarrhea who received ORS packets	HP/VHW/CHV/SA/ORC record of JJ distribution	Quarterly
<input type="checkbox"/> % of above 10 population who attended diarrhea and ORS education session	HP/VHW/CHV/SA/ORC/NFE/WG record of diarrhea education session participant number	Quarterly
<input type="checkbox"/> % of children under two and under five years with diarrhea in past two weeks who were treated with ORS	Survey data with information by child's age	Annual
<input type="checkbox"/> % of faillies with children under two and five years who have at least one family member knowing correct preparation and use of JJ	Survey data with information by child's age	Annual
<b>[C] ACUTE RESPIRATORY INFECTION:</b>		
<input type="checkbox"/> % of mothers with child under two and five years who know signs for detection of pneumonia which requires medical treatment (cough and rapid difficult breathing)	Survey data with information by child's age	Annual
<input type="checkbox"/> % of mothers who know where to go for treatment for sever ARI	Survey data	Annual
<input type="checkbox"/> % of mothers who sought medical treatment for their child with sever ARI	HP/ORC/VHW record of treatment	Quarterly

INDICATOR	DATA SOURCE	PERIOD
<b>[D] NUTRITION:</b>		
<input type="checkbox"/> % of infants between six to twenty-four months who are being given solid or semi solid foods additional to breast milks.	Survey	Annual
<input type="checkbox"/> % of mothers who received nutrition education	VHW/CHV/ORC record	Quarterly
<input type="checkbox"/> % of children under five years who received vitamin-A supplementation	VHW/ORC record	Quarterly
<b>[E] MATERNAL HEALTH:</b>		
<input type="checkbox"/> % of pregnant women who have an antenatal checkup	HP/ORC record	Quarterly
<input type="checkbox"/> % of deliveries attended by trained TBA or health workers	HP/TBA record	Quarterly
<input type="checkbox"/> % of post natal mothers followed up by trained TBA or health workers	HP/VHW/TBA record	Quarterly
<input type="checkbox"/> % of women 15-45 who are reached by the message of 3 cleans for safe delivery	HP/VHW/TBA/NFE/CHV record	Quarterly
<input type="checkbox"/> % of women 15-45 who know 3 cleans for safe delivery	Survey	Annual
<b>[F] FAMILY PLANNING:</b>		
<input type="checkbox"/> % of currently married 15-45 woman using permanent method of FP.	HP/DPHO record	Quarterly
<input type="checkbox"/> % of currently married 15-45 woman using spacing method.	HP/VHW/CHV/ORC record	Quarterly
<input type="checkbox"/> Couple years of protection (CYP) from permanent and spacing methods of family planning	HP/VHW/CHV/ORC record	Quarterly
<b>[G] AIDS/STDS:</b>		
<input type="checkbox"/> % of men and women aged >10 who know at least three main modes of AIDS/HIV transmission and three protective behaviours	Survey	Annual
<input type="checkbox"/> % of population >10 years reached by AIDS/STDs education message	HP/VHW/CHV/NFE record	Quarterly
<input type="checkbox"/> % of STDs infected men and women treated in the special STD camps	STDs camp record	Quarterly



**E. CURATIVE SERVICES: # Children :**

**Diarrhea** \_\_\_\_\_

**ARI** \_\_\_\_\_

**Vit A Deficiency** \_\_\_\_\_

**Immunizable Diseases (specify):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. ORT CORNER:**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Demonstration only** \_\_\_\_\_

**# Children with Diarrhea** \_\_\_\_\_

**# JJ Packets Distributed : Sick Child** \_\_\_\_\_

**Well Child** \_\_\_\_\_

**Health Workers / Volunteer:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. HEALTH EDUCATION:**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Topic** \_\_\_\_\_

**Lesson Plan Yes** \_\_\_\_\_ **No** \_\_\_\_\_ (please attach)

**# Mothers Attending Education Session** \_\_\_\_\_

**Health Workers / Volunteers** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. ADEQUACY OF HEALTH WORKERS AND VOLUNTEERS:**

Were there enough health workers? Yes \_\_\_\_ No \_\_\_\_

Why not? \_\_\_\_\_  
\_\_\_\_\_

Were there enough health volunteers? Yes \_\_\_\_ No \_\_\_\_

Why not? \_\_\_\_\_  
\_\_\_\_\_

**5. ADEQUACY OF SUPPLIES / EQUIPMENT:**

What supplies / equipment were not adequate and why?

A. Drugs:

B. Jeevan Jal:

C. ORT Corner:

D. EPI:

- Cards
- Syringes
- Vaccines
- Sterilizer/Fuel

E. Nutrition:

- Vitamin A capsules

F. Health Education Materials:

**6. SUCCESS STORY:**

**7. PROBLEMS / SOLUTIONS:**

**Prepared by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**MCH CLINIC MANAGEMENT COMMITTEE REPORT - #1**

**SAVE THE CHILDREN US / NUWAKOT DPHO**

**ILAKA # \_\_\_\_\_ / \_\_\_\_\_ HEALTH POST**

<b>SITE</b>	
<b>DATE SCHEDULED</b>	
<b>DATE CONDUCTED</b>	
<b>SC REPORT</b>	
<b>COMMITTEE REPORT</b>	
<b>SUPERVISION</b>	

**1. ACCOMPLISHMENTS / SUCCESS STORY:**

**2. PROBLEMS / SOLUTIONS:**

**Prepared by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**SAVE THE CHILDREN US**  
**MUWAKOT HEALTH PROGRAM**  
**IEC / TRAINING \* ACTIVITY**  
**QUARTERLY SCHEDULE**

\_\_\_\_\_ TO \_\_\_\_\_ 1993

ACTIVITY	DATE SCHEDULED	DATE CONDUCTED	REPORT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			

\* Please mark type of activity.

**SAVE THE CHILDREN US  
NUWAKOT HEALTH PROGRAM  
TRAINING ACTIVITY REPORT**

1. **Type of Training** : \_\_\_\_\_
2. **Date(s) Scheduled** : \_\_\_\_\_
3. **Date(s) Conducted** : \_\_\_\_\_
4. **Venue** : \_\_\_\_\_
5. **Facilitator(s)** : \_\_\_\_\_  
\_\_\_\_\_
6. **Participants** : (Please attach list with name,  
workplace and title)
7. **Lesson Plan(s)** : (Please attach)
8. **Major Outcomes** :
  
9. **Problems/Solutions** :
  
10. **Recommendations** :
  
11. **Summary of Expenses:**  
Per diem  
Travel  
Snacks  
Supplies  
Consultant fee  
  
TOTAL

**Prepared by:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

MCH PROGRAM MONTHLY SCHEDULE

STATE THE CHILDREN US/MUWAKOT OPHO

BEST AVAILABLE COPY

CLARA # \_\_\_\_\_ HEALTH POST

1993

TUC	OUTREACH CLINIC MANAGEMENT COMMITTEE MEETING							HP COMMITTEE MEETING		
								SANWDRATAR	GANWERAKA	CHAP
DATE										
DATE										
DATE										
DATE										
DATE										
DATE										

TUC	OUTREACH MCH CLINIC							HP MCH CLINIC	
DATE									
DATE									
DATE									
DATE									
DATE									
DATE									

EPI MONTHLY SCHEDULE

SAVE THE CHILDREN US / NUWAKOT DPHO

DATA / HEALTH POST

1993

	V D C / WARD #											
SCHEDULED												
CONDUCTED												
REPORT												
SUPERVISION												
SCHEDULED												
CONDUCTED												
REPORT												
SUPERVISION												
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REPORT												
SUPERVISION												
SCHEDULED												
CONDUCTED												
REPORT												
SUPERVISION												

dfp



**Qualitative Study On Knowledge, Attitude And Practice  
Regarding STDs And AIDS**

**DRAFT**

***Report Of Focus Group Discussions And In-depth Interviews  
Conducted In Ilakas 1, 12 & 13  
Of Nuwakot District.***

***Save The Children US  
Maharajgunj, Kathmandu, Nepal,  
Post Box # 2218***

***September, 1993***

***Navin K. Pyakuryal***

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## **I. Introduction**

### **I.1. Background:**

**Save The Children US (SC/US), in October 1992, initiated a Child Survival Project {Funded by United States Aid for International Development (USAID)} and an AIDS Education Prevention Project {Funded by the World Health Organization (WHO)} in three Ilakas of Nuwakot District. These three Ilakas cover 14 Village Development Committees (VDC) out of the 62 VDCs in the district. Geographically, Nuwakot lies in the central region of Nepal and is adjacent to Kathmandu district. Although the project area is near the capital city, it is virtually inaccessible by any modern means of transportation and communication. The target population of 38,098 includes 6,098 children under five years of age and 7,620 women between 15 and 45 years of age.**

