

SAVE THE CHILDREN

FINAL EVALUATION

**Save The Children (USA)
Siraha District, Nepal
Child Survival VII Project**

December 1994

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Selected Abbreviations

AHW	Auxiliary Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
CDD	Control of Diarrheal Diseases
CDO	Chief District Officer
CHV	Community Health Volunteer
CS	Child Survival
DEO	District Education Officer
DIP	Detailed Implementation Plan
DPHO	District Public Health Officer
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded Program on Immunization
FP	Family Planning
FPAN	Family Planning Association of Nepal
HIS	Health Information System
HMG/N	His Majesty's Government of Nepal
HP	Health Post
IGA	Income Generating Activities
IE&C	Information, Education and Communication
INGO	International Nongovernmental Organization
K & P	Knowledge and Practice
LDO	Local Development Officer
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MOH	Ministry of Health
MoECSW	Ministry of Education, Culture and Social Welfare
MUAC	Mid Upper Arm Circumference
NFE	Nonformal Education
NGO	Nongovernmental Organization
ORC	Outreach Clinic
ORS/T	Oral Rehydration Solution / Therapy
PEM	Protein Energy Malnutrition
PVO	Private Volunteer Organization
SC	SAVE THE CHILDREN (USA)
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
US A.I.D.	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception

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The Evaluation Team would like to extend its thanks for the good cooperation to all the staff at SCF/US Kathmandu Head Office, SCF/US Project Offices in Siraha, NFE supervisors and facilitators, to all the staff members in ilaka 4 & 5, to all those who are directly involved in the various program activities, and to the large number of individuals, NGO representatives, and Government officials who, by providing essential information and their valuable comments, helped the Team to come to a better understanding of this complex program and assess its strong and weak points objectively.

Executive Summary

The Final Evaluation of the Save the Children (US) CS-VII Program in Siraha District/Nepal was conducted from December 07 - 18, 1994. The Evaluation Team consisted of 5 members: Dr. A. Tariq Ihsan, Ms. Karen Le Ban, Dr. Mahendra K. Chhetri, Mr. Tya Bahadur Shrestha, and Ms. Joan Venghaus (team leader). The Team was accompanied by representatives from US A.I.D. and SC.

Both, quantitative and qualitative methodologies were used to assess the progress and impact of the program. Following detailed document research, structured interviews were carried out with SC staff in Kathmandu and Siraha District, MOH staff, representatives of MoECSW, Village Health Workers, Community Health Volunteers, Traditional Birth Attendants, Health Post and Outreach Clinic Management Committees, women's groups, members of nonformal education-classes, and some representatives of local NGOs, as well as some social workers and local leaders. The Team visited MCH programs at HPs and outreach clinics in both, SC-supported and non-supported areas.

Prior to this evaluation, a Final Knowledge and Practice Survey had been conducted by SC staff during November - December 1994 to document and compare changes that had occurred since the initial baseline survey.

The 3-year program was based in ilakas 4 & 5 of Siraha District in the Sagarmatha Zone of the Eastern Development Region in Nepal. The program area, located in the *terai* of Southern Nepal, had been chosen by SC and the 'Social Welfare Council' following a serious earthquake in 1988 and based on criteria, such as potential for economic development, earthquake damage, lack of existing development support, potential for community participation, geographic and ethnic diversity, and families poverty levels. The program incorporated two main strategies: (a) to reduce infant and young child mortality and morbidity through *strengthening of the MOH service delivery system and creating a sustained community demand for health services*, and (b) to emphasize the role of Community Health Volunteers (CHVs), Traditional Birth Attendants (TBAs), and mothers' groups in creating *improved knowledge and practice of protective health behaviors at the household level*. The project objectives were set in 1991 and revised in 1993, following a Mid-Term Evaluation. However, no quantitative study was carried during this Mid-Term Evaluation since it was deemed too early to notice any significant changes among the communities.

The Evaluation Team can confirm that, despite the short project life, the program had made considerable progress and had a substantial impact on the community at large. Probably one of the strongest points of the program is the noticeable success in mobilizing the communities and establishing community-based management structures. This can be contributed to the clear identification of community health priorities at the start of the program. Another commendable success is the strong bond between nonformal education activities, community health and the empowerment of women. The attainment of literacy, in general, has contributed to a rise in the status of women through income generation and improved self-reliance. At the same time, the impact of educational activities and health related interventions can be measured by the substantial improvement in ante-natal care and the higher utilization of TBAs. The management of diarrheal diseases, most prevalent in these high-risk communities, has been greatly enhanced, particularly the use of *Jeevan Jal*. Also noted were improvements in the areas of TT coverage, ARI diagnosis and treatment, and EPI awareness.

Despite all these positive impacts, the Team was somewhat disappointed that only a few of the recommendations made by the Mid-Term Evaluation had been taken on board and many of the previously mentioned problems persist. Reference is made here to the individual subject headings, achievement levels, the conclusions and the numerous recommendations as described below.

Probably two of the main weaknesses of this program are: (a) the project life, and (b) its close attachment to the Government structure in Nepal.

(a) A three-year time frame is far too short to accommodate the complexity of this program, since this time limitation does not provide for the necessary flexibility to cater for any unplanned events - a prerequisite when working with Government authorities in Nepal. Three years is also too short to bring about long-lasting and substantial changes in communities' attitudes and practices given the complex cultural and ethnic nature of the program area. The time constraint and the importance given to 'targets' resulted in several activities being carried out under pressure and in haste.

(b) After the establishment of the popular movement in Nepal, the country experienced a planning standstill, and it was not before 1992/93 (Nep. Cal.) that HMG/N formulated its 8th Development Plan with the overall strategies for the various sectors. It is, therefore, not surprising that several objectives of the program, relating to MOH, could not be fully achieved since the implementation period coincided with the transitional phase. However, this also demonstrates that, during the planning stage, it is important to consider the political scenario and its possible consequences. Close links to governmental structures, such as MOH, need clear agreements outlining in detail the roles and responsibilities of each partner. They also require the partner NGO to consider realities, such as financial constraints of the Ministry, and planning cycles which should correspond with the country's planning traditions.

The program incorporated a 'phasing-over' strategy by identifying and revitalizing HP Management and ORC Management Committees as a vehicle through which services will be carried out on a cost recovery basis.

Considering the many positive impacts as well as the shortcomings of the program, the Team came to the conclusion that, in the interest of the communities, SC should utilize the program's positive momentum and try to overcome the various constraints by continuing the program on a more focused basis with private funds. However, since SC is not the service provider, it is highly recommended to review carefully the future relationship with MOH and explore possibilities to influence MOH's involvement more actively both in terms of supervision and advice.

(For more detailed findings and recommendations, please, refer to the specific activity headings and particularly to section IV./C. 'Lessons Learned', page 30-33.)

I. PROJECT BACKGROUND and DESCRIPTION

Save the Children, US (SC) initiated a Child Survival (CS) VII project in Ilakas 4 & 5 of Siraha District, Nepal in October 1991. Siraha District is one of the seven districts of Sagarmatha Zone in the Eastern Development Region of Nepal and has a population of 444,627. The district covers some 1,188 km² in the rural, subtropical *terai* (= lowlands) area and borders the Republic of India in the south. The population is of diverse ethnic and socio-economic status; approximately 85% is Maithili speaking. (Appendices 8 & 9, 10 Maps)

The target population of the project area is 104,237, including 14,886 children under five years of age and 21,763 women of the reproductive age group (15 - 45 years).

Following a serious earthquake in 1988, SC began rural development and reconstruction activities. To facilitate selection of a project area, extensive interviews were held within the district and the activities of other agencies in the area were reviewed and considered.

The primary criteria for selecting these two ilaka included:

- * families below poverty level;
- * access to transport and communication;
- * potential for economic development;
- * damage from the 1988 earthquake;
- * lack of existing development support;
- * geographic and ethnic diversity;
- * potential for community participation.

It was found that ilaka 4 & 5 of Siraha District most fully fulfilled the above conditions. By 1989, a community development office was established in the town of Golbazaar, coordinating activities in six *panchayats* (now: Village Development Committees / VDCs) of Ilakas 4 & 5.

With the identification of Primary Health Care and child survival as priority needs in the area, and following a request from HMG/N to work with the MOH service delivery system at ilaka level, SC expanded its coverage to all 24 VDCs of Ilakas 4 & 5. The total population then was estimated to be 103,542 in 19,199 households.

The **overall goal of the project**, as stated in the DIP, was two-fold:

to reduce infant and young child mortality and morbidity through **strengthening of the MOH service delivery system and creating a sustained community demand for health services.**

The project emphasizes the role of Community Health Volunteers (CHVs), Traditional Birth Attendants (TBAs), and mothers' groups in creating **improved knowledge and practice of protective health behaviors at the household level.** The project objectives were set in 1991 and revised in 1993.

The project is registered under the 'Social Welfare Council' of HMG/N. In order to carry out the objective of strengthening the MOH service delivery in Siraha district, a tripartite agreement had to be drawn up between MOH, Social Welfare Council, and SC. This proved a slow and lengthy procedure and took a total of one year.

The **project interventions** included: diarrheal disease management, immunization, vitamin A supplementation, management of acute respiratory infection (ARI), promotion of ante-natal care and improved delivery services and practices, family planning, and literacy training for women.

Information concerning the health knowledge and practices of mothers with children under two years of age was collected through **CS VII Baseline K & P Survey** in February 1992 .

Further baseline information was obtained through a **100% Family Enrollment Survey** of the project area during December 1991 - January 1992. During the project period, additional qualitative and quantitative studies were conducted to adjust the implementation of the project

A **Mid-Term Evaluation** was conducted during March 25 - April 7, 1993, but no quantitative assessment was made since the evaluation team as well as project staff were of the opinion that it was too early to expect significant changes in K & P. However, several quantitative studies were undertaken during the last six months of the project to look at specific changes in health status. These included the *Final Knowledge, Practice and Coverage Survey*, the *Pre-Harvest Nutrition Survey*, a *Study of the Impact of Non-Formal Education Classes on the Health Behavior of Women*, and a *survey on the Quality of VHW Registers*.

Eventually, a **Final Knowledge and Practice Survey** was undertaken during November - December 1994. This survey is, in effect, the first comprehensive quantitative study to document changes in K & P since the initial Baseline Survey.

It is worth noting that **no study was done on ethnic groups** although the ethnic diversity in the project area is considerable and was recognized during the initial planning process. During the baseline survey in 1992, project staff had identified over 50 caste and ethnic groups during the family registration process, and attempted to extend health benefits to as many diverse groups as possible. The influence of specific caste behavior and attitudes on health outcome was increasingly recognized as more complex than anticipated during the initial planning process. While additional qualitative and quantitative studies were conducted to adjust the implementation of the project, specific studies relating to ethnic groups were considered to be outside the scope of the project.

No literacy tests were conducted.

II. THE FINAL EVALUATION TEAM, SCHEDULE, METHODOLOGY and FIELD VISITS

II.A. Objectives of the Evaluation

US A.I.D. requires an end evaluation on completion of all child survival projects. The final evaluation should have been conducted in October 1994, however, SC was granted a no-cost project extension of three months by US A.I.D. due to difficulties in data collection during the *monsoon* season, hence the final evaluation was scheduled for December 1994. The evaluation is supposed to provide project staff with an external perspective on the progress since the start of the project, assess whether the project was carried out in a competent manner with priorities clearly defined, help the PVO to assess lessons learned, and identify new strategies or methodologies applicable to other CS projects.

The main objectives of this Final Evaluation are detailed in the '*BHR/PVC Guidelines for Final Evaluation & Sustainability Assessment of Child Survival Projects ending in 1994 (CS-VII)*'. The team's specific terms of reference included:

Reviewing the SC / CS-VII project activities and related documents, such as quarterly reports, survey reports, and the DIP;

Meeting with key members of the project staff in Kathmandu and Siraha to review the design implementation, constraints and achievements of the project;

Reviewing the project activities with the MOH both, in Kathmandu and Siraha, and others knowledgeable about the project activities;

Collection and analysis of information on selected project aspects (FP, EPI, vitamin A, maternal health, etc.) including the development of these findings into a written format complying with the outline of the Final Evaluation Report;

Submission of the Final Evaluation Report by December 30, 1994 latest.