**Nuwakot was selected for this project by SC/US largely because many recent studies had identified this district as the one with the most severe girl trafficking problem in Nepal. The AIDS Education and Prevention Project intends to implement key interventions such as identification and counseling the at-risk population, training of non-governmental organization (NGO) and His Majesty's Government of Nepal (HMG) staff about STDs and AIDS education, interpersonal contact through AIDS Educators and Peer Counselors, dissemination of information and education regarding STDs/AIDS and protective behaviors, as well as treatment of STD cases.**

**The more remote areas of Nuwakot are inhabited primarily by the Tamangs, one of the largest Mongolia tribes in Nepal. Tamangs are basically a Buddhist, Tibeto-Burman ethnic group mostly concentrated in the upper reaches of the middle hills of central Nepal. Occupational caste families like Sarki, Damai and Kami often live on the fringes of Tamang settlements. Primarily Tamang, but also occupational caste girls, are at especially high risk to becoming prostitutes through girl trafficking . The traffickers often prefer Tamang girls because of their beauty, light skin and lack of political and legal protection. Poverty, low education and lack of any technical or vocational skills make this group the most vulnerable to trafficking and prostitution. The Knowledge, Attitudes and Practice (KAP) survey regarding STD/AIDS carried out by SC/US last November (1992) has revealed that almost 90 percent of the aged 15 to 45 females are illiterate. The same survey has also shown that general awareness of STDs is very low (15%), and for Tamangs it is only 8%. However, more respondents knew about AIDS (24%), although for Tamangs it is still only 15%.**

Regarding female living outside of their villages, the survey could not give a real figure. Only 3.3% of the females were reported to be outside of their village, which is clearly an under-reporting by the respondents, perhaps due to shame or fear. Together with this, many other issues regarding STDs/AIDS, and condom use could not be sufficiently explored in the quantitative survey.

Hence as proposed in the project workplan, a qualitative study was undertaken for further investigation. This present study intends mainly to discuss and find out information on the most intimate and sensitive issues like STDs/AIDS knowledge, girl trafficking, and protective/risk behaviors, all of which could be of immense help in designing program strategy and developing STDs/AIDS education messages and materials.

## **I. 2. Objective of the Study:**

The main purpose of this study is to generate qualitative data with which to more fully understand the problems and to design strategy/materials. The objectives envisaged for this study are as follows:

- 1) Identify sexual and other high risk behaviors;
- 2) Assess the level of knowledge regarding transmission and prevention of STDs/AIDS;
- 3) Find out myths, beliefs and misinformation regarding STDs/AIDS;
- 4) Ascertain receptivity of STDs/AIDS related IEC program; and
- 5) Confirm low rate of condom use and underlying reasons for non-use.

## **II. Methodology**

This study employed qualitative research techniques in order to learn more about important social and cultural aspects of transmission, prevention and cure of STDs/AIDS. Two major techniques utilized were focus group discussion (FGD) and individual in-depth interviews (IDI). Focus group discussion, as a qualitative research method with a definite goal, is essentially a group discussion among people of more or less the same age, socio-economic status, sex, etc. Generally, a small number of respondents, under the guidance of a moderator, talk about topics believed to be of special importance to the investigation. Originating from market research in the 1950s, FGDs have in recent years been increasingly used in applied social science research. Similarly, in-depth interviews

can also play a very important role. They are intensive discussions on a particular topic with a knowledgeable person or key informant in a one-one situation. Sensitive and personal issues as well as opinions which deviate from commonly held attitudes and perceptions are best probed in in-depth interviews.

### **II.1. The Study Sample:**

For the FGDs, the population in the project area was first categorized in terms of cultural and social differences:

- i) Advantaged groups consisting of dominant castes Brahmins, Chhetris and Newars.
- ii) Disadvantaged groups consisting of the major ethnic group, Tamang, and the occupational castes Sarki, Kami, and Damai.

However, due to the difficulty of gathering enough occupational caste participants for discussion as they are not concentrated in any particular area, and as it was also not considered appropriate to mix them in the Tamang groups, they were not included in the FGD sample. Rather, their opinions and views were collected through in-depth interview.

Both advantaged and Tamang groups were further stratified into male and female in order to maintain group homogeneity. On the basis of age and marital status, males were divided into 2 categories of young males and adult males. Similarly, females were divided in 3 categories of young females, married females and adult females. This extra category of married females was deemed necessary as its members are neither ignorant young girls or ever-intruding adult women. For the sake of consistency, two discussions were planned with each of the 10 groups. Altogether, 20 FGDs were held with a total of 165 participants.

Twenty-five in-depth interviews were carried out with key informants like social/political leaders, teachers, health volunteers, priests/faith healers and members of minority ethnic/caste groups in the area. Both FGDs and individual in-depth interviews were planned in the three Ilakas. However, due to difficulty in organizing the group and finding particular types of key informants within a given time frame, Ilaka 1 was less proportionately represented than other two ilakas. The overall sample design has been presented in the matrix below:

### Sample Design:

	Ilaka #1	Ilaka #12	Ilaka #13	Total
<b>Focus Group Discussions:</b>				
<b>Tamang</b>	-	-	2	2
<b>Young Male (&gt; 17-30 yrs)</b>				
Adult Male (> 30 yrs)	-	1	1	2
Young Female (14-19 yrs)	-	-	2	2
Married Female (17-30 yrs)	1	-	1	2
Adult Female (> 30 yrs)	1	-	1	2
<b>Advantaged:</b>				
Young Male (17-30 yrs)	1	1	-	2
Adult Male (> 30 yrs)	-	2	-	2
Young Female (14-19 yrs)	1	1	-	2
Married Female (17-30 yrs)	1	1	-	2
Adult Female (> 30 yrs)	-	2	-	2
<b>Total Groups</b>	<b>5</b>	<b>8</b>	<b>7</b>	<b>20</b>
<b>In-depth Interviews:</b>				
Teachers	1	1	3	5
Social/Political Leaders	-	4	2	6
Health Volunteers	3	3	2	8
Priest/Faith Healers	1	-	2	3
Minority Ethnic/Caste Members	-	2	1	3
<b>Total Informants</b>	<b>5</b>	<b>10</b>	<b>10</b>	<b>25</b>

### II.2. The Field Research Team:

The field research team was organized from among the sectoral staff members of SC/US, Nuwakot program. This team itself was given complete responsibility for organizing and conducting the focus group discussions and in-depth interviews, as well as for preparing the reports. The team was divided into five pairs (two of males and three of females) for conducting the study in different areas. The names of these researchers are given in Annex - I of this report. On average, each pair completed four FGDs and five IDIs. These pairs were free to decide which member will moderate or record.

The field research teams were supported by three logistic assistants who were mainly responsible for gathering the community people for discussion, gate keeping, interpreting when necessary, and arranging for tea and snacks and other supplies. Their role was found to be very helpful for facilitating uninterrupted discussions by allowing full attention of the moderator/ researcher.

### **II.3. Research Tools:**

Initially, two separate semi-structured topic guides were developed for the focus group discussions and the in-depth interviews. However, after discussions with the field research team and use pretests, it was felt that with slight modifications, a single guide could be prepared for use in both the FGDs and IDIs.

The discussion guide started with information about high risk behaviors like pre-marital sex, girl trafficking, polygamy and mobility of population. Issues like perceptions and beliefs regarding STDs/AIDS were raised in the course of the discussions. After dissemination of information and discussion of condom use, the discussion was designed to be gradually pulled towards non sensitive topics like effective communication. The field research team were free, however, to alter the course of the discussion and adopt a more appropriate sequence if necessary.

Together with the topic guide, a form to record participants' profiles was also developed and used in the research. This form contained identification codes and main characteristics including name of individual participant, age, sex, and education.

A cassette recorder was also used to record focus group discussions, although not in-depth interviews.

### **II.4. Training of the Research Team:**

A five day training for the field research team was organized on qualitative research techniques. Altogether, 10 people received this training, out of which seven were selected to become moderators and recorders. These later teamed up with three previously trained staff to form the field research team. The other remaining three team members were given the responsibility of logistic support.

The main objective of the training was to make the team members capable of moderating and recording the discussions and interviews and of preparing summary reports. The first day was devoted mainly on the differences between quantitative and qualitative research, and to the introduction of the FGD and IDI techniques. On the second day the team members discussed the importance of these techniques and the basic steps of conducting them. On the third day, team members were involved in role plays and provided opportunities for each of them to practice. On the fourth day, team members discussed the topic guides and prepared a plan and schedule for the actual research. On the last day, team members went to a nearby village to practice with real community members and to

**test the practicability and timing of the topic guide. The daily activity schedule of this training has been presented in Annex II.**

## **II.5. Study Procedures:**

**Once the field research team reached a selected village, the non formal education (NFE) facilitator was contacted and requested to invite a pre-determined type of community people to attend the discussion. This was normally one day before the actual discussion.**

**The participants usually came one or two hours later than the set time and there were occasionally far more people gathered than the desired number. Just before the discussion, the participants were screened, and a minimum of six and a maximum of ten were chosen for the discussion. For the sake of saving the other people from humiliation and to avoid disturbances (because they were not included in the discussion), the other accompanying staff member had to either start a public speech on the benefits of SC/US program or engage them in mock discussions. However, these informal discussions also would yield valuable information regarding village setting, history, population ethnic mix, economic standard, and social/cultural customs and taboos.**

**The discussions were mostly conducted inside a room of a nearby school, VDC building or shrine. One or two discussions were also conducted under the tree, during which care was taken to maintain a fair distance from the spectator crowd to minimize distraction.**

**Whenever space permitted, the participants were made to sit in a circle; the moderator sat with them. The note taker would usually sit just opposite of the moderator, behind the participants. The logistic assistant would sit right by the gate. After the introduction and describing the purpose of the meeting, permission for cassette recording was requested. However, after two or three discussions the practice of permission was abandoned as the participants seemed most indifferent to recording what they said and it took a considerable time to explain about cassette recording and the concept of their consent.**

**While facilitating the discussion, the moderator just threw a particular topic out to the group and let the group discuss on it. Only when the discussion drifted too far from the topic or if there was very low participation by a particular member or members would he/she interfere.**

**The total discussion time from the introduction to closing and thanks took one to one and half hours. The field research team were instructed not to hurry if the**

group wanted to continue the discussion. Light snacks and tea were provided to the participants after the discussion.

It was much easier to hold individual interviews than to hold the group discussions as there was no need to assemble many people at the same time. Wherever the research team conducted a FGD, they also tried to contact one or two persons in the key informant category. Each issue in the topic guide was deeply discussed and the findings from FGDs were verified in interviews. Except for one or two interviewees, all of them were quite enthusiastic to talk and were frank and knowledgeable in their views. Many important findings regarding girl trafficking has been obtained from these individual in-depth interviews.

The study in field took almost one month, from March 6 to March 31, 1993.

## **II.6. Analysis of the Data:**

The analysis was done at two levels; in the field and in Kathmandu. In the field, after completing the discussion and interview, the field research team sat together and keenly reviewed and discussed the results. Based on the running report, cassette record and personal observation they prepared a summary report together which classified data under each category and also wrote their impressions and comments on 'what was not said'. Similarly, a summary report was prepared for the individual in-depth interviews.

In Kathmandu, all these materials were carefully reviewed, and the data was categorized into topics for all types of sample groups. Verbatim codes were picked up. A data log with a complete inventory was prepared in order to establish the strength of the information produced. A final analysis was done based on tape records, running reports, summary report, categorized data and data log. At that stage, data was separated for the major two groups, advantaged and Tamang, and trends were established. However, in the presentation, this distinction was not always made. Rather, it is discussed separately whenever one group deviates from the general trend.

## **II.7. Limitation:**

Various limitations were confronted by the present study and it is imperative to caution the readers by stating them loud and clear.

The results of this study cannot be fully generalized to the whole project area ( the three ilakas ) in Nuwakot. In spite of large numbers of focus group discussions

**and individual in-depth interviews which were distributed almost equally over the area, the study sample cannot be claimed to be based on probability selection. Hence, as in case of any other qualitative research, this study suffers selection error.**

**In most of the focus groups, the participants hesitated to answer queries related to topics of high social sensitiveness. Facts like girl trafficking could not come out explicitly in these discussions as participants were reticent in confirming the practice which they thought would be taken as morally degrading by the outsiders even if it was already accepted as a reality by their society.**

**Similarly, mostly in discussion with Tamang adolescent girls and married women and in some cases even in discussion of male groups, the more sensitive issues like STDs/AIDS and condom use might have been sidelined as not knowing because of shyness. The participants were encouraged by the moderator to discuss freely, but the moderator still could not get full participation.**

**Sometime language became a barrier played as barrier and the researchers had to rely completely on the logistic assistant to ask questions and receive the answers. Naturally, the quality of the data produced will have deteriorated. However, the inclusion of these assistants in the training would have helped them in understanding the topic guide and interpreting the discussion in an acceptable standard.**

**The interviews of key informants had not been recorded on cassette so that while writing the report, confirmation was not possible and the researcher had to completely rely on the written notes only.**

**During the discussion and interviews, a lot of data was produced and the discussion occasionally drifted away to topics of lesser concern. Hence, not all of the rich information generated in the discussions has been analyzed. Most of the interesting but not immediately useful information regarding local customs and fairs, causes and ways of girl trafficking and migration occupation could not be processed and presented in this study.**

**Given the qualitative nature of this study, it was not possible to enumerate the findings exactly, hence the strength of this information could not be precisely established. As the purpose of this study was not to find out how many people hold certain opinions or engaged in certain behavior but to find out only what type of opinions and behaviors exist in the society and possible reasons for these patterns, not much effort was given to quantifying the data. However, data**

inventory of each discussion was prepared for the analysis and particular care was taken in not introducing researcher bias while analyzing and report writing.

### **III. Findings of Study:**

Findings from both type of methods; focus group discussion and in-depth interviews have been presented in this section. In order to avoid repetition the findings have not been separated. Only in case of contradictions and new information from the text have been separately given under the name of in-depth interviews.

#### **III.1. Sexual and other Risk Behavior:**

##### ***III.1.1 Pre-Marital and Extra marital Relations:***

Most of the participants agreed on the possibility of pre-marital and extra-marital sexual relations, particularly among young boys and girls. Chances of intimate mixing is easily available to them during local festivals (*Jatra*) and social gatherings. During the festivals, large group of people spend night singing, dancing and drinking together. As this is more common with the Matawali caste, the Tamangs and the occupational caste groups, they are more exposed to the risk of sexual contact. The girls and women of the advantaged castes are usually restricted from spending all night at the festival, although there is no such restriction for the men and many youths of this group who also enjoy nights of singing, drinking and, if they get opportunity, sexual activity.

In the focus group discussions, most of the Tamangs, especially the married women and adult men rejected the possibility of sexual activity outside the institution of marriage. If some people are found to be indulging in such a relation, social pressure makes them marry soon. These participants accepted that men and women drink, sing and dance together, as well as that they might stay out all night at a festival, but that does not necessarily imply that they would have sexual contact.