II.B. The Evaluation Team

The Evaluation Team was composed of:

- Dr. Tariq Ihsan, Project Manager (Health), SC Pakistan
- Ms. Karen Le Ban, Manager (Health, Population & Nutrition), SC
- Dr. Mahendra K. Chhetri, Planning & Foreign Aid Division, MOH, HMG/N
- Mr. Satya Bahadur Shrestha, Monit. & Evaluation Section, MoESCW, HMG/N
- Ms. Joan Venghaus, independent consultant (Team Leader)

The team represented a wide range of professional background and experience, including medicine, public health, family planning, health care systems, nursing, epidemiology, management, IE&C, NFE and finance.

The Evaluation Team was accompanied by:

- Ms. Barbara Winkler, Technical Advisor, US A.I.D. Nepal
- Ms. Mary Linehan, Technical Advisor, US A.I.D. Nepal
- Ms. Jennifer Day, Technical Advisor, SC (Nepal)
- Ms. Chanda Rai Shrestha, Asst Director Public Health, SC (Nepal)

II.C. Schedule / Field Visits

The Final Evaluation was carried out **from December 7 to December 19, 1994**. Document research in Kathmandu was carried out during December 7 - 10, 1994. During the same time, the Team met with SC Project staff at the Head Office and received briefings from the Country Representative and project members. A meeting took place with the 'John Snow, Inc.' (JSI) in its capacity as policy advisors to HMG/N - MOH, to discuss child survival programs. A further meeting took place with 'Redd Barna' on TBA training and the cultural practices of breastfeeding. The Team proceeded to Siraha on December 11, 1994 where project staff provided the necessary field briefing (Appendix 6 - Field Itinerary). All members of the Team returned to Kathmandu on December 16, 1994 where a one-day team conference was held on December 17, 1994. Debriefings of US A.I.D. Nepal, as well as SCF/US took place on December 19, 1994.

The Evaluation Team felt strongly about the **insufficient time allocated for a Final Evaluation of such a complex program** (only 4 full days in Siraha). Due to this time constraint, several important issues could not be addressed in sufficient depth (e.g. HIS). It would have been also beneficial to meet additional INGOs in the field. This was, unfortunately, not possible.

Due to logistic reasons, two team members had to leave almost immediately after the return of the Team to Kathmandu. Considering the lack of electricity in the field and the resulting need to compile all documentation in Kathmandu, the hasty departure posed an additional strain on the Team's work.

II.D. Methodology

The members of the Evaluation Team met, for the first time, on December 7, 94 and an introduction meeting was arranged with the staff of SC. The Team was provided with a complete literature review (Appendix 7 - Documents Reviewed).

During several discussion and meetings, a guideline set of questions was developed. These questions represented the minimum level of information needed to assess the project, and were based on the guidelines provided by US A.I.D. (Appendix 11 - Questionnaires)

The Team split into three groups to accommodate the complexity of the program, maximize the use of the short time available, and utilize best the professional background of the team members. The Team visited HP and Outreach Clinics both, supported and not supported by SC, in order to compare activity levels and assess the impact of the project. Interviews were held with HP-staff, Management Committees, project- and field staff of SC and MOH, women's groups, relevant Government representatives, and local NGOs. NFE classes were observed, and supervisors, facilitators and participants were interviewed. On the community level, the Team held discussions with TBAs, VHWs and CHVs (Appendix 5- Contacts). A literacy test was conducted.

Although a lot of achievements were noted, the Team is of the opinion that the allocated project time of 3 years was not sufficient. It recommends that SCF/US continues to strengthen the project through private funds, and has, therefore, prepared recommendations for the future under each activity's sub-heading.

III. PROJECT OBJECTIVES

The original project objectives were stated in the DIP. Following the Mid-Term Evaluation in 1993, the project targets were revised as shown in the table below, after discussions with and with the approval of US A.I.D.

(Changes in comparison to the original objectives are shown in *high-lit italics* in each respective section.)

No	<i>Original Objectives (as per DIP)</i>	<i>Revised Objectives</i>
Immunization		
1	60% of children of 12-23 months will be completely immunized with BCG, DPT, Polio and Measles vaccines	60% of children aged 12-23 months will be completely immunized with BCG, DPT, Polio and Measles vaccines
2	50% of women aged 15-45 years will have received 2 doses of TT	50% of women aged 15-45 will have received <i>at least</i> 2 doses of TT.
Diarrheal Disease Management		
3	60% of families with children <2 years will know how to prepare and give JJ correctly	60% of families with children <2 years will know how to prepare and administer JJ correctly.
4		90% of mothers will have access to ORS / JJ sachets (<i>New objective</i>)
5	40% of children <2 years with diarrhea will be treated with JJ and receive more food fluids during and after diarrhea	25% of children <2 years with diarrhea will be treated with JJ and receive more food and fluids during and after diarrheal episodes. (<i>reduction</i>)
6	50% of mothers with children <2 years will correctly name 3 causes of diarrhea	
Vitamin A / Nutrition		
7	40% of mothers with children <2 years will give appropriate weaning foods	
8	60% of children 12-23 months will have received two doses of vitamin A	60% of children aged 12-23 months will have received <i>at least</i> 2 doses of vitamin A.
9	60% of lactating mothers of children 0-12 months will have received one dose of vitamin A	
10		A study on the impact of recent crop failures on household food availability, distribution of food within the household and nutritional status of children will be conducted.
Prenatal / Delivery		
11	25% of women will eat more during pregnancy	
12	30% of pregnant women will receive an ante-natal check-up	30% of pregnant women will have an ante-natal check-up
13	40% of mothers of children <2 years will know the '3 cleans' for safe delivery	40% of mothers of children <2 years will know the '3 cleans' for safe delivery
ARI		
14	25% of mothers of children <2 years will seek advice or treatment from health workers when their child has difficult respiration	25% of mothers of children <2 years will know the signs of ARI and seek advice or treatment from health workers (<i>changed objective</i>)
15		80% of mothers will know where treatment for coughs and colds is available (<i>new objective</i>)

Family Planning		
16	20% of eligible couples will be using temporary or permanent methods of contraception	20% of eligible couples will use temporary or permanent methods of contraception.
Nonformal Education		
17	80% of CHVs, and 50% of trained TBAs and mothers' group members will have basic literacy skills	70% of CHVs and 20% of trained TBAs will have basic literacy skills (reduction from 80% to 70% CHVs, reduction from 50% to 20% TBAs, "mothers' groups members" dropped)
18	The MOH will have designed and adopted a plan to sustain those aspects of service delivery and quality of care developed in Siraha district. (Reference: Mid-Term Evaluation)	(objective dropped)
Other Objectives		
19		60% of VHWS' registers will be up-to-date (new objective)

IV. PROJECT ACCOMPLISHMENTS and LESSONS LEARNED

A. Project Accomplishments

A.1. **IMMUNIZATION**

A.1.1 *Discussion*

Immunization sessions are carried out twice a month at the Health Posts and through VHWs in their respective VDCs. With assistance from SC, MOH staff conduct MCH clinics in two HP and 13 outreach clinics. It is the MOH policy to target children under one year of age for vaccinations. Women of the age group 15 - 45 years are encouraged to have two doses of TT. Outreach clinics have been established to bring the services closer to the people, particularly in those areas where the walking distance to the nearest HP is too far.

The evaluation team visited two areas, one supported by SC and the other not supported. Considerable differences in the attitude, knowledge and practice of people were noted between the two areas:

An Outreach Management Committee is functional in the SC area. The aim of this committee is to facilitate and to generate funds to support MCH-clinics. In non-SC areas, these committees do not exist.

In the SC area, a sense of ownership of this service is found among committee members, CHVs and those mothers interviewed. Committee members arrange MCH and EPI services at the site of the ORC. During a meeting with one of the Outreach Management Committees, members showed their awareness of existing MOH budget limits and their willingness to generate the required funding to continue the activity in future.

In the non-SC area people were dependent upon the VHWs' schedule and their visit which, according to them, sometimes did not materialize. During a health education session witnessed, Health Management Committee members expressed their desire to be trained in EPI management in order to facilitate mobilization of target groups within their area.

It is clear that, generally, training and motivation sessions conducted by SC have created an awareness among people and the committees to understand their needs and seek alternative resources.

Although, vaccination sessions were going on in the both areas visited, mother's knowledge about the importance of vaccines, completion of vaccination schedules, side effects (but no concern), contraindications (that there were none), and the six immunizable diseases (The answers mainly included TB, whooping cough, measles and Tetanus) was high in the SC impact area. This statement is also supported by the Final K & P survey, which indicates that 74.4% mothers knew that TT protects both mother and the new-born, 64% mothers knew that more than two doses of TT vaccines are required to protect the new-born against neonatal tetanus.

In the non-SC area, most of the women and men interviewed thought that immunization protects against small pox only and protects children from illness.

Mothers interviewed in the waiting queue at the SC ORC strongly stated that their children were less frequently subject to illness, and that less children were dying from measles.

Only in the SC area was health education being conducted as a means of promoting protective behaviors. Methods used included group discussions, use of flip charts, wall posters, and role plays/drama.

Awareness among the MOH staff regarding the EPI/MCH program, the need for training, and the need to identify problems was found to be higher in the SC impact area. Staff clearly indicated their desire to receive more training, particularly in aspects of target calculation, coverage assessment, and the preparation and use of reports. This shows that training has had a sustainable impact on the staff and helped them to understand the need to look further into programmatic issues and seek support.

During the visit of the Team, several issues related to the quality of service were noted. These issues, however, were common to both areas, SC supported and not supported

Certain cultural practices in the area prohibit children of one caste to receive any kind of injection until the age of two years when the child will undergo a specific ceremony. At the same time, it has become MOH policy to limit vaccinations to children under the age of one year. This situation obviously creates a serious health risk which has, so far, not been resolved.

In both areas, vaccines were adequate and within expiry dates ('95, '96), however, there was a general complaint of frequent shortages.

Cold Chain maintenance is very poor in most of the areas. The practice of collecting vaccines the evening prior to the session in vaccine carriers without thermometers, vaccination between 10am and 4pm, and the returning of left-over vials to DPHO after 4pm in the evening, seriously and adversely affects the principle of a cold chain.

In most areas, VHWs' knowledge about doses and vaccination technique was very good, however, some doses were affected by incorrect handling of syringes and their quality (worn out, no graduation).

Steam sterilization is the only technique applied. In both areas, UNICEF steam sterilizers and syringes were in use. Actual sterilization was witnessed in Golbazaar HP (SC supported), where a 5 minutes high and 15 minutes low heat technique was practiced. However, in one non-SC area visited, sterilization was carried in the home of the CHV and the VHW could not check the procedure as he could not enter the house for cultural reasons.

In both areas, sterile techniques were not adhered to (e.g. removing syringes from the sterilizer by hand, leaving sterilizer open throughout the vaccination session).

In neither area was a sufficiently effective system of disease surveillance (for the six immunizable diseases). The periphery (VHWs and CHVs) reported measles only on outbreak.

Because immunization sessions in the HP are carried out only on the 7th and 28th of every month, the HP-staff miss a good opportunity of carrying out an effective immunization program on a daily basis. This issue had previously been taken up with the DPHO by SC, however, with no obvious effect.

There is no system of defaulter tracing in either area.

A.1.2 Achievements

Objectives	Baseline Results	Final Results / Achievements
60% of children 12-23 months were completely immunized with BCG, DPT, Polio, Measles vaccines - KPC survey with card - VHW Register	10.5% -	22.9% 29.6%
50% of women 15-45 years had received at least 2 doses of TT. - KPC survey with card - VHW Register	17.6% -	27.7% 58.5%

A.1.3 Conclusion / Recommendations

The CS-VII project obviously had a significant positive impact in the project area as depicted in the above findings. As recommended by the Mid-Term Evaluation,

- project targets have been changed;
- TT and cards are offered at all Outreach Clinics and HP;
- Management Committees report to the HP;

However, certain issues related to practices and quality of services have not yet been resolved:

SC should work with the community to discuss and develop creative solutions to supplying vaccines to the project area until the MOH reinforces its EPI logistics system. Some committee members had expressed interest in working out a temporary community-based solution. While this is not a long-term sustainable solution, this service is critical due to measles outbreaks in the area, the high incidence of Vitamin A deficiency in the area, and the incidence of ARI.

If SC focuses on EPI as one of its activities, then additional training and support for HP staff, Management Committee members, VHWs and CHVs are needed to maintain the quality of services.

A.2. DIARRHEAL DISEASE MANAGEMENT

A.2.1 Discussion

The incidence of diarrheal disease in the project area is reported by HP- and SC- project staff as being very high due to a poor sanitation system and the lack of clean water.

During visits to outreach clinics and HPs, it became very obvious that staff undertook significant efforts to create an awareness about diarrheal diseases, their prevention and treatment. This demonstrates well the implementation of the recommendations made by the Mid-Term Evaluation.