In the in-depth interviews the members of occupational caste groups also confirmed the possibility of sexual contact in the local fairs. The other key informants also told that lot of young girl and boys seek their partners in fairs and tie in the nuptial cord. Other youths specially in Tamang and Sherpa community sing, dance and drink and sometime may have opportunity of sexual contact.

"It (sexual contact) may happen if both the girl and the boy agree." -YTM

**"God-fearing person will not be indulged." -ATM**

**"Sexual relation is sure to happen when they are characterless men and women."  
- AAF**

**"At festival, and fairs sometimes four or five men sleep with one girl."  
- YAM**

**"Such relations are more common among the Matawali Jat." - YAM**

### ***III.1.2 Marriage Pattern:***

In the advantaged caste groups, marriage of a girl is usually arranged by her parents when she reaches the age of 15 - 17 years. In case of Tamang and occupational caste groups, the age at marriage is a little higher. In this group, girls and boys usually choose their own partner during festivals. If a boy likes a girl, he can pull her and perform marriage. However, if the girl is not willing, he cannot force her to marry. If the parents and the girl both agree, then a wedding takes place.

Polygamy is still found among the advantaged caste people. Unlike this group, a Tamang woman instantly abandons her husband if he brings home a second wife. Eloping is more common among the Tamang and occupational caste groups than among the advantaged groups. When a wife elopes to a second husband, he has to pay a penalty (*Jari*) to the former husband of NRs. 500/- to 12,000/-, depending upon the economic status of the families and the beauty of the woman. Such eloping normally takes place during local festival. Some women even elope three or four times. A woman with children may also abandon her husband and marry another if she is not happy or well kept by her husband. Such remarriage takes place also if a husband goes outside for work (Lahore) and does not return for five or six years. In any case, Tamang women will not elope with other ethnic people. Similarly, those men who have gone outside sometimes marry a new girl there and bring her to the village. When a man does not have children from his wife, he can, with her consent, take a new wife.

**"Those going to foreign lands may bring back a new wife." - ATM**

**"The property enjoyed by prostitutes is similar to forest destroyed by buffalo."  
-MTF**

**"Only the characterless girl elopes." - YAF**

**"Sometime the men come to pull an underage 12/13 years girl also from home." - YTF**

**"The woman elopes if she does not like the husband. No one can stop her." - ATM**

### ***III.1.3 Girl Trafficking:***

The participants reported that girl trafficking is very prevalent in the study area. It is more common among the Tamang and occupational caste groups than among the advantaged groups. In almost all discussions, participants reported that only a few had gone out from their own villages, but when asked about other villages, they reported that a lot of girls being sent out.

As soon as a girl reaches puberty, she is approach by traffickers or their local agents and lured by telling about the attraction of the city, luxury life in the big city, *Thulo Gaon* (Bombay), employment and economic benefits.

The family usually does not caution a girl against such temptation, but instead they expect her to go out and earn a nice living for them. The girl may or may not know about the type of illicit activity she will be doing, but she usually agrees and actually goes. The minors or adolescents are taken with parents' consent, and those who had somehow resisted going out, are tempted with false marriage and later sold. The smaller girls are kept in Kathmandu carpet weaving for some time to learn manners and language. From there, they are directed to various parts of India. If a woman is beautiful, even a mother of two or three children can be enticed to run away from home.

Most of the girls are taken to Bombay and others to Delhi or Calcutta. From there, more beautiful girls are trafficked to foreign lands such as Saudi Arabia. These girls fetch a price from Rs. 5,000/- to 35,000/- on the Indian market. Almost all of this money is taken by the broker and only in some cases is a little money also given to the girl's parents. The girl ultimately lands in a brothel and after a few days resistance, enter into prostitution. Participants reported that former prostitutes from Nuwakot have become "*Gharwali*" brothel owner and now run their own businesses. They have very good local connections back home and get a regular flow of fair hill girls through traffickers. Poverty, illiteracy and lack of any other skills were named as the primary reasons for uninterrupted girl trafficking from Nuwakot.

**Some participants reported that the girls who have returned from Bombay are in high demand for marriage in the villages, particularly among the Tamangs and occupational caste people. The main attraction to have a Bombay bride is their wealth, in the form of purchased fixed assets and cash deposits. Furthermore, they also look smart because of their modern dresses, fashion and Indian accent. Because of these attractions, sometimes even the advantaged caste men have married a Bombay returned girl. Some Bombay girls, after marriage also return to their profession to earn money for their husbands, but others have become real housewives and are staying in the villages.**

**Usually the very sick Bombay girls do not come back to the village. However, some of the participants have known such sick girls. They reported that even if they look healthy from the outside, they are normally sick. In some participants' opinions, Bombay girls are usually unable to bear children.**

**No participant reported knowing or seeing any Bombay girl doing prostitution in the village for money. However, in local fairs, these girls with their style and beauty are found to attract a lot of boys to sing with them. Thus there exist possibilities of sexual contact between these ex-prostitutes and their local lovers.**

**Most of the participants personally felt that girl trafficking is a social evil but they reported that their society has accepted it as a reality. The fellow villagers show respect to newly arrived Bombay girls and call on her home with a chicken or other delicious food. Parents also respect these girls as they sometimes get opportunities to visit India and have a nice living back home.**

**Key informants in interviews reported girls between the age 12-30 years are at high risk of trafficking. Even the married women are taken to Bombay for the illicit profession. The local men are specially involved in the trafficking trade and even the advantaged class men and influential leaders are now engaged in this lucrative business. The occupational caste informants said that the parents may not know first when their daughter is trafficked but they seldom oppose it and later are happy with the earning from the daughter. According to the key informants bad economic condition, lack of employment opportunities in home, sometime pressure for repayment of loan and no restriction by the parents are mainly responsible factors for this social evil. Sometime even the in-laws and husband permit the girl to go Bombay. The women who already are in Bombay motivate their close relatives or families also to send daughters and sisters. Some key informants in Tamang villages were hesitant to speak frankly on the girl trafficking issue. The girl returning from Bombay can easily fetch a better husband for marriage as they have sizable amount of cash earning. Those who have Rs. 100,000/- to 200,000/- come and settle in the market centre around the village.**

Whereas others earning more prefer to stay in Kathmandu or other urban centers. They have seen some seriously sick girl returning from Bombay and one or two even died.

"Girls go forever, only a few return back." -YAM

The tree falls only after strong wind." -ATM

"Better to die rather than earn a living by selling others' sisters and daughters."  
-ATM

"They take girls by trick." -YAM

"Most of girls going out are engaged in none prestigious jobs." -YTF

"Those whose father wears '*phyanga*' and mother wears '*panga*', wear nice smelling clothes when they return from foreign land." -AAM

"Four footed cattle can be herded but no one can take care of the two footed."  
YTM

"You and me let us go to Bombay, there you can wear nice saree and walk on a plain land." -MAF

"Parents do not care about good or bad when they can get a bundle of currencies."  
-AAF

#### ***III.1.4. The Male Migratory Patterns***

Men have also gone out from the villages. However, their stay outside is shorter than that of females. The Tamang men go out for work. Being poorly educated or illiterate, they mostly are engaged as porters in the nearby market area or in Kathmandu. Some of them also work as cart or rickshaw pullers and tempo drivers in Kathmandu. Few of the Tamang men from the study area work in India, and only some have joined the army. Participants reported that some parents or relatives occasionally visit Bombay or other cities in India to see the girls and then return after receiving good hospitality and money.

In the advantaged group, the men go out of the village to study or for work, usually inside Nepal. They are mostly engaged in white collar jobs rather than manual

ones. Some participants reported some people from this group also occasionally visit India to see their sisters or daughters.

"In earlier days, people were outcast if they went out crossing the river, but not now."

- ATM

### ***III.1.5 Skin Piercing and Tattooing:***

Piercing the ears of both boys and girls is a common tradition in Nuwakot, but nose piercing is done only to girls. In Tamang group, piercing is done on the third day after birth or after one year. The advantaged caste people traditionally pierce their babies on the eleventh day, at the name giving ceremony *NWARAN* or occasionally festivals like 'Shree Panchami'.

Earlier piercing was usually done with a locally available thorn known as *madhise* or *bhaise kanda*. However, now people prefer to pierce with needle and thread. People seldom boil or sterilize the needle before use. Only one participant said that she had burnt the needle in the flame of a lamp in preparation for piercing. If there are other children who also needing piercing, they do it with the same needle without sterilizing it each time. Some participants reported that they prefer to do this in winter to avoid infection and boils.

Tattooing or *Naja* is very popular among Tamang females. Actually, almost all Tamang women in the focus group discussions were found to have tattoos on their chin or beautiful tattoo patterns on their arms. Advantaged caste women did not usually have tattoos, except for the occasional few. For tattooing, also, they use the same needle for many girls and do not sterilize the needle before use. They apply the black dust of lamp in the tattoo part to make it permanent. Participants said that the custom of tattooing is gradually decreasing in the area. A few participants also reported that people now prefer piercing and tattooing by electric instrument in Kathmandu.

"Those who are willing, make beautiful patterns in their body." - MTF

"I pierced due to desire when young." - ATF

"*Naja* (tattoo) was popular before, but not now." -YTM

"Four or five children are assembled in a place on Wednesday and Thursday and are pierced with one needle." -MAF

**"It will bleed while tattooing." - YTF**

### **III.2. Sexually Transmitted Diseases (STDs):**

#### **III.2.1 Awareness/Source of Information:**

**Only about half of the participants were aware of STDs. As the literary term for STDs in Nepali was not understood by many participants, the more common word, *bhirangi* or syphilis, was used to explain about the diseases. Most of the Tamang females reported not knowing about STDs. However, they might have been confused even with the word *bhirangi* as they are not native Nepali speakers. Awareness among the advantaged group was higher as compared to the Tamangs. The main source of information regarding STDs was the friends, neighbors and relatives. Some had read it in adult evening classes. A few participants reported having seen STD victims among returned Bombay girls.**

**Only some participants said that they knew the symptoms of STDs and most of them mentioned difficulty in walking; other symptoms pointed out by them are as follows:**

- Itching and irritation in the sex organ;**
- Boils and pimples on the body and sex organ;**
- Pus or white discharge from the sex organ;**
- Decay of and worms in sex organ;**
- Fever;**
- Lean, thin and whole body becomes black;**
- Difficulty in urinating; and**
- Bad smell from the body of participants.**

**"It is dirty disease *pant* in bad organ." -YTM**

**"We say it AIDS in our Tamang language." -ATM**

**"White discharge like rice water from vagina." -ATF**

**"This disease is more in young women and less in men." -AAM**

**"Those with STDs cannot give birth." -AAM**

**"They walk making apart the feet." -MAF**

### ***III.2.2 Causes of transmission:***

Only some participants knew about causes of transmission of STDs. Most of the Tamang females did not answer how it is transmitted. Participants expressed the view that mainly it comes from India; that Bombay girls bring it to the villages. Sometimes the participants confuse the symptoms of AIDS and STDs and hence mixed both together. Even the key informants were not with correct knowledge on transmission. They mentioned extra marital relations, sitting on the warmth of infected person and using patient's clothes also in the probable cause of communicating this disease. Reported mode of transmission of STDs were:

- Prostitution;
- Sexual contact with infected person;
- Not cleaning sex organ properly;
- Sitting or sleeping on a warm place used first by an infected person;
- From air;
- Defect in blood;
- Mosquito bite;
- Use of unsterilized syringe and needle; and
- Transmission through mother to baby in womb.

"The person going to foreign land gets this disease." -YAF

"Those always in search of boys have this disease." -AAF

### ***III.2.3 Prevention:***

Almost all the participants knowing about STDs had good knowledge about its prevention also. As most of the Tamang females were unaware of the disease, they also did not know how to prevent it. Prevention through sex related measures were suggested by many participants finding from IDIs are almost similar. Following are the preventive measures mentioned by them:

- Abstain from prostitution;
- Sex only with wife;
- No extra-marital sex;
- Avoid sex with Bombay returned girl and with infected person;
- Use condoms;
- Clean the private parts;
- Send the patient for treatment; and
- Do not eat together with infected person.

### ***III.2.4 Treatment:***

Participants stated that nowadays STDs are curable, and that they have seen Bombay returned girls well after treatment. However, most of the participants did not know what treatment is done as most of the time the infected person seeks a cure secretly. Some participants suggested the health post, hospital and medicines for such persons. When asked regarding local treatment, they said some indigenous herbs are available, but failed to mention the exact name. As with any other disease or illness it is common custom to seek the cure from faith healers in the villages first.

"Rice and coins for faith healers and sickness for us." -AAM

### **III.3. Acquired Immune Deficiency Syndrome (AIDS):**

#### ***III.3.1 Awareness and Source of Information:***

Most of the participants, except for the females in the Tamang groups, were aware of AIDS. They had heard about it from different sources such as radio, adult literacy classes, drama. Some participants also mentioned motivators and doctors in STD camps. Local fairs were also a source of information about AIDS, some had heard songs about AIDS in the fairs. A few participants also mentioned TV, seminars and visits to Kathmandu and the Terai as their information source. But nobody had heard about it from the hospital or health post. Some key informants had known it from SC/US staff and video shows also.

Very few participants could identify the symptoms of AIDS. Most of them said it is a new disease so they do not know about its symptoms. Some participants, especially in the male groups, said that the symptoms of AIDS are not visible from the outside. Some participants in the advantaged female group were quite knowledgeable and said that it can be diagnosed by laboratory blood test in the form of HIV positive. The matrix presented below illustrates the symptoms cited by the participants.

### Cited Symptoms of AIDS

Groups	Male	Female
<b>Tamang</b>	Does not appear	- Always seriously ill - Death - No improvement after treatment
<b>Advantaged</b>	- Lean and thin - Weight loss - Fever - Loss of appetite - Face turns yellow	- Does not appear for five years - HIV positive in blood test - Frequently urinating - Frequent diarrhea - Always seriously ill

The key informants added following symptoms of AIDS:

- Headache
- Common cold and cough
- Depression
- Giddiness
- Hearing problem
- Sweating
- Regularly running nose
- Loss of blood in the body

"This disease does not blow any trumpet to know the symptom." - YAM

"Unseen symptoms he does not tell, we can not see." - AAM

"Tiger will kill only if one goes to forest." - ATM

#### ***III.3.2 Causes of Transmission:***

All those who were aware of AIDS could tell about the causes of transmission. All of them cited sexual contact as the primary mode of transmission. Prostitution and sexual contact with Bombay returned girls considered particularly risky. Some participants said they are afraid when they see any girl coming from outside. The men from the advantaged group could state more causes of this disease. However, they were not always correct as they also included cat claws, mosquito bites, and respiration in the mode of transmission list. All the responses from these discussions have been concised in the matrix given below:

### Cited Causes of AIDS Transmission

Group	Male	Female
<b>Tamang</b>	<ul style="list-style-type: none"> <li>- Sexual contact</li> <li>- Same needle</li> <li>- Share same mat</li> </ul>	<ul style="list-style-type: none"> <li>- Sexual contact</li> <li>- Prostitution</li> </ul>
<b>Advantaged</b>	<ul style="list-style-type: none"> <li>- Same needle</li> <li>- Sexual contact</li> <li>- Sitting /sleeping on a warm seat left by the infected</li> <li>- From respiration</li> <li>- From scissors during hair cut</li> <li>- From blade during shaving</li> <li>- Mosquito bite</li> <li>- Cat claws</li> <li>- Blood</li> </ul>	<ul style="list-style-type: none"> <li>- Same needle</li> <li>- Sexual contact</li> <li>- Sitting/sleeping on the warm seat left by infected person</li> <li>- From respiration</li> <li>- Blood mixing</li> <li>- Sharing comb</li> <li>- Sharing handkerchief</li> </ul>

Even some of the key informants believed that AIDS is communicable through handshaking, eating together, sitting closely, use utensils , sharing toilets, etc. However, most of them knew about the mode of transmission like sexual contact, blood transmission, shaving instrument and from mother to child.