All HPs and outreach clinics had ORT-corners established. Health education was carried out with the use of flip charts. Mothers were taught how to prepare and administer *Jeevan Jal* correctly. Emphasis was also given to the importance of adequate dietary and fluid intake during diarrheal episodes.

While interviewing mothers on the treatment of diarrhea and dehydration, all mothers knew *Jeevan Jal* and were able to describe the correct preparation. Likewise, health staff displayed good knowledge on the subject including the need for diagnostic stool test prior to medication. In the absence of sufficient laboratory facilities, staff was also able to differentiate between various other diarrheal diseases (e.g. giardia, ascariasis, amebiasis) using conventional diagnosis, and provide appropriate treatment.

As an improvement of the findings in the Mid-Term Evaluation, there was a good stock of ORS sachets in both. HP and outreach clinics, and families were encouraged to have at least 2 sachets in their home.

However, on one occasion, serious over-prescription of medication for diarrhea by a "village doctor" was witnessed, when an 8-months old child was brought to the HP at Nainpur in a semi-conscious state due to overdosage. Following emergency treatment, including intravenous infusion, the child gained consciousness and was referred to the hospital for further treatment.

A.2.2 Achievements

Objectives	Baseline Results	Final Results / Achievements
90% of mothers with children <2 years will have access to <i>Jeevan Jal</i> packets.	74.5%	87.6%
60% of families with children <2 years will know		
- how to prepare <i>Jeevan Jal</i>	11.9%	40.9%
- how to administer <i>Jeevan Jal</i>	3.0%	19.0%
25% of children <2 years with diarrhea will		
- be treated with <i>Jeevan Jal</i>	16.0%	50.0%
- receive more fluids	7.4%	6.4%
- (receive more or same fluids)	19.7%	41.0%
- receive more foods	6.2%	3.9%
- (receive more or same food)	17.8%	37.2%
- receive more breast-milk	7.4%	21.8%
- (receive more or same breast-milk)	19.7%	73.0%

A.2.3 Conclusion / Recommendations

This program component had one of the most noticeable positive impacts on the population in the project areas.

The Final K & P Survey shows a very significant change in the mothers' knowledge and practices regarding diarrheal disease and particularly in the use of ORT. This is supported by the Final *Jeevan Jal* Preparation Survey (Appendix 3 - Survey Results) which documented that 40.9% of households with a child below two years had a family member who demonstrated the correct preparation of *Jeevan Jal*. 87.6% of households reported that *Jeevan Jal* was available.

In the future, SC should utilize this positive momentum and continue to support the HPs and outreach clinics with training and strengthening *Jeevan Jal* training for CHVs and TBAs. *Jeevan Jal* campaigns should also be continued through NFE classes.

In an attempt to improve the underlying causes of diarrheal diseases in the area, contact should be made with other NGOs regarding the possibility of a drinking water program. SC should also continue its latrine promotion program to address the existing needs for better sanitation.

It is further recommended, to include "village doctors", traditional healers and local medical store keepers in the training for management of diarrheal control.

A.3. NUTRITION / VITAMIN A

A.3.1 Discussion

Following the Mid-Term Evaluation, the focus of nutrition was shifted to include:

- the promotion of adequate feeding practices during and after illness;
- the promotion of foods high in vitamin A content;
- support to MOH's Vitamin A Supplementation Program;
- an assessment of the impact of recent crop failures on the nutritional status of children.

A.3.1.a. Nutrition

The pre- and post-harvest studies showed chronic malnutrition in the project area, with a significant worsening of nutritional status as measured by MUAC from 22.1% (moderate) and 4.6% (severe) in the post-harvest period to 30% (moderate) and 66% (severe) in the pre-harvest period. Due to the limited time and resources, the project chose to prioritize other interventions, such as ARI, CDD, improved weaning practices, and health education. However, SC did reinforce growth monitoring and promotion services at the MCH clinics in accordance with MOH guidelines, and used private funds to provide therapeutic food (Sarbotum Pitho) to severely under-nourished children (totaling 362 children). Functioning growth monitoring and promotion activities were not observed in any of the non SC/US project areas.

The health education has resulted in a significant increase in the percentage of mothers giving appropriate foods, such as gruel in addition to breast milk, to children of 4-9 months. (Baseline 34.5%, Final K & P Survey 53.9%)

The practice of continued breastfeeding through 2 and even 3 years in the project area has remained very high. However, the practice of initiation of breastfeeding within the first eight hours of birth and exclusive breastfeeding through 4 months is quite low and complicated by cultural patterns and different beliefs by various castes and ethnic groups.

Growth monitoring activities were conducted (as per the MOH guidelines) during MCH clinics. The Evaluation Team observed several limitations of the current MOH efforts, e.g. scales were not properly adjusted prior to weighing, children were weighed in their clothes, marking and recording were not conducted properly in several instances, the Road to Health cards were discarded once they were filled out with medications, and information was not transferred from the old card to the new card, intervals between weights often exceeded four months, and that the majority of children brought by their parents for weighing were children over one year of age. The Team did not discern adequate promotional health education and counseling activities after monitoring.

A.3.1.b. Vitamin A

The K & P Survey's results of 55.2% of children of 12 - 23 months who received 2 doses of vitamin A, was considered by the Evaluation Team to be very good, particularly since dosing does not begin until 6 months of age and the mean age of children in the K & P Survey was 10 months of age.

Approximately 18 months before the end of the project, the MOH changed its protocol for vitamin A programs. Therefore, SC had to change its role from service delivery to working closely with HMG/N. SC was requested to support the new National Vitamin A Bi-yearly Campaigns, and complied with this request by promotional activities, training, supervision and by focusing on kitchen gardening. SC private funds were used to support kitchen gardening programs, which are necessary to support long-term reduction of Vitamin A deficiency.

SC assisted the MOH to conduct 3 campaigns, each achieving at least 90% coverage for children 6 - 60 months. After the change in policy, the project organized and conducted with HP-staff a one-day refresher training for 24 VHVs followed by one-day refresher training for 216 CHVs.

Timeliness of reports was considered to be excellent in the CS-VII area as compared to non CS-VII areas.

The project focus was solely on vitamin A deficiency prevention through capsule distribution; objectives and strategies to address treatment protocols for vitamin A deficiency were not in the original project design. Vitamin A deficiency is very prevalent in Siraha District, although it has been reduced over the years through capsule distribution. Children exhibiting symptoms of vitamin A deficiency were seen in the target population during the evaluation. HP and DPHO staff did not recognize deficiency symptoms, and were unaware of the use of Vitamin A for measles treatment.

A.3.2 Achievements

Objectives	Baseline Results	Final Results / Achievements
60% of children 12 - 23 months will have received at least two doses of vitamin A - <i>K&P Survey</i> - <i>Vit A Report (6-59 mos.)</i>	- -	55.2% 90.0%
A study of the impact of recent crop failures on household food availability, distribution of food within the household and nutritional status of children will be conducted.	post-harvest study conducted (02/94)	pre-harvest study conducted (08/94)

A.3.3 Conclusion / Recommendations

The Evaluation Team encourages SC to continue with these efforts and to document the effect of gardening on basic indicators such as MUAC, wt/ht, xerophthalmia, dietary recall, food intake, and intra-household food distribution patterns. A study conducted by CARE with the support of 'VITAL' would be an excellent reference tool.

SC should continue to promote specific educational messages about appropriate weaning practices between four and six months as a means to address chronic malnutrition.

The Evaluation Team recommends that the SC conduct focus groups discussions to better understand the nature of breastfeeding practices among various ethnic groups and how appropriate and life saving breastfeeding practices can be strengthened in this area.

The Team felt that growth monitoring practices should be improved and that an additional staff should be assigned to assist with counseling, allowing one worker to focus efforts on quality monitoring, and the other staff to use the growth monitoring session as a health education tool to promote breastfeeding, weaning, and referral for food supplementation. If this is not possible due to limited MOH resources, the Team recommends that growth monitoring be dropped in the MCH clinics to allow for more focused staff attention on some of the other services.

The Team recommends that the staff continues to support vitamin A capsule distribution and achieve even higher coverage levels through intensive support of HP efforts. Additional work is needed to establish an accurate denominator and to identify eligible children by age at all levels within the project area to prepare for future campaigns.

It is recommended that case treatment protocols for HP staff should be strengthened in future project efforts.

A.4. ANTE-NATAL / DELIVERY

A.4.1 Discussion

Ante-natal care, in general, has improved considerably since the baseline survey with 41.6% of pregnant women having ante-natal check-ups either with card or as per report, compared with only 9.6% at the beginning of the program.

Ante-natal care is provided at the outreach clinics and HP by ANMs. SC refurbished the delivery rooms at the HPs. The rooms are exclusively used for ante- and post-natal services, deliveries, and FP. All facilities visited in the SC supported area were clean, while those in non-supported areas were exceedingly unhygienic and used for dressings and any type of treatment. According to the ANMs, approximately 5-6 deliveries occur each month. Patients are checked for anemia, blood pressure and weight are recorded, the position of the fetus is determined. The Team also witnessed the active encouragement of TT coverage, and the provision of iron supplement for anemic patients.

Although the visited HP were clean (which constitutes an improvement since the Mid-Term Evaluation), there seems to be little continuity in services since essential equipment, i.e. the 'Kit Box' and fetoscope, were not present. This condition had, already, been pointed out during the Mid-Term Evaluation.

The number of ANMs in each HP had been reduced from 2 to 1. This poses a staffing problem in the HP, particularly during the 6-7 outreach clinics per month during which the ANM is not present at the HP.

A major problem encountered by the project is the referral of high-risk patients or complicated pregnancies. The only referral hospitals available are Siraha District Hospital, Lahan Hospital and Janakpur Hospital, of which only the latter has the capacity to deal with Cesarean sections. The distances to these hospitals (e.g. Janakpur two hours by car) result in transportation costs usually too high to be affordable for poor clients.

A.4.2 Achievements

Objectives	Baseline Results	Final Results / Achievements
30% of pregnant women will have an ante-natal check-up		
- K&P Survey with card	1.2%	20.6%
- K&P Survey by report	9.6%	41.6%
40% of mothers with children <2 years will know the '3 Cleans' for safe delivery.	-	51.3%

A.4.3 Conclusion / Recommendations

Although there is no baseline or mid-term information to be compared with, it is worth noting that, according to the Final Survey, 74.4% of deliveries were attended by TBAs and nearly half (48.0%) were attended by trained TBAs. Reasons for this could be (a) the increased number of TBAs trained under the project, (b) the encouragement given by VHWs to seek the services of the HP for ante-natal care and those of the TBAs for deliveries, and (c) the inclusion of health messages in the NFE.

The SC project had a referral fund which was available through the "Poorest of the Poor" Program. This program subsidized 50% of all drug costs and provided 100% of transportation costs. Approval for the utilization of this fund was made by the HP Committee. This funding system was discontinued in the second year of the program since it was found unsustainable. Since the general system of referrals and hospital care have not significantly improved, SC should explore the possibility of establishing a referral fund system through the HP Committee or women's groups.

A.5. ARI

A.5.1. Discussion

ARI activities were not planned until the second year off the project. SC has been promoting efforts to diagnose and treat ARI. This has been done through technical training for MOH staff, and the promotion of ARI messages through CHVs, TBAs and NFE classes.

The Team interviewed mothers, CHVs, VHWs, AHWs, and Health Assistants in both SC impact areas (Golbazaar and Pipra) and non-impact areas (Baryar Pati and Tenwanpati) by visiting HP, outreach clinics and homes.

A.5.1.a. Medical Aspects

In the SC areas, a considerable amount of effort has been put into disseminating ARI messages to mothers as was noted during interviews in Pipra and Golbazaar. Six out of eleven mothers knew that fast breathing and chest in-drawing are two main features of pneumonia. They knew that there was no home treatment for pneumonia and the child should be referred to the HP. This statement is supported by figures in Final K&P Survey where 91% mothers knew about fast breathing and 76% about chest in-drawing. Similarly, the CHVs that were interviewed had a very good knowledge about the ARI program.

In the non-SC area, knowledge of mothers was generally poor.

The dissemination of ARI messages is also part of the curriculum of NFE classes.

Although the knowledge regarding the ARI program is generally better than in the non-SC area, the actual *practice* of accurate diagnosis is limited. Neither the counting of respiration nor a check for chest in-drawing was observed in either area visited. This could result in children, suffering from pneumonia, not being properly diagnosed.

The OPD registers checked in both SC and non-SC areas show that treatment of ARI is not in accordance with WHO guidelines, e.g. inappropriate choice of first line antibiotics, prescription of two antibiotics simultaneously.