#### **III.3.3 Prevention:**

Most of the participants were not knowledgeable about the prevention of AIDS. The participants from advantaged group were slightly better informed than the Tamangs participants. Avoiding prostitution and sexual contact with the high risk group people were cited as most effective ways of prevention. Checking girl trafficking and controlling prostitution within Nepal were cited as the most important measures to take. Using only boiled syringes, using condoms and that infected women should avoid pregnancy were points made by only a few participants.

"The government could not prevent it, then how can we prevent AIDS"

**Ways to Prevent AIDS:**

<b>Group</b>	<b>Male</b>	<b>Female</b>
<b>Tamang</b>	- Do not sit together	- Avoid sexual contact - Avoid sleeping together
<b>Advantaged</b>	- Use sterilized syringe - Use condom - Restrain from sexual contact - Boil blade used by other for shaving - Restrict prostitution - Restrict girl trafficking - Do not eat same food eaten by infected person	- Cover mouth while speaking - Do not speak - Do not sit together - Use boiled syringe/needle - Avoid sitting on warmth of infected person - Sex only with own wife - Avoid child birth by infected women

**III.3.4 Treatment of AIDS:**

Most participants did not know about what treatment is available to cure AIDS. Only a few of the participants were interested in discussing treatment. Most said that no medicine or treatment is available for AIDS. Interestingly, Tamang females were more knowledgeable than their male counterparts regarding the treatment of AIDS. A few participants said that the AIDS victim should be sent to a hospital for treatment and another few reported they had recently heard about new discoveries of medicine for AIDS. The matrix presented below will be helpful in studying their responses.

"If treated, he will be all right, otherwise he will die" - ATM

"Cannot stand on this earth after 10 years of AIDS infection" - YAF

**Treatment of AIDS:**

<b>Group</b>	<b>Male</b>	<b>Female</b>
<b>Tamang</b>	- Medicine - Hospital	- No treatment - Hospital
<b>Advantaged</b>	- May be faith healers - No treatment/ medicine	- No medicine - Recently some medicines have been discovered

**III.3.5 Behavior/Feeling towards AIDS Infected Person:**

Most of the participants said they would immediately spurn the AIDS infected person. Some opined that they should be kept in solitary confinement in order to save the other villagers. A few even suggested that the AIDS victim should be punished for their sins and be killed with poison. Some participants were reluctant to even provide a night's shelter to such persons. Some participants were afraid to be near or to talk with AIDS infected people. The reaction of Tamang people regarding this was very low as they said they did not know much about it.

Regarding behaviors which do not cause AIDS, most of the participants could not answer. Out of those who could answer anything, only a few were from Tamang groups who had received this information through non-formal education classes. It is interesting to note that females were more knowledgeable than males in terms of what behaviors do not cause AIDS.

"Infected persons should not be kept in the village." -ATM

"Give advice for treatment for such infected persons." -YAM

"If they try to spoil others, kill them by poisoning, otherwise they can stay in the community." -YAM

"We contempt your deed."

**Safe behavior with AIDS infected persons**

<b>Group</b>	<b>Male</b>	<b>Female</b>
<b>Tamang</b>	-Embracing -Eat together	-Sharing same food -Embracing -Sitting together -Eating together -Working together
<b>Advantaged</b>	-Embracing -Eat together -Talking	-Embracing -Hand shake -Eating together -Same clothes -Sit together

Only a few key informants were of the view that the AIDS patient should get the love and sympathy of society. Others believed such persons should be avoided as much as possible and socially abandoned.

### **III.4. Condom Use**

#### **III.4.1 Knowledge/Source of information:**

Most of the participants had heard about condoms except for some Tamang female groups. However, they did not know much about the using technique. In female groups, elaborate discussion on condom use was not possible because of their shyness. Regarding questions about what is a condom, their responses were quite interesting. They said it was to put in the pipe of men, for use in the dirty place, that it is made of rubber. In one young Tamang female group, there was the misconception that condoms bring on AIDS. Some Tamang females had never seen the Dhaal packet and thought it may be a type of food like biscuits.

The most common source of information about condoms were radio, health post/health workers, friends and neighbors. Their responses regarding their information source are presented in the following matrix:

**Source of Information on Condoms:**

<b>Group</b>	<b>Male</b>	<b>Female</b>
<b>Tamang</b>	-Radio -Shown in village -From outside	-Friends -Boys from Bombay -Health post
<b>Advantaged</b>	-Radio -Fellow villagers -Health posts -VHWs	-Radio -Friends -Children were blowing

Even among the key informants there were fewer users of condom. Most of these users had used it to prevent conception during first few weeks of undergoing vasectomy. In their opinion cumbersome use procedure and need to wear it every time before having sexual intercourse is the main reason for non use. Further it also lessens the height of sexual pleasure and may burst during use. These reasons have diverted people towards permanent and semi-permanent methods like sterilization or injectable. Condom is usually in short supply with health posts and CHVs, hence people cannot depend on it fully for family planning. Only if freely distributed people will use condom but they are not prepared to pay for it.

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**III.4.2 Benefits of condom use:**

Most of the participants except the Tamang female had good knowledge about the benefits of condom use. They said that it is useful for preventing pregnancies. However most of the participants were unaware that it is also helpful in preventing sexually transmitted diseases. These responses, however, were in most cases based on what they had heard from others or what they read, and not their own experience or use. Their perceptions about the benefits of condom use are summarized in the matrix below:

**Benefits of Condom Use:**

<b>Group</b>	<b>Male</b>	<b>Female</b>
<b>Tamang</b>	<ul style="list-style-type: none"> <li>- Prevent birth</li> <li>- Prevent disease</li> <li>- Not to spill over the sperm</li> <li>- Prevent AIDS</li> <li>- Control family size</li> <li>- Sexual contact with wife</li> <li>- Male contraceptive</li> </ul>	<ul style="list-style-type: none"> <li>- Medicine to prevent birth</li> </ul>
<b>Advantaged</b>	<ul style="list-style-type: none"> <li>- Contraceptive</li> <li>- Prevent disease</li> <li>- Birth spacing</li> <li>- Sexual contact</li> <li>- Delay birth</li> </ul>	<ul style="list-style-type: none"> <li>- Balloon for children</li> <li>- Male contraceptive</li> <li>- Medicine for birth control</li> <li>- Prevent disease</li> <li>- Prevent AIDS</li> <li>- Vasectomized men use for a few months</li> </ul>

Key informants also cited family planning as the main benefit of condom. Some respondents however also mentioned STDs and AIDS prevention as other benefits of use.

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### ***III.4.3 Reasons for Not Using Condom:***

Most of the participants had never used a condom before and answering they said they were not sure why they did not use it. Most of them said that they had only recently heard about it so could not have used it before. Many said that even if they had heard about it, they could not use it because they did not know how to use it and for what to use it. Some participants had used it before, but were not happy with it as it reduced sexual enjoyment, and in some cases had burst when a little force was used. Some females said they prefer sterilization or copper-T because of reliable control for birth. Others were of the view that it was simply not necessary either because of old age or because they were unmarried. No one had the idea that unmarried people should use it for protected sex.

#### **Reasons for Non Use of Condom:**

<b>Group</b>	<b>Male</b>	<b>Female</b>
<b>Tamang</b>	- Do not know use technique	- Do not know how to use - Will use if taught
<b>Advantaged</b>	- Less sexual enjoyment - Unreliable (burst) - Unmarried - Date expired - No faith in it	- Not necessary - Did not know before - Prefer other methods

In the in-depth interviews, the respondents mentioned community health volunteers (CHVs) school and training by SC/US also as their source of information on condom.

### ***III.4.4 Availability of Condom:***

Most of the participants aware of condoms could mention at least one condom distribution outlet. Many had the idea that it was available in shops, but thought it was available only in shops located in urban areas like Katmandu or Trishuli Bazaar. Most of the Tamang women did not know where condoms were available. The condoms distributed by extension workers like village health workers (VHWs) and volunteers like community health volunteers (CHVs) was not commonly known. Only a few participants mentioned VHWs as an outlet of distribution.

### Condom Distribution Outlet:

Group	Male	Female
Tamang	-Shop - Village distribution	- Health post - Do not know
Advantaged	-Shops - Health posts - VHWs	- Kathmandu - Health post - Hospital - Shop - Shops in towns only

### **III.5. Information, Education and Communication (IEC):**

#### ***III.5.1 Local Opinion Leaders:***

In order to facilitate future programming for STDs/AIDS education, issues related to effective communication channels were raised in the focus group discussions.

When asked to whom to go for advice, most of the participants mentioned Village Development Committee (VDC) or ward member. However, participants expressed that whom they go to for advice depends upon the nature of the problem. For health problems they consult a 'Jhankri' (faith healer), a 'Lama' (priest), or a doctor (paramedicals are also known as doctors in rural areas). For other matters, they may go to teachers and social workers as well as the political leaders like ward/VDC members.

Key informants said that VDC/ward members are the most respected persons by the villagers so that they were elected. In the ID<sub>3</sub> the name of Health Assistant also was mentioned as the influential person.

**Local Opinion Leaders:**

<b>Group</b>	<b>Male</b>	<b>Female</b>
<b>Tamang</b>	<ul style="list-style-type: none"> <li>- Ward member/chairman</li> <li>- Faith healers</li> <li>- Doctors</li> <li>- Lamas</li> <li>- NFE facilitator</li> </ul>	<ul style="list-style-type: none"> <li>- Faith healers</li> <li>- VDC member</li> <li>- Social worker</li> <li>- Teacher</li> <li>- Old man</li> </ul>
<b>Advantaged</b>	<ul style="list-style-type: none"> <li>- Priest</li> <li>- Educated person</li> <li>- Unselfish social worker</li> <li>- Teacher</li> </ul>	<ul style="list-style-type: none"> <li>- Ward member</li> <li>- Social worker</li> <li>- APCP motivator</li> <li>- Women worker</li> <li>- Mukhia</li> <li>- Teacher</li> </ul>

**III.5.2 Acceptability of Condom/AIDS related IEC materials/media:**

Participants had different opinions regarding the acceptability of condom and AIDS related print materials. When asked whether they would like to keep booklets on condoms or AIDS, some women objected, saying there may be embarrassing pictures. Some said there no use in keeping as they did not know how to read booklet. However many persons in the male groups were quite interested in receiving such booklets when available. Some participants opined that such materials would be appropriate for postering on a wall to convey the desired message.

Participants unanimously said that people of rural areas would view dramas and videos with keen interest. They said even if the subject were contraception and AIDS, they would be ready to watch dramas or video/film shows. As these media can clearly depict the real picture, it would be very effective in disseminating the intended message, and because of the entertainment element, it will always gather a large crowd.

Most of the key informants suggested the materials on AIDS/STDs be developed considering the social and cultural norms of the society to make it acceptable. The reach of booklets will be limited as most of the villagers are illiterates.

**III.5.3 Suggestions for IEC Activities:**

Most of the participants were unable to suggest anything regarding IEC activities and said whatever the office does is good for them. Some of the important suggestions given by them have been listed below:

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- **Speech on public gathering;**
- **Wall postering;**
- **Dance and songs;**
- **Use of local language in all media/materials;**
- **Extensively use drama and videos;**
- **Special IEC program for Tamang;**
- **Present cases of Bombay girls to the villagers; and**
- **Emphasis in girl child education.**

The respondents of the IDIs expressed that the women educated in the NFE classes can play a crucial role in communicating desired message to the villagers. Organizing occasional STD camps street drama and recruiting female motivators were some of the important suggestions by the key informants.

#### **IV. SUMMARY OF FINDINGS:**

##### **IV.1. Sexual and Other Risk Behaviors:**

- IV.1** There is possibility of pre-marital and extra marital sexual relations during local festivals, fairs and social gatherings.
- IV.2.** Polygamy is still found among the advantaged caste people whereas eloping and remarriage occur among Tamang and occupational caste groups.
- IV.3.** Girl trafficking is a serious problem in the project area. The young girls of Tamang and occupational caste groups are at high risk of trafficking as compared to those of advantaged groups.
- IV.4.** Girl trafficking has been accepted by the society as a reality. The Bombay girl is not looked down upon by the community: rather people respect them because of their cash earnings and most of the village youth aspire to marry them. There is no evidence of prostitution in the villages by the Bombay returnees.
- IV.5.** The men also frequently travel to India or within Nepal for jobs and study. People occasionally visit Bombay or other cities in India to see their daughter/sisters and to collect earnings from them.
- IV.6.** The practice of ear and nose piercing of girls is a common custom in Nuwakot. Tattooing is popular, specially among the Tamang women. Both for skin piercing

**and tattooing unsterilized needles are used; if needed, the same needle is used for many girls/women.**

### **Sexually Transmitted Diseases(STDs):**

- IV.7. Only about half of the participants were aware of STDs: if they are aware of STDs, they are likely to know only about Bhirangi (Syphilis). They have learned about syphilis mainly through friends and neighbors. Participants perceived irritation, itching, boils and discharge from sex organ to be the main symptoms of STDs.**
- IV.8. Routes of STD transmission are not known to many. Participants cited prostitution, sexual contact and failure to clean sexual organs as the main cause of STDs. Similarly, they believe STDs can be communicated through air, mosquito bite or sharing an affected person's clothes. For prevention they suggested no prostitution or no extra marital sex. Some also mentioned condom as a method of safe sex.**
- IV.9. Participants think STDs are curable. As a treatment measures they mentioned health post, hospital and medicine, seeking cure from faith healers and local treatment is also common in villages.**

### **Acquired Immune Deficiency Syndrome (AIDS) :**

- IV.10. Except for some Tamang females, most of the participants are aware of AIDS. They have heard about it from friends/relatives, posters, pamphlets, radio, adult literacy classes and drama. Many participants said symptoms were not necessarily visible: visible symptoms included seriously illness, weight loss, frequent diarrhea, loss of appetite and death.**
- IV.11. Sexual contact was the main route of transmission as reported by the participants. Some of the misconception regarding transmission were sitting/sleeping in places previously occupied by infected persons, respiration, sharing combs and handkerchiefs. However, some people also correctly identified cuts from scissors, blades and blood transfusion as causes of AIDS infection.**
- IV.12. Abstinence from prostitution, use of sterilized syringes, restriction on girl trafficking and use of condom were mentioned as the measures to prevent AIDS. Some misconception about preventive methods included covering mouth while speaking, not sitting together and not sharing food with AIDS infected persons.**

- IV.13. Most participants did not know about treatment. Mostly they said no medicine or treatment is available for AIDS. Some, however, suggested treatment at hospital or use of certain medicines.**
- IV.14. Most of the participants said AIDS patients should be immediately spurned and kept in solitary confinement. They think even normal contact like talking and visiting should be avoided.**
- IV.15. Only a few participants knew that such behaviors as embracing, eating together, sharing food, sitting together, talking and sharing clothes did not cause AIDS.**
- IV.16. People had heard about condoms but did not know the proper use technique. They had heard about condoms mainly from Radio, health post, health workers, friends and neighbors.**
- IV.17. Most of the participants knew about the benefits of condom use. But knowledge was primarily limited to use of condoms only for family planning. Only some of them knew that condoms also help prevent sexually transmitted diseases including AIDS.**
- IV.18. Only a few participants were found to have ever used condoms. Reasons for low levels of condom use included perceptions that condoms were cumbersome and reduced sexual pleasure; the need for condoms to be worn at time of each intercourse; and lack of availability.**
- IV.19. Most of participants could mention at least one condom distribution outlet. They know condoms are available in shops besides health posts. However, distribution of condom by extension workers (VHWs) and volunteers (CHVs) was not commonly known.**