MOH staff complained of a general shortage of medicines, particularly antibiotics. Although SC is providing some important medicines (e.g. Cotrimoxazole) to the HP and outreach clinics on request, this supply is often not adequate resulting in children with severe pneumonia being sent home with no treatment except Paracetamol.

A.5.1.b. Training Aspects

SC has used many health education methods for the dissemination of health messages in their target areas, among them the most commonly used are messages through paintings drawn on the school and street walls, wall posters, street dramas, group discussions, demonstrations and more sophisticated ones such as the use of videos.

The Team was able to observe one street drama on ARI played by several boys. The main message was to tell people about the signs and symptoms of pneumonia and that the child with pneumonia should be immediately referred to the HP. The drama drew a large crowd of women and children. Drama was quoted by most mothers and committee members as one of the best means of promoting ARI messages. Wall posters showing a mother taking her child with pneumonia to the HP was noted in the OPD room, and verandah of the Golbazaar HP.

Several wall posters displayed in HPs and OR clinics (Golbazaar and Pipra), including SC wall posters on immunization for under ones, immunization for women of child bearing age, nutrition and pregnancy, the three cleans, family planning and ARI. Other posters developed by UNICEF and MOH had messages on the use of vitamin A and *Jeevan Jal*. Wall posters and wall paintings were also found during our trips to few villages.

A.5.2 Achievements

Objectives	Baseline Results	Final Results / Achievements
25% of mothers with children <2 years will - know the signs / symptoms of ARI - seek advice or treatment	- -	46.2% 84.0%
80% of mothers with children <2 years will know where (appropriate) treatment is available (MOH system)	-	65.1%

A.5.3 Conclusion / Recommendations

The Evaluation Team regards the above achievements as very good considering the short period during which this component had been implemented. However, it is felt that the program is currently not yet strong enough to sustain itself, mainly due to the absence of a uniform training standard, lack of supplies, and not yet established diagnosis and treatment protocols. The program would, therefore, benefit from the following recommendations:

There is a strong need to establish a system to assist with client flow both, at the HP and outreach clinics, in order to identify high-risk clients.

SC should continue to support the ARI program by supplying adequate amounts of appropriate antibiotics, and discuss with the Health Management Committee the possibility to utilize part of available funds for the purchase of essential drugs.

SC should continue to train the target population through CHVs, women's groups, street dramas, especially during MCH clinics, with emphasis on the principles of ambulatory care.

Clear protocols should be developed, together with the MOH, on the diagnosis and treatment of ARI. Careful monitoring and continuous on-the-spot technical assistance should be provided.

More educational material needs to be made available at all HP and ORCs.

SC should explore, together with the MOH, possibilities of training CHVs in the diagnosis and treatment of ARI, however, this would require extensive training and close supervision.

Training should be carried out for medical shopkeepers and "village doctors" (the former malaria workers), and traditional healers in ARI diagnosis and treatment. This is supported by the results of the Final K & P Survey which indicates that 37% of the interviewees use "village doctors", 27.3% traditional healers, and 17.6% medical shops. IE&C messages should also be displayed at pharmacies and village doctors.

A.6. FAMILY PLANNING

A.6.1 Discussion

Since the contraceptive prevalence level in Siraha is 14%, compared to the national level of 25%, there is an obvious need for more proactive FP interventions. However, FP is generally a rather sensitive issue in Nepal and to a large extent a question of attitudinal and cultural barriers, particularly the preference for male descendants. Therefore, eligible couples frequently wait until they have completed their family with at least one boy or, what they feel, a sufficient number of children.

During the visit to the ORC, the issue of FP was discussed with both, a group of men and women separately. Women were generally aware of the concept of FP and the various methods available (except Norplant), however, there seems to exist a considerable amount of 'myths' concerning possible side-effects (e.g. incapacitating back-pain, excessive bleeding, tiredness). Some women preferred condoms since they were deemed safer. Men also knew some methods of FP (condoms, pills, sterilization), however, none of the interviewees would consider vasectomy.

The Evaluation Team visited a SC supported and a non-supported clinic. However, the non-supported clinic was not functional, hence a comparison between the two clinics can not be made.

In October 1994, due to the high demand for female sterilization, SC supported the MOH in conducting a 'Sterilization Camp' during which 347 mini-laparotomies were performed.

On the visits to HP and outreach clinics, the Team encountered difficulties in discussing FP with HP-staff. There was a lack of awareness of the need for FP, limited education material of information was available. However, much more eagerness and interest was found among the CHVs.

The Team also visited various *medical stores*. At Golbazaar, the Team was refused permission to enter the stores. At Nainpur, some 50 vials of 'Depo- Provera' and 2 full boxes of syringes were found, however, the syringes did not match the vials. Packets of pills and condoms were found lying on the floor. There was no stock-keeping system. The only reason why the Team was granted permission to visit the store was the presence of MOH-staff on the team. The Team visiting the DPHO were shown only records and existing systems but no physical verification could take place.

During the visit to Nainpur HP, the team took due notice of the existing unsafe sterile practices. Six un-dismantled disposable syringes had been boiled and readied for re-use the same morning. According to information received at the HP, these six syringes / needles were then used throughout the day. There were no glass syringes available. The only boiling equipment available is an EPI pressure cooker since the project's sterilizer had been stolen shortly before the visit. This raises the question of how other clinic equipment is being sterilized. In view of the health risk, the Team immediately advised the HP-staff to discard the disposable syringes and use those from the store until more supplies arrive.

VHWs have been trained to give 'Depo-Provera', however, the Team did not have time to review 'Depo-Provera' activities listed in VHW rosters.

The team also witnessed a **lack of FP Counseling**.

A.6.2 Achievements

Objective	Baseline Results	Final Results / Achievements
20% of eligible couples use temporary or permanent contraceptive methods. - K&P Survey	10.7%	9.0%

A.6.3 Conclusion / Recommendations

With the exception of one sterilization camp, where 374 women were sterilized, there appears to be very little focus on FP within the CS-VII project.

Breastfeeding is common practice and encouraged by the project. It may be the main form of contraception which could contribute to the low response to the question of FP and the low achievement rate (A.6.2).

Both the objectives and the indicators need to be reviewed and revised to ensure that the objective can be measured by the indicator. The KPC Survey was not an appropriate tool to measure the objective, especially given that the mean age of the mothers interviewed was 25 years and 60% of the mothers had a child under one year of age. Either an additional survey should be conducted to measure the objective, or the indicator be changed.

Should the program be continued, it would benefit from the following recommendations:

Since FP is one of the weakest components of the CS-VII program, more emphasis needs to be placed on the training aspects both technical and counseling, existing training material needs to be revised, and linkages with NFE should be maintained and strengthened.

The project should identify a staff member, suitably experienced in FP, to coordinate the implementation.

A certified trained counselor should be employed as a trainer.

SC should investigate the FP-activities of other NGOs in Siraha District and explore possibilities of project coordination (e.g. Nepal Red Cross is implementing a 'Depo-Provera' Outreach Program in the area, GTZ is in the process of implementing a new program involving FP).

The program should work in close cooperation with Lahan Hospital to encourage regular VSC services and 'Norplant' implants.

Jointly with MOH, the project should develop an effective recording and reporting system.

Secure logistics would need to be established to guarantee a regular supply of material.

HP-staff needs to be trained in the diagnosis and treatment of STDs. This, in turn, requires good counseling skills.

Any future program needs to address also the male population.

A.7. NONFORMAL EDUCATION

A.7.1 Discussion

Throughout the evaluation, it was observed that the most knowledgeable on health and sanitation issues were the women attending NFE classes and NFE graduates. The NFE classes are a superb link between SC development programs and the CS-VII project activities. The classes not only improve female literacy but also raise the status of women, particularly through income generating activities. Literacy curricula include health issues, and this was distinctively observed with regard to the use and preparation of Jeevan Jal.

A.7.1.a Literacy

No test was done regarding literacy and math skills during the Mid-Term Evaluation. An achievement test on literacy was therefore administered to the 40 basic level NFE graduates (30 mothers + 6 CHVs + 4 TBAs) of the 17 VDCs. The test was comprising Reading (FM = 40), Writing (FM = 30), and Arithmetic (FM = 30). The overall score of the entire sample was 70.7 including a high rate of literacy retention.

Overall, the respondents' performance was found very satisfactory in reading, writing as well as in arithmetic, however, writing skills (average score 15.3%) are low in comparison to other literacy skills. It should also be noted that, unlike other NFE evaluation results, in general numeracy skills are better than reading (average score 26.5 %) and writing skills.

A.7.1.b. Focused Group Discussion

49 basic NFE graduates took part in the focus group discussion which was conducted in order to evaluate the impact of the NFE classes on the behavior of women including health.

Benefits of literacy - The most frequent answers were "own affairs can be better managed", "no need to fear in speaking in front of others", "able to teach children", "able to earn money", "able to care for family health" and "help in village development".

Qualitative analysis - The group placed high importance to education. Most of the participants expressed that NFE classes provided knowledge on health and cleanliness. They had learned to keep their homes and surroundings as well as cooking utensils clean, and observe personal hygiene principles. They reported using soap and ash to wash their hands after latrine use. However, five of the 49 group participants were still using soil to wash their hands after latrine use, and two still used sand. Only six participants out of 49 had latrines.

Some of the participants claimed that they had become more confident in their daily business, and most of the participants expressed that they did not feel uncomfortable any more to speak in front of others.

Also, most participants stated they consult the HP / hospital in case of health problems. CHVs were only contacted for the provision of vitamin A, ORT, immunization, and simple First Aid treatment.

A.7.1.c. On-Going NFE Classes

One advanced and four basic literacy classes were observed. Almost all participants were found highly motivated to become literate in order to improve their

standard of living. Generally, standard teaching techniques were used, however, the technique of questioning needs to be improved among some of the facilitators. One supervisor (in Chandra Ayodhyapur) did not understand the suggestions written by the NFE supervisor in the supervisors book. Lighting was insufficient in all 5 classes with only 4 lanterns provided for a class of 32. In some classes space was very limited.

A.7.1.d. Advanced Literacy (Women's Group)

This package includes integrated programs on health, environment, sanitation, group work, women's group formation, etc. The focus, however, is on child survival interventions. Three women's groups were visited.

All the groups had opened their bank accounts. Their funds consisted of their initial deposit plus monthly savings plus seed money provided from SC private funds.

The group were mainly involved in income-generating activities, such as kitchen gardening, nurseries, pig and goat farming, and these activities were found to be very encouraging. However, some individuals had lost some of their money due to drought and the lack of irrigation. Pig farming had failed among some of the scheduled castes. Muslim women, who had completed their advance literacy class, did not form women's groups but joined the Muslim school.

Leadership skills were found impressive among the women. All meetings were minuted and accounts kept up-to-date.

A.7.1.e. NFE through local NGOs / Clubs

Officials in four local NGOs were interviewed (Appendix 5 - Contacts). All expressed that they had been playing an important role in conducting NFE classes and income generating activities (IGA) in collaboration with SC. The activities are catering for the "poorest of the poor", and include kitchen gardening, goat and pig farming tree nurseries, bicycle repairs, carpentry tools, and the installation of tube-wells. The NGO officials expressed their desire to have training in IGA and accounting.

During a meeting, the LDO expressed his dissatisfaction over the lack of involvement in the program and the absence of information from SC. He was not aware of SC' health education activities and would prefer more feedback in order to incorporate the project activities in the district profile. He did, however, appreciate other SC activities outside the project, such as the construction of bridges and retention walls.

The DEO, likewise, had not received any written documentation on the project although he was aware of the educational activities. He criticized the lack of communication, particularly in view of the DEO's office also conducting NFE classes which include women's education, out-of-school programs, and adult literacy classes in eight VDCs.

A.7.2 *Achievements*

Objectives	Baseline Results	Final Results / Achievements
70% CHVs have basic literacy skills	29.6%	77.2%
20% of trained TBAs have basic literacy skills	1.7%	35.5%

A.7.3 Conclusion / Recommendations

NFE classes are an effective way to deliver messages, e.g. on health education, to the local community. The impact of the NFE program was seen not only in changes of knowledge, skills and attitudes, but also behavioral changes were distinctly observed in the project areas, e.g. all women attending NFE classes had enrolled their children in school, had established and were maintaining kitchen gardens, and were aware of health problems and appropriate preventive measures including vaccination.

However, these positive changes were less prominent in the utilization of latrines and issues of sanitation. The program should, therefore, encourage people to construct pit latrines and establish disposal pits.

Once literate, the graduates currently lack any facilities to practice their new skills, hence there is a danger of a gradual decline in literacy. SC should address the question of establishing community reading centers, and possibly contact "World Education", an organization that has designed post-literacy material. Alternatively, the establishment of regular and systematic refresher courses should be considered.

In support of women's income generating activities, banking knowledge and skills should be incorporated into the Basic Literacy Course.

The project should continue the positive process of utilizing and involving local NGOs / Clubs, and providing literacy training to CHVs for whom these skills are especially pertinent.

A.8. OTHER OBJECTIVES

A.8.1 Discussion

One of the objectives of the program was to strengthen the existing HIS of the MOH. This was to be done by checking VHW registers, and by improving the accuracy and timeliness of the reporting and recording system from CHV, VHW and HP, to the DPHO and SC.

Given the MOH commitment to establish a nationally standardized HIS, the CS-7 project followed the protocols of MOH. Earlier this year, the ministry had developed new Management Information System (M.I.S.) reporting formats. They are very similar to SC- formats, hence data transfer from the SC-format can be done easily. However, these new format do not incorporate a detailed breakdown of certain illnesses, such as anemia in pregnancy, nor do they differentiate between morbidity and mortality patterns in children under or over 5 years of age

Information was reportedly processed through the M.I.S. system to the DPHO Office and, by using the SC-formats, to the supporting SC Area Offices at Golbazaar and Dhangari. However, on checking the CHV registers, it was found that the old formats were still in use since the new formats had not yet been distributed. This resulted in CHVs encountering difficulties in maintaining their registers, and in reporting to VHWs. Since the Evaluation Team could not find any clear pattern on the actual reporting, this observation was discussed with the DPHO. It became apparent that no supervision of the CHV records by VHWs was possible, although no precise reason was given. When the Team inquired about the EPI-coverage rates, the HIS officer at the MOH office was unable to provide this information, since this "would require extensive calculations". This example demonstrates the lack of an efficient reporting system.

In order to evaluate the record-keeping by the VHWs, a simple random survey was carried out. The total survey size was 120 household. Only 60.8% of the registers were filled out properly, 29.2% were incomplete, and 10% were missing altogether. The DHO, DPHO, HP staff as well as village leaders stated that the supervision system for VHWs was problematic.

A.8.2 Achievements

Objective	Baseline Results	Final Results / Achievements
60% of VHW registers will be up-to-date	-	60.8%

A.8.3 Conclusion / Recommendation

With a standstill in governmental planning from 1991-1993, the introduction of systems such as the above was greatly delayed. However, once the new formats have been introduced to the community level, SC should help in the introduction and proper utilization by fully supporting the MOH initiative. Periodic lot quality assessments of VHW rosters could aid in identification of those VHWs requiring additional reinforcement.

B. Project Expenditure

B.1 Pipeline Analysis

Please refer to Appendix 1 for a breakdown of expenses by year and by budget line items specified in the Cooperative Agreement. Actual expenses are through September 30, 1994. Project staff expect that the majority of funds will be disbursed by the end of the project, December 30, 1994.

B.2 Budget Comparison Between DIP and Actual Expenditures (Appendix 1 - Finances/Staff List)

Budget categories of major line items were slightly modified during the life of the project to correspond to project developments throughout the three years. All modifications were in accordance with line item flexibility standards established by US A.I.D..

FIELD BUDGET

Line Item	DIP Budget	Revised Budget
Supplies	37,650	50,773
Consultants	28,823	28,823
<i>Subtotal Procurement</i>	66,473	79,601
Evaluation	10,500	11,669
<i>Subtotal Evaluation</i>	10500.00	11669.00
Salaries/Fringe	145,084	146,978
Travel	84,065	77,775
Other	35,750	25,650
<i>Subtotal Other Program Costs</i>	264,899	250,503
TOTAL	341,772	341,772

B.3 Proper Handling of Finances

Several control mechanisms were established to ensure proper handling of finances. Internal systems included an on-site accountant at the project site charged to the project, monthly checking of expenses by a Kathmandu based Finance Officer, periodic site visits from the Finance Officer, Stores Officer, and the Office Manager (Internal Auditor), and a system for external Save the Children audits (the most recent audit was conducted in September, 1994). Monthly finance statements were also checked at SC/Headquarters by the Operations Support Unit and the Finance Department.

Systems for finance management at the Siraha project office included submission of purchase request forms by project staff to the Project Manager for coding and secondly to the Program Manager (Ilaka-in-Charge) for authorization before being sent to the Stores Officer for purchasing and recording. Bills passed through the same system -- to the Project Manager for coding, Program Manager for authorization and to the Accountant for payment and recording. Monthly statements of expenses with receipts were sent to the Kathmandu Office for verification and consolidation of field and Kathmandu expenses. Consolidated reports were sent back to the field.

The Program Manager kept a separate system of accounts by activity, with reference to project line items. This enabled the Program Manager to more accurately budget for specific activities (surveys, training, etc.).

B.4 Lessons Learned Regarding Project Expenditures

Finance staff recommended that costs be built into the project for conducting training for accountant and program staff on US A.I.D. grant management and compliance issues in future projects

Life of grant reports from Headquarters which included the consolidation of all grant expenses by line item against the approved budget seldom reached the field level staff. These reports would have facilitated the budgeting process.

Given the total budget of USD 500,000 over a 39 months period, and using a direct beneficiary population of 16,865 children under 6 years of age, 24,046 women aged 15 - 49 years, and an average increase in births totaling 2,524, **the cost per beneficiary per year equals USD 3.54.**

C. Lessons Learned

The CS-VII Program has achieved an impressively **high level of community mobilization and participation**. The creation of Management Committees at HP and outreach clinic level has proved to be a **useful and appropriate strategy** to secure community participation and 'ownership' of health services. Both, clinic managers and committees are strong and motivated, and the identification of the communities' health priorities has enabled the program to address relevant issues appropriately.

The program has developed **very strong links between literacy training** (NFE-classes) **and an integrated community development program**, taking particular care to support women. This, again, is a very appropriate and successful development strategy, particularly in the area of health education. The attainment of a higher level of literacy has substantially improved the status of women, particularly through income generating / self-reliance activities

A **substantial improvement in health-related services** was noted. These improvements became obvious in the more frequent and wide-spread utilization of TBAs, a greater TT coverage, and impressive successes in better ARI diagnosis and treatment. The management of diarrheal diseases as well as utilization of and knowledge on ORS has risen significantly, and EPI coverage came close to target.

Although the project can record several remarkable successes and a significant positive impact on the population of the implementation area, the Team realized that some of the 'lessons learned' and recommendation of the Mid-Term Evaluation had not been taken on board. The Final Evaluation shows that the problem areas previously identified have not seen much improvement and that almost identical problems still persist.

1. Problems relating to the project implementation and follow-up

- a. The standard of care at governmental health facilities is relatively low. SC, on the other hand, saw the program's role primarily as preventive, which left many underlying problems linked to MOH unresolved, e.g. the quality of care at the HP. Although most commendable, it is not sufficient to refurbish parts of a HP to accommodate their use within the program while not addressing the more pressing needs of general care issues.
- b. As already pointed out in the Mid-Term Evaluation, a three-year time frame for such a complex program is far too short. It did neither provide sufficient room for adequate flexibility in the implementation of the program, nor did it have the possibility to fully accommodate unplanned events, a pre-requisite when working closely with Government authorities in Nepal. Three years is also too short to have a sustainable impact on any community and/or to bring about a significant change in knowledge, attitude and practices. What takes several years or even generations in industrialized countries can not possibly be achieved within three years in a developing country, particularly since it can take anything up to one year to mobilize communities, gain their trust and confidence, hire suitable staff and establish the necessary committees.

- c. In support of the above, the Team had the impression that the project was under a **significant time pressure to achieve the set targets**. This resulted in many time-consuming activities being done hastily and, sometimes, superficially, e.g. training of staff involved in the program. A more long-term strategy avoids this and allows for the proper time needed for the various activities.
- d. The program **should have had an on-going evaluation process**. Such process of continuous, on-going evaluation helps identify weaknesses at an early stage and usually in sufficient time to take corrective actions before the problem aggravates.
- e. As pointed out in the Mid-Term Evaluation, the program focused unnecessarily on the statistical achievement of targets. Although an important planning tool, care must be taken that reaching targets does not become the main concern of the staff.
- f. Phase-over strategies have varied according to the intervention. SC sought and obtained funds from USAID/Nepal to continue to support community based efforts in FP prior to the termination of this project to support long-term sustainable goals. SC began phase-over of literacy activities to indigenous NGOs during the life of the project and has plans to continue and follow-up these efforts. In addition, SC is committed to supporting the more successful community outreach activities (MCH clinics, revolving funds) with private funds. The immediate continuation and support of project efforts will enable SC to retain qualified staff and maintain community interest and demand, thereby creating the framework for a successful long-term phase-over of project activities.
- g. **More consideration must be given in future to financial realities when involving ministerial staff**. Unless a program has already been included in the Government's plans, an additional budget can not be allocated easily. The MOH has no financial resources to pay the same salaries as NGOs to MOH-staff in the field. It is, therefore, unrealistic to anticipate the same commitment and work of the HP-staff as can be expected from project staff.
- h. The Team noticed, that a **substantial amount of documentation has been produced over the past three years**. Many of these documents demonstrate similar or even identical problems with respective recommendations. The documentation is of high quality and could be extremely useful. An important lessons learned, therefore, should be that **consolidation is now needed**. The program should have sufficient flexibility to step back, look at what has been achieved, analyze what has remained a problem and why, determine its own strengths and limitations, and incorporate the results, findings and recommendations of the numerous documents in a **revised strategy for future planning**.

This would also fall in line with the need to **prioritize**. As already mentioned in the Mid-Term Evaluation, the program suffers from the same ailment as many similar programs in Nepal: The needs for improvement in Nepal are manifold. Therefore, many agencies, commendably, try their best and attempt to address a multitude of needs by very complex approaches, with the result that outputs usually fall short of expectations. A highly recommended **prioritization and a focus on three to four main components** is certainly more productive in the end. It would also enhance the program's public image since a "few things can be done better than many". It would create more reliability and the community might significantly increase its support, ultimately resulting in improved perception of ownership and commitment, i.e. long-term sustainability.

In order to gain a more realistic perspective of inputs vs. outputs, a **basic cost / benefit analysis should be done**, the results of which could aid in the above process of prioritization.

4. As already mentioned in the Mid-Term Evaluation, there is a definite need to review the **quality of training, training supervision, and training material**, particularly in the field of health education, MOH-staff, person-to-person teaching approaches. It will be beneficial for the program to establish a **core group of 'master trainers'**.

Lessons learned from evaluations and workshops should be disseminated to all relevant levels of staff to demonstrate that they are not only part of the implementation but also of a planning team. This positive attitude would certainly be reflected in the attitude of the communities.

2. Problems relating to the partnership with MOH

A significant and frequent change of MOH-staff was noted. Obviously this is beyond the control of SC, but care should be taken in future agreements of a similar kind with a Government authority to clearly spell out the conditions, requirements and the need for resource stability. The possibility of paying incentives or 'salary top-ups' could be one way for the partnership NGO to **gain more influence on the staff deployment practice of MOH** (see also above 1.h.) and avoid too drastic, too rapid and too frequent changes of key personnel. If MOH systems are found to have limited stability, a NGO strategy of strengthening the private sector to deliver services might be considered.

Future plans of the Government must be viewed **more realistically** and with less enthusiasm (see A.8. 'HIS'). The fact that a Government 'plans' to introduce a system does not necessarily reflect a realistic and viable time frame. It is unlikely that objectives can be achieved, if a large part of the program builds on the responsibility of a Government authority, particularly if the program is linked closely to the MOH system with all its problems and the known lack of resources. Furthermore, the **political scenario at any given time needs to be considered when planning any similar program**, and project planning 'in isolation' must be avoided. The transitional phase that followed the establishment of a popular movement in Nepal resulted in a two-year planning standstill, and it was only in 1992/1993 (Nepl. Cal.) that HMG/N formulated its 8th Plan with an overall development strategy for the country in all its sectors. It is, therefore, not surprising that several objectives of the program, relating to the MOH, could not be fully achieved, since the implementation period coincided with the above mentioned transitional phase.

The standard of care at governmental health facilities is, generally, poor. SC saw its role as purely preventive, so the underlying problems linked with MOH were left unresolved (e.g. HPs). While preventive health care must, certainly, remain one of the prime foci, prevention in itself will not entirely remedy the shortfalls of curative care in Nepal. Any program with the objective of bringing lasting and community-based solutions to health problems, should contain a **sufficiently balanced approach between preventive and curative medicine**.

3. Problems relating to staff

- a. Similar to MOH, there has been a **high turnover of program staff**. While the changing of staff is not necessarily something negative, care must be taken to safeguard continuity and to avoid the program becoming endangered by too frequent changes. **More stability in staffing patterns** is needed and, possibly, an improved system of recruitment, contractual terms, and regular evaluation could bring about this stability.
- b. As already mentioned in the Mid-Term Evaluation, **staff performance** could be improved through a **system of regular assessment and evaluation**, with corrective action if and when required. Likewise, an incentive or reward scheme would lift the performance level of staff with outstanding performance. Staff evaluation is also highly recommended to determine the suitability of personnel currently employed. .
- c. As already mentioned in the Mid-Term Evaluation, there remains a tremendous **need for improved supervision** on all levels of the health care delivery system. However, while the Mid-Term Evaluation brought this issue to a more generalized level of discussion, the Team of the Final Evaluation would like to see concise measures to be taken to establish closer supervision and follow-up of project staff both, nongovernmental and governmental.

V. PROJECT SUSTAINABILITY

A. Community Participation

A.1 Identification of Community Leaders and Members Interviewed

Please refer to Appendix 11 for a list of HP Management Committee, MCH ORC Management Committee, Women's Group, and Literacy Group leaders and members that were interviewed (information pertaining to the VHVs and CHVs will be found in the next section pertaining to counterpart institution participation).

A.2 Community Perception of Most Effective Project Child Survival Activities

All project interventions and activities (MCH clinics, EPI, ARI, Maternal Care and CDD) were mentioned by one group or another as being effective and important. All groups mentioned the importance of the MCH Outreach Clinics and MCH Clinics conducted at the HP that provided a comprehensive package of services (EPI, GM/P, Ante-natal and Post-natal Care, FP, Oral Rehydration Corner, Health Education, and Curative Services) for women and children. These comprehensive clinics, although part of the MOH strategy, had not occurred previously in the project area. The clinics provided a forum for women and men to discuss health knowledge and practices together, as well as a key entry and linkage point for contact with MOH services. It was the first occasion for some groups, such as the *musahaar*, to have access to MOH services. Demand for these services was high, and clinics visited by the evaluation team were very well attended. The high demand for these services could be seen at MCH clinic held at the Golbazaar HP where women from other districts outside of the project area also attended.

Project activities related to CDD were also mentioned as extremely important. Cultural beliefs had predicated treatment for diarrhea through holding of all fluids and foods, often resulting in death of children due to diarrhea. Unfortunately the incidence of diarrhea remains very high in the project area due to lack of safe water and sanitation systems. Attendance at the Oral Rehydration Corners observed by the team was high.

A.3 PVO Efforts to Enable Communities to Meet Health Needs / Sustain Activities

The project used four different strategies to mobilize communities to meet their health needs and to sustain activities in the future:

- * strengthening of HP Management Committees
- * establishing and supporting Outreach MCH Clinic Management Committees
- * establishing and supporting community managed revolving funds
- * increasing literacy of women through basic, advanced and business literacy classes.

A.4 Community Participation in Design, Implementation and Evaluation of Child Survival Activities

HP Management Committees are part of the Government's National Plan. SC's innovation in the project was to work with the HP Management Committees to further decentralize health management to the VDC level by creating and supporting Outreach MCH Clinic Management Committees. Members of these selected MCH outreach sites in

the most central locations, attended and organized the MCH/EPI clinics and supported MOH efforts to delivery services and provide health education. In addition they managed revolving funds, made local decisions on how best to work with poorest families, and supported VHW and CHV activities. SC conducted periodic feedback meetings to discuss project activities, achievements, problems and possible solutions with them, and MOH representatives. SC also conducted quarterly coordination meetings between HP and ORC Management Committees.

A.5 Number of Functioning Health Committees; Representation of Community

The 2 HP Management Committees were selected by the community based on MOH guidelines. This all male group, with the exception of one CHV, represented the community on the basis of equity between political parties. The evaluation team found that only one committee was very active. In non-CS-VII areas, the HP In-Charge stated that, while this committee existed, none of the members were available for interviews. Thirteen MCH Outreach Management Committees were established by the project during the past year and a half; ten of them remain active. Standards for activity were committee member regular participation in clinics, updated records, updated bank account records, and monthly meeting attendance. The committee is made up of a representative of each ward, one SC representative, one HP-staff, and the one female member, the CHV. These committees did not exist in the non-CS-VII area.

Committee meetings and clinics held during the past six months were as follows:

Type of Activity	# Scheduled	# Conducted
ORC Management Committee Meetings	78	51
HP Management Committee Meetings	12	9
DPHO Meetings	2	2
Outreach MCH Clinic	24	22
HP MCH Clinic	78	76

A.6 Significant Issues Addressed by Health Committees

The committee members are responsible for organizing and setting up the clinic site, assisting with clinic registration and fee collection, assisting the VHW and HP-staff in any clinic activity, deciding how to assist poorest community women and children receive necessary medical care, and managing the funds collected to better meet community health needs.

A.7 Methods Used by Committees, Precise Role in Providing Project Direction

Each Committee has established their own guidelines. The Outreach Committee has been very successful in serving as a linking point between community members and the MOH system. They are supportive of the VHW, advocate for increased and more quality services to the HP staff, and seek additional technical and managerial training from SC staff.

A.8 Resources Contributed by Community

SC has created an excellent community base of support. Community members through participation in HP Management Committees, ORC Management Committees, women's groups, literacy groups, farmers groups and the community health network of CHVs and TBAs have contributed substantial inputs of time to project activities. Knowledge and skills gained will continue after the project ends. A base for revenue collection has been created throughout both ilakas. (Please, refer to Section V.D. Cost Recovery Efforts for specific details.)

A.9 Reasons for Success or Failure of Committees to Contribute Resources

Community participation has been very successful because community mobilization and concomitant responsibility and ownership of activities were successfully started from the beginning of the project. Lack of cash resources and general poverty were the most often cited reasons for not increasing cost recovery efforts further.

B. Ability / Willingness of Counterpart Institution to Sustain Activities

B.1 Identification of Persons Interviewed

Please, refer to appendix 5 for a list of persons interviewed including the DHO, DPHO, CDO, LDO, EDO, Ilaka 4 & 5 HP staff including VHWs, CHVs interviewed from ilaka 4 & 5, and local NGOs.

B.2 Linkages Between Project and Activities of Key Health Development Agencies

The project is closely linked with the MOH system as follows:

- * through bimonthly support of MOH MCH-clinics with HP-staff;
- * through periodic training of MOH staff including VHWs, TBAs, and CHVs;
- * through support of district vitamin A campaigns;
- * through quarterly meetings and updates with the DHO, DPHO, and CDO;
- * through periodic coordination meetings with the LDO and EDO;
- * through periodic review meetings with the MOH at national level.

B.3 Key Local Institutions Involved in Project Sustainability

The project depends on a functioning MOH system including the HP-staff, VHWs, TBAs and CHVs for health service delivery. Local NGOs are being funded and strengthened to continue literacy and non-formal educational activities.

B.4 MOH Perception of Effective Child Survival Activities

All staff interviewed stated that the literacy classes for women were an excellent means to mobilize the community and to influence positive health behavioral practices. The other significant achievement cited was the decrease in deaths caused by diarrheal dehydration due to widespread use of *Jeevan Jal*.

B.5 NGO Efforts to Strengthen Skills of MOH Personnel

Regular training was conducted by the project for MOH and SC-staff. Additional training in EPI / ARI / Cost Management was often cited as a need by the MOH-staff and HP/ORC Community Management Members. (Appendix 11 - List of Training)

B.6 Current Ability of MOH to Provide Necessary Resources to Sustain Project Activities

Based on observations described in various project report sections and given the current changes within Nepal, the MOH does not appear to have the required capability to sustain the preventive components of the project. However, TBAs and CHVs are part of the MOH system and should continue to mobilize the community to seek services and to continue to provide sound advice about diarrhea management, prenatal care, and delivery.

B.7 Counterpart Perception of Effective Project Activities

The CDO was very enthusiastic about the cost recovery efforts begun by the project and had heard no complaints from community members. He felt these practices could be extended to other areas in the district. All persons interviewed were very supportive of the outreach efforts (getting services to those who have traditionally been overlooked) including the literacy classes.

B.8 Phase-Over of Project Responsibilities and Control

The literacy methodology has been taught to local NGOs who have begun to conduct classes. HP and ORC Management Committees have displayed a good sense of ownership in the project and willingness to continue activities. They will require additional reinforcement from SC throughout the next few years before activities can be totally phased over to them. Additional reinforcement of MOH services, especially with regard to updated EPI, ARI, and FP training, will be required as well as support to the popular MCH-clinics.

B.9 Financial Commitment of Counterpart Institution to Sustain Project Benefits

No financial commitments were made. However, according to the DIP, the DPHO at that time had expressed a willingness to provide manpower and material support, when and where available, given the limited resources available to him.

B.10 Success or Failure of Counterpart Institutions to Keep Financial Commitment

Manpower and material support were provided to the project. However, given the frequent changes in the Nepali Government during the project period and the concurrent shifts in the MOH structure as well as frequent changes in key staffing positions, support was inconsistent.

B.11 In-Country Agency Participation in Design, Implementation, or Analysis of the Mid-Term Evaluation and Final Evaluation

USAID/Nepal participated in the implementation of an analysis of project findings in both the Mid-Term and Final Evaluation.

The MOH participated in all stages of both the Mid-Term and Final Evaluation.

The MoE participated in all stages of the Final Evaluation

The DHO, CDO, VDC, and members of community committees attended a feedback session following the KPC final evaluation survey to analyze findings and recommend future actions.

C. Attempts to Increase Efficiency

C.1 Strategies to Reduce Costs, and Increase Productivity and Efficiency

The Program Manager's separate accounting records by project activity was the only mechanism available for increasing project efficiency. This tool enabled the staff to compare costs of similar activities across ilakas and by time periods.

C.2 Reasons for Success/Failure of Attempts to Increase Efficiency

Accounting systems were set up to monitor the project by the project agreement line items, rather than by other systems, such as administrative versus program delivery costs, or costs by program activities.

C.3 Lessons Learned Regarding Efficiency

Monitoring of program expenses would be easier and more efficient if expense categories were divided between administrative costs and program delivery costs, rather than grouping expenses under categorical line items of supplies, equipment, etc. This would enable staff to systematically look at administrative costs per services delivered, and make necessary adjustments to maximize direct program delivery costs. It is recommended that the field office adjust accounting systems in future grants to better enable project staff to address project efficiency.

D. Cost Recovery Mechanisms

D.1 Specific Cost Recovery Mechanisms Implemented by Project

Several cost recovery schemes were attempted throughout the life of the project which are briefly described in this section. The evaluation team was unable to examine any of the funds in detail. Several community members and SC staff have expressed the desire to conduct a more formal study and internal audit of each of the funds to extract lessons learned for future sustainability. The project team supports and encourages that this be carried out during 1995.

a. HEALTH POST REFERRAL FUND

At the beginning of the project, SC used match funds to initiate a referral, transport and drug fund for emergency cases to be taken to the Lahan Hospital. The HP Management Committee would approve the individual case based on established guidelines and refer the patient to the SC Office for payment. This system proved to be very labor intensive for SC staff, and was subject to unnecessary referrals, and a higher than average request for costly pharmaceuticals. The Management Committee did not feel ownership of this scheme and did not raise any additional funds to supplement the service. This fund was dissolved during the first year of the project, and new schemes were developed.

b. EMERGENCY REFERRAL REVOLVING FUNDS

SC worked with the HP Management Committee of Ilaka 4 and Ilaka 5 to develop joint revolving fund schemes. Each ilaka chose a different strategy.

Golbazaar: Ilaka 4. Using match funds, SC made three disbursements to the HP Management Committee totaling NRs 25,000 after a set of new guidelines were developed on prioritization and use of these funds for referral and pharmaceuticals for children and pregnant women. The Management Committee was unable to revolve the funds because they felt that families were too poor to be able to repay the cost of transport, services and treatment. SC also felt that the poorest members of the community, those living the furthest from the HP, were unable to utilize the service because they could never get to the HP in emergency situations. Spot client checks were conducted and while it was found that funds were properly spent, the program was discontinued in Year 2 since it was found to be unsustainable.

Dangodh: Ilaka 5. This HP Management Committee decided to divide SC match funds totaling NRs 25,000 between each of the 7 ORC Management Committees based on population size. SC staff provided training and orientation to each of the ORC Management teams on fund management. Funds were deposited into a bank account. Staff stated that these funds have not yet been used by any of the ORC committees.

c. DRUG REVOLVING FUNDS

Due to a high incidence of snake bites and kala-azar cases, and the high cost of treatment for both illnesses and unavailability of the necessary drugs, both HP Management Committees requested assistance to establish drug revolving schemes for anti-snake venom and sodium antimony.

Anti-Snake Venom. SC purchased 25 vials of anti-snake venom for each HP to be managed through the HP Management Committee. Anti-snake venom is sold at cost (NRs 240/vial) to the client and payment is made through cash or through labor if the person is poor to the Management Committee. The fund is working and 100% of costs have been recovered.

Sodium Antimony. SC purchased 300 vials of sodium antimony for each HP. The kala-azar treatment is sold at 50% cost (NRs 60 out of a total cost of NRs 120). Once again, the committee decides on alternative payment methods if the family is unable to meet this cost. Spot checks have shown that the fund is revolving.

d. MCH OUTREACH and HEALTH POST CLINIC FUNDS

Each committee has responsibility to set its own policies for charging fees to attend the MCH clinic. Fees ranged from NRs 2/ each MCH-Clinic attended to an annual fee of NRs 10/pregnancy and NRs 10/child under five years. The registration fee entitled the woman or child to all services offered including pharmaceuticals/drugs for ARI, worms, anemia, and diarrheal caused dehydration. It is the committee's responsibility to decide what to do if a person cannot pay. Each of the Management Committees (2 HP Committees, 8 ORC committees in Ilaka 5 and 6 ORC committees in Ilaka 4) had established bank accounts and accounting procedures.

e. NFE GROUP FUNDS

Each NFE group participant is charged a NRs 5 registration fee, a monthly fee of NRs 1 and a total book charge of NRs 3/class (Basic Class, Advanced Class and Business Class). This money is deposited into a separate bank account for each of the women's groups to be used by them for income generation activities or revolving credit funds upon graduation.

f. JEEVAN JAL REVOLVING FUND

102 volunteer community-based sellers of *Jeevan Jal* purchased ORS packets wholesale from SC. They sell these packets to the community at retail, enabling them to make profits to purchase additional supplies.

D.2 Estimated Amount of Costs Recovered

In ilaka 5, the 8 ORC Management Committees have collected a total of NRs 15,872 over a one year period, ranging from NRs 1,197 to NRs 4,005 per committee. The HP charges NRs. 2 per client, however, the Team was not in a position to verify total amounts collected throughout the year.

In ilaka 4, the 6 ORC Management Committees have collected a total of NRs 11,453 over a one year period, ranging from NRs 969 to NRs 2,727 per committee. The HP Management Committee had collected a total of NRs 45,000 from MCH registration fees, police cases, deliveries, and *Aidhyde*-tests.

The Evaluation Team did not have time to investigate other account funds. Nepal has recently endorsed the Bamako Initiative, and is exploring cost recovery schemes for health services after a long period of providing free health benefits. The lessons learned regarding cost recovery in the project area are significant as examples of how much money people are willing to pay for health services. In many instances, the Evaluation Team discovered very poor families willing to pay high costs to spiritual healers, village doctors and pharmacists for poor quality services. If confidence in the health system can be established and high quality of services provided, there is potential for recovery of costs. These activities should be continued in future project activities with documentation of efforts (human resource and financial investments) with corresponding outcome of these efforts, including studies on the management and use of these funds.

D.3 Effects of Cost Recovery on Equity of Services and PVO Reputation

The CDO, DHO and DPHO were all interested in the efforts of the project to initiate cost recovery schemes and supported the cost recovery initiative. Officials said they had received no complaints about the charges. The evaluation team also heard no complaints from any community member interviewed. A possible inequity in services to the very poor was addressed because each Management Committee had the authority and responsibility to address individual cases and provide local solutions to local problems. Community leaders stated that since these schemes were developed they have increased their awareness of poverty in various caste and ethnic groups far removed from the service centers, and are attempting to improve services for all.

D.4 Reasons for Success/Failure of Cost Recovery Efforts

The project has demonstrated that some cost recovery for services is possible. The amount collected is not enough to ever pay for the full cost of services provided, but does provide some opportunity for purchase of drugs, supplies, and emergency transport and referral services. SC has supported MCH Outreach clinics by payment of per diem costs to government staff. Revenues collected would not offset these costs. SC plans to continue these efforts after the project with private funds, and to continue to explore methods for sustainable cost recovery systems.

The project team cannot evaluate if the schemes are successful in the long-term because they have been initiated only within the past year. It is recommended that SC document these efforts, focusing on attitudes about cost recovery through focus group discussions and management of funds, during 1995 and again in three years.

D.5 Lessons Learned Regarding Cost Recovery

SC should continue cost recovery efforts in the new project area and should coordinate efforts with other international and local PVOs in the area to ensure that one group does not undermine the other by providing free services while another charges basic costs. The establishment of MCH Outreach Management Committees and their corresponding authority and responsibility for charging and managing finances is an innovation of the CS-7 project area. SC should further refine the system and then work with the DHO and DPHO to see if this system can be attempted on a trial basis throughout the district.

New projects implementing cost recovery schemes should not underestimate the project staff needs to provide institutional development and management training and on-site supervision to newly formed groups. The investment in appropriate staff during the project should lead to a greater potential for long-term sustainability and safeguards to ensure proper management of funds once the donor leaves.

E. Household Income Generation

E.1 Household Income Generating Activities

Household income generating activities were not carried out under the CS-7 project. However, through other funding sources, SC implemented complementary activities in the project area in sustainable agriculture and economic opportunities (focused primarily on women participants). According to staff and community members, these activities have been popular and have been vehicles for some health education activities. The final K & P Survey showed an increase in income generation activities by women with children under two years of age from 10.5% baseline to 38.2% in the final K & P Survey. The project strategy is that women who have completed basic literacy classes, advanced literacy classes and business classes will then be supported to engage in income generation activities. Only recently has the first class of graduates established themselves as a women's income generation group.

E.2 Estimated Income Added to a Family or Household's Annual Income:
(not applicable)

E.3 Contribution of Additional Revenues to Meeting Health Costs:
(not applicable)

E.4 Lessons Learned Regarding Household Income Generation:
(not applicable)

COOPERATIVE AGREEMENT PDC-0500-G-00-1077

CHILD SURVIVAL VII SUMMARY

30-Nov-94

BUDGET VS. ACTUALS FOR YEAR 3 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT

	<u>YEAR 3: EXPENSES VS. PLANNED BUDGET *</u>							<u>LIFE OF GRANT CUMULATIVE EXPENSES VS. TOTAL GRANT</u>			
	EXPENSES YEAR 1	EXPENSES YEAR 2	EXPENSES 09/30/94	PLANNED BUDGET	BALANCE	% SP'NT	BUDGET YEAR 4	CUMULATIVE ACTUALS	TOTAL GRANT	BALANCE	% SP'NT
Headquarters											
Salaries	8,540.79	12,046.88	12,408.33	13,216.00	807.67	93.9%	5,283.33	32,906.00	39,087.00	6,091.00	84.4%
Fringe	1,281.12	2,908.09	3,954.93	4,938.00	983.07	80.1%	1,033.89	8,145.04	10,162.00	2,016.96	80.2%
Travel	996.27	4,911.43	5,712.01	10,408.00	4,783.00	54.4%	0,575.30	11,619.71	25,970.00	14,350.29	44.7%
Other Direct Costs	50.55	383.86	2,509.98	2,750.00	240.02	91.3%	1,755.59	2,944.39	4,940.00	1,995.61	59.6%
Subtotal Headquarters:	10,868.73	20,251.16	24,585.25	31,400.00	6,814.75	78.3%	17,648.11	55,705.14	80,168.00	24,462.86	60.5%
Nepal											
Total Direc' Costs:	99,436.04	107,462.28	141,878.57	148,603.32	6,814.75	95.4%	66,348.36	348,776.80	421,940.00	73,163.11	82.7%
Indirect Costs	18,395.66	19,838.95	26,239.69	39,825.39	13,585.70	65.9%	0.00	64,474.30	78,060.00	13,585.70	82.6%
TOTAL COSTS	117,831.70	127,301.23	168,118.26	188,518.71	20,400.45	89.2%	66,348.36	413,251.19	500,000.00	86,748.81	82.7%

* Final Field Office, Home Office and Overhead through 09/30/94
 ** Budget per DIP
 *** Supplies are individually under \$500 per item.

Year 1 = August 27, 1991 - September 30, 1992
 Year 2 = October 1, 1992 - September 30, 1993
 Year 3 = October 1, 1993 - September 30, 1994
 Year 4 = October 1, 1994 - December 30, 1994

NO-COST EXTENSION THROUGH 12/30/94 APPROVED - MODIFICATION NO. 03

COOPERATIVE AGREEMENT PDC-0500-G-00-1077

CHILD SURVIVAL VII: NEPAL

30-Nov-94

BUDGET VS. ACTUALS FOR YEAR 3 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT *

Procurement	YEAR 3: EXPENSES VS. PLANNED BUDGET *							LIFE OF GRANT CUMULATIVE EXPENSES VS. TOTAL GRANT			
	YEAR 1 EXPENSES	YEAR 2 EXPENSES	EXPENSES 09/30/94	PLANNED BUDGET**	BALANCE	% SPENT	BUDGET YEAR 4	CUMULATIVE ACTUALS	TOTAL GRANT	BALANCE	% SPENT
Supplies***	11,444.55	10,672.15	20,161.02	20,161.02	0.00	100.0%	2,500.00	48,277.72	50,777.72	2,500.00	95.1%
Consultants	9,552.89	7,179.50	8,452.87	8,452.87	0.00	100.0%	3,637.74	25,185.26	28,823.00	3,637.74	87.4%
Sub-Total	20,997.44	17,851.65	34,613.89	34,613.89	0.00	100.0%	6,137.74	73,462.98	79,600.72	6,137.74	92.3%
Evaluation	713.19	6,303.35	152.03	152.03	(0.00)	100.0%	4,500.00	7,168.57	11,688.57	4,500.00	61.4%
Other Program Costs											
Salaries	33,285.31	34,472.81	37,410.91	37,410.91	0.00	100.0%	9,562.98	105,169.03	114,732.01	9,562.98	91.7%
Fringe	8,915.36	11,519.74	8,311.97	8,311.97	0.00	100.0%	3,599.08	28,747.07	32,346.15	3,599.08	88.9%
Travel	19,812.73	10,612.83	27,105.96	27,105.96	0.00	100.0%	20,243.03	57,531.52	77,774.55	20,243.03	74.0%
Other	4,843.28	6,450.74	9,608.56	9,608.56	0.00	100.0%	4,657.42	20,992.58	25,650.00	4,657.42	81.8%
Sub-Total	66,856.68	63,056.12	82,527.40	82,527.40	0.00	100.0%	38,062.51	212,440.20	250,502.71	38,062.51	84.8%
TOTAL	88,567.31	87,211.12	117,293.32	117,293.32	0.00	100.0%	48,700.25	293,071.75	341,772.00	48,700.25	85.8%

* Final Field Office, Home Office and Overhead through : 09/30/94

** Budget per DIP

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

Year 1 = August 27, 1991 - September 30, 1992

Year 2 = October 1, 1992 - September 30, 1993

Year 3 = October 1, 1993 - September 30, 1994

Year 4 = October 1, 1994 - December 30, 1994

NO-COST EXTENSION THROUGH 12/30/94 APPROVED - MODIFICATION NO. 03

CS-VII STAFF LIST

#	Name of Member	Designation	Sector	CS-VII % from grant
<u>Kathmandu Staff</u>				
1	Sunder Gopal Mulepati	Research Officer	KTM Field Office	25%
2	Min Dhoj Karki	IEC Officer	Health	50%
3	Ang Pasang Sherpa	Cook	KTM F.O.	
4	Sita Bista Mahat	Comp.Info.Officer	KTM F.O.	
5	B.M.- Devkota	Program Director	KTM F.O.	
6	Chanda Rai	Asst. P.D. & PHC	Health	
7	Udaya Manandhar	Asst P.D. & Education Officer	Education	
<u>Siraha Staff</u> District Office				
1	Krishna B.B.K.	Accountant	Multisector	100%
<u>Siraha Staff</u> Ilaka #4				
2	Khil Nant Niraula	NFE Coordinator	Education	100%
3	Chola Kant Sharma	IEC Supervisor	Health	100%
4	Dhana Malla	Project Coodinator	Health	100%
5	Janaki Shrestha	Staff Nurse	Health	100%
6	Krishna Lamsal	Staff Nurse	Health	100%
7	Lekh Hari Dahal	Staff Nurse	Health	100%
8	Ram Dayal Shah	HIS Supervisor	Health	100%
9	Renu Rai	ANM	Health	100%
<u>Siraha Staff</u> Ilaka #5				
10	Gopal Pd. Tamang	Field Coordinator	Multisector	100%
11	Rajesh Limbu	Staff Nurse	Health	100%
12	Ishwor Khattri	Dep'y F.C.	Education	50%
13	Bhusan K. Chaudhary	Staff Nurse	Health	100%
14	Ram Asish Roy	ANM	Health	100%
15	Beenita Adhikari	MCHW	Health	100%
16	Anita Chaudhary	MCHW	Health	100%
17	Bela Ghising	MCHW	Health	100%
18	Kalyami Shah	MCHW	Health	100%

PVO: Save The Children (USA)

COUNTRY: Nepal

FUNDING YEAR: Oct '91 - Dec '94

New or Expansion Project:

New

Baseline or Final Survey:

Final

#	INDICATOR (submit results only for indicators that reflect project interventions)	RESULTS Numerator (N) Denominator (D) Percent (P)
1	<u>NUT: Initiation of Breastfeeding</u> - Percent of infants/children (less than 24 months) who were breast-fed within the first eight hours after birth	N= _____ P= _____ D= _____
2	<u>NUT: Exclusive Breastfeeding</u> - Percent of infants under four months, who are being given only breast milk	N= _____ P= _____ D= _____
3	<u>NUT: Introduction of Foods</u> - Percent of infants between five and nine months, who are being given solid or semi-solid foods	N= _____ P= _____ D= _____
4	<u>NUT: Persistence of Breastfeeding</u> - Percent of children between 20 and 24 months, who are still breastfeeding (and being given sold semi-solid foods)	N= _____ P= _____ D= _____
5	<u>CDD: Continued Breastfeeding</u> - Percent of infants/children with diarrhea in the past two weeks who were given the same amount or more breast-milk	N= 57 P= 73.1% D= 78
6	<u>CDD: Continued Fluids</u> - Percent of infant/children (less than 24 months) with diarrhea in the past two weeks, who were given the same amount or more fluids other than breastmilk	N= 32 P= 41.0% D= 78
7	<u>CDD: Continued Foods</u> - Percent of infants/children (less than 24 months) with diarrhea in the past two weeks, who were given the same amount or more food	N= 29 P= 37.2% D= 78
8	<u>CDD: ORT Usage</u> - Percent of infants/children (less than 24 months) with diarrhea in the past two weeks, who were treated with ORT	N= 31 P= 50.0% D= 78
9	<u>Pneumonia Control: Medical Treatment</u> - Percent of mothers who sought medical treatment for infant child (less than 24 months) with cough and rapid, difficult breathing in the past two weeks	N= 42 P= 84.0% D= 50
10	<u>EPI: Access</u> - Percent of children 12 to 23 months who received DPT1	N= 47 P= 49.0% D= 96
11	<u>EPI: Coverage</u> - Percent of children 12 to 23 months, who received OPV3	N= 28 P= 29.2% D= 96
12	<u>EPI: Measles Coverage</u> - Percent of children 12 to 23 months, who received measles vaccine	N= 27 P= 28.1% D= 96
13	<u>EPI: Drop Out Rate</u> - Percentage change between DPT1 and DPT3 [(DPT1-DPT3)-DPT1] for children 12 to 23 months	N= 17 P= 36.2% D= 47
14	<u>MC: Maternal Card</u> - Percent of mothers with a maternal card	N= 49 P= 20.6% D= 238
15	<u>MC: Tetanus Toxoid Coverage (Card)</u> - Percent of mothers, who received two doses of tetanus toxoid vaccine (card)	N= 66 P= 27.7% D= 238
16	<u>MC: Ante-Natal Visits (Card)</u> - Percent of mothers, who had at least one ante-natal visit prior to the birth of the child (card).	N= 49 P= 20.6% D= 238
17	<u>MC: Modern Contraceptive Usage</u> - Percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method	N= 18 P= 9.0% D= 201

**SAVE THE CHILDREN / US
CHILD SURVIVAL VII
SUMMARY OF JEEVAN JAL PREPARATION FINAL SURVEY FINDINGS
NOVEMBER 1994**

The Save the Children / US Child Survival VII project aims to reduce infant and child morbidity and mortality due to diarrheal diseases through improved access to MOH health services and improved knowledge and practices regarding the management of diarrhea at the household level. Appropriate management of diarrhea in the household depends on knowledge of the preparation and administration of Jeevan Jal (JJ), the Nepali oral rehydration solution. Therefore, the following project objective was selected:

60% of families with a child <2 years will know how to prepare and give Jeevan Jal correctly.

In November 1992, project staff conducted a baseline survey of JJ preparation and found that only 11.9% of the 220 households interviewed had a family member who could correctly prepare JJ. Among these same households, 21.4% had a family member who knew the correct dose of JJ for a child under two years (1/2 glass after each stool), while 23.6% knew the correct dose of JJ for a child over two years (one glass after each stool). Only 16.8% of the households had a member who stated the correct dose of JJ for both age groups.

In November 1994, a 30 cluster sample survey was conducted to assess the impact of the project on knowledge of JJ preparation and administration. A total of 210 households with a child under 2 years were interviewed (7 per cluster). If available, the youngest child's caretaker was interviewed. The caretakers or other household members were asked if they knew how to prepare JJ, those who did were then asked to demonstrate doing so. These respondents were also asked about the administration of JJ.

FINDINGS

I. FINDINGS ABOUT JJ PREPARATION

162 (77.1%) of the 210 households interviewed had a household member who stated that they could prepare JJ. In 131 of these households the respondent was the caretaker; while in 31 households the respondent was another member. Correct preparation was defined as: washed hands, used clean pot, used clean drinking water, used six tea glasses of water, used one packet of JJ, and mixed thoroughly.

The following table shows that just over half of the respondents who thought they could prepare JJ correctly actually gave a correct demonstration. Therefore, 41.0% of the 210 households sampled had a family member who knew how to prepare JJ correctly.

Criteria	Number of Respondents Correct	% of 162 Respondents Correct	% of 210 Households with Respondent Correct
Washed hands	133	82.1	63.3
Used clean pot	146	90.1	69.5
Used clean drinking water	156	96.3	74.3
Used six tea glasses water	134	82.7	63.8
Used one packet JJ	154	95.1	73.3
Mixed JJ thoroughly	155	95.7	73.8
All criteria	86	53.1	41.0

Only 86 respondents covered the pot without prompting (53.1% of 210 households).

2. FINDINGS ABOUT JJ ADMINISTRATION

After preparing the JJ, the respondents were asked about how to give JJ:

Criteria	Number of Respondents Correct	% of 162 Respondents Correct	% of 210 Households with Respondent Correct
1/2 glass JJ after each stool for a child <2 years	40	24.7	19.0
1 glass JJ after each stool for a child >2 years	27	16.7	12.9
As desired	107	66.1	51.0

Only 75 respondents correctly stated the length of time that JJ can be stored (24 hours) This was 35.7% of the households interviewed.

3. FINDINGS ABOUT USE OF JJ DURING DIARRHEA

Of the 210 households interviewed, 68 reported that the child under two years had had diarrhea during the past two weeks (32.4%). In 30 (44.1%) of these households the child with diarrhea was given JJ. 137 households (65.2%) reported that a medical shop is the nearest place to get JJ. Another 15% stated that the CHVs home is the nearest place. 185 households (88.0%) stated that JJ is available when needed.

4. FINDINGS ABOUT SOURCES OF INFORMATION ABOUT JJ

In the 210 households surveyed, information about JJ was obtained from:

Source	Number of IIIs	Percent of IIIs
CHV	49	23.3
Health post/hospital	42	20.1
Radio/street drama	26	12.3
VHW	6	2.9

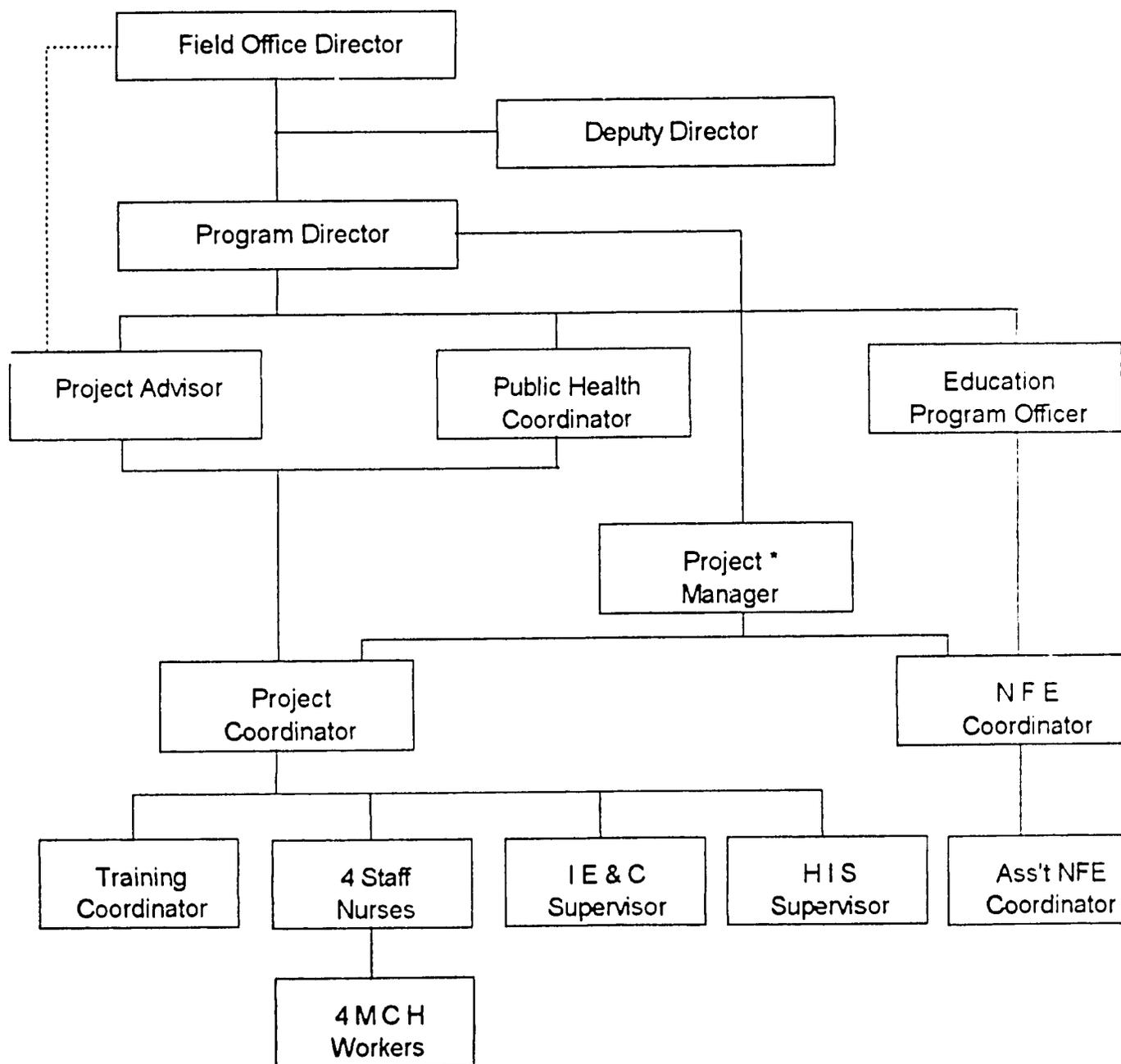
To increase families' knowledge and improve their practices regarding the management of diarrhea, the project conducted JJ campaigns. During these campaigns highly motivated CHVs demonstrated the preparation of JJ in their villages and taught women about the appropriate management of diarrhea. These activities were supported by placement of signs marking the CHVs' homes, where JJ was available for sale. Other local leaders and TBAs who expressed interest were included as sources for education about the management of diarrhea and as sales agents for JJ.

DISCUSSION AND RECOMMENDATIONS

The findings of the final survey compared to the baseline survey indicate that while knowledge of JJ preparation and use of JJ during diarrhea episodes has increased, knowledge of how to give JJ has declined as shown in the following table:

Indicator	% of IIIs in Baseline JJ Survey	% of IIIs