**Information, Education and Communication (IEC):**

- IV.20. Regarding source of advice VDC and ward members were reported most commonly by the participants. For health related matters, however, they would seek advice from Jhankri (faith healers), Lama (priests) and health personnel. They also mentioned teachers and other social workers as the popular advisors.**
- IV.21. People, especially women, had some reservations about accepting explicitly illustrated IEC print materials on AIDS and condoms. Participants, however, unanimously welcomed the idea of drama and video shows and said such shows will always gather a large crowd.**

**IV.22. Some suggested other important channels for IEC activities: e.g.; public speeches, posters, dances, songs and drama/video shows. They also suggested that it was important to use the local language in all media/materials and to design special IEC programs for Tamangs and girl children.**

## **Annex - I**

### **Field Research Team**

<b>Ilaka No.</b>	<b>Moderator/Recorder</b>	<b>Logistic Assistant</b>
<b>1</b>	<b>Ms. Meera Rana and Ms. Maya Gole Mr. Rajeshwor Devkota &amp; Mr. Biswo R. Shrestha</b>	<b>Ms. Bina Thapa</b>
<b>12</b>	<b>Ms. Durga Regmi and Jamuna Lama Mr. Krishna B. Gurung and Mr. Bind Chapagain</b>	<b>Ms. Radhika Kuikel</b>
<b>13</b>	<b>Ms. Sharmila Shrestha and Ms Ranjana Khanal Mr. Rajeshwor Devkota and Mr. Bishwo R. Shrestha</b>	<b>Ms. Maya Gurung</b>

**List  
of  
Training and Conferences**

<b>SR/#</b>	<b>TOPIC</b>	<b>DURATION</b>	<b>PARTICIPANTS</b>
1	International AIDS Conference DELHI, INDIA	5 days	- Public Health Co-ordinator
2	AIDS Prevention Strategy Training THAILAND	10 days	- Dy. Public Health Co-ordinator - Project Co-ordinator CS-VIII
3	TOT for NFE KATHMANDU	10 days	- 3 NFE Co-ordinators
4	TOT and Leadership Training KATHMANDU	7 days	- 3 Women Development Co-ordinators
5	Focus Group Discussion Research KATHMANDU	9 days	- 3 Staff Nurse - 1 Auxiliary Nurse Midwife (ANM)
6	Cluster Sample Survey NUWAKOT	5 days	- All Project Staff
7	Early Childhood Development, Observation LAMJUNG	5 days	- 4 Women Development Co- ordinators
8	Asia Pacific Regional Health Workshop KATHMANDU	4 days	- Project Co-ordinator CS-VIII
9	NFE Observation Tour GORKHA	10 days	- 3 NFE Co-ordinators - 9 NFE Supervisors
10	Early Childhood Development, TOT	6 days	- 3 Women Development Co- ordinators
11	Semi-Annual Meeting KATHMANDU	2 days	- Project Co-ordinator CS-VIII - 3 Field Co-ordinators
12	TOT on Communication Skills KATHMANDU	10 days	- 1 NFE Co-ordinator - 3 Staff Nurse - 2 Comm. Medicine Auxiliaries (CMAs)
13	Health Meeting GORKHA	2 days	- Project Co-ordinator CS-VIII - 1 Staff Nurse
14	AIDS Conference BERLIN	5 days	- Public Health Co-ordinator - Country Director
15	NFE Center Supervision GORKHA	5 days	- 10 NFE Supervisors
16	Gender Analysis Workshop KATHMANDU	4 days	- 1 Field Co-ordinator
17	Legal Rights Workshop GORKHA	3 days	- 1 Field Co-ordinator

18	Training of Trainers KATHMANDU	5 days	<ul style="list-style-type: none"> <li>- 3 Women Development Co-ordinators</li> <li>- 1 Field Co-ordinator</li> <li>- 2 NFE Co-ordinators</li> <li>- 1 Information Education Communication Co-ordinator</li> <li>- Health Research and Training Officer</li> <li>- Dy. Public Health Coordinator</li> </ul>
19	Focus Group Discussion (FGD) Research on AIDS NUWAKOT	7 days	<ul style="list-style-type: none"> <li>- 4 Women Development Co-ordinators</li> <li>- 1 Field Co-ordinator</li> <li>- 3 Community AIDS Educators</li> <li>- 1 Information Education Communication (IEC) Co-ordinator</li> <li>- Accountant</li> </ul>
20	Early Childhood Development Conference SINGAPORE	7 days	1 Women Development Program Officer
21	Early Childhood Development Training KATHMANDU	3 weeks	2 Women Development Co-ordinators
22	Leadership Training BANGLORE	4 weeks	<ul style="list-style-type: none"> <li>- 1 Field Co-ordinator</li> <li>- 1 ANM</li> </ul>
23	Vitamin-A Training <i>(see Appendix-B)</i> NUWAKOT	5 days	<ul style="list-style-type: none"> <li>- 3 NFE Co-ordinators</li> <li>- 2 Field Co-ordinators</li> <li>- 3 Staff Nurses</li> <li>- 2 CMAs</li> <li>- 1 ANM</li> <li>- 1 Information Education Communication Co-ordinator</li> <li>- 1 Women Development Co-ordinator</li> </ul>
24	AIDS Training NUWAKOT	5 days	<ul style="list-style-type: none"> <li>- 3 NFE Co-ordinators</li> <li>- 3 AIDS Motivators</li> <li>- 3 Staff Nurses</li> <li>- 4 Women Development Co-ordinators</li> <li>- 2 Field Co-ordinators</li> </ul>

**SAVE THE CHILDREN  
Pipeline Analysis**

**Appendix I**

COOPERATIVE AGREEMENT FAO-0500-A-00-2034

21-Oct-93

CHILD SURVIVAL VIII:NEPAL

	YEAR 1: EXPENSES VS. PLANNED BUDGET						LOG: CUMULATIVE EXPENSES VS.TOTAL GRANT			
	EXPENSES 07/31/93	PLANNED BUDGET	BALANCE	% SPENT	BUDGET YEAR 2	BUDGET YEAR 3	CUMULATIVE ACTUAL	TOTAL BUDGET	BALANCE	% SPENT
Evaluation	1,780.85	1,666.00	(114.85)	106.9%	9,785.00	8,365.00	1,780.85	19,816.00	18,035.15	9.0%
Personnel	25,312.45	44,448.00	19,133.55	57.0%	47,058.00	50,740.00	25,312.45	142,245.00	116,932.55	17.6%
Travel	9,483.04	17,091.00	7,607.96	55.5%	13,500.00	8,500.00	9,483.04	39,091.00	29,607.96	24.3%
Communications	2,007.40	10,172.00	8,164.60	19.7%	6,210.00	6,300.00	2,007.40	22,682.00	20,674.60	8.9%
Facilities	838.69	2,700.00	1,861.31	31.1%	2,900.00	3,200.00	838.69	8,800.00	7,961.31	9.5%
Other direct	4,142.04	8,299.00	4,156.96	49.9%	16,279.00	12,907.00	4,142.04	35,965.00	31,842.96	11.5%
Procurement										
Supplies*	19,256.37	22,816.00	3,559.63	84.4%	20,753.00	13,998.00	19,256.37	57,567.00	38,310.63	33.5%
Consultants	178.05	6,000.00	5,821.95	3.0%	4,000.00	6,500.00	178.05	16,500.00	16,321.95	1.1%
Services		0.00	0.00		0.00	0.00	0.00	0.00	0.00	
sub-total Procurement	19,434.42	28,816.00	9,381.58	67.4%	24,753.00	20,498.00	19,434.42	74,067.00	54,632.58	26.2%
Total Direct	62,998.89	113,190.00	50,191.11	55.7%	120,485.00	110,510.00	62,998.89	342,686.00	279,687.11	18.4%

Year 1 = Sept.30,1992 - Sept. 30, 1993

Year 2 = Oct. 1, 1993 - Sept. 30, 1994

Year 3 = Oct. 1, 1994 - Sept. 30, 1995

Budgets revised to Amendment 3

\*Supplies are individually under \$500 per item.

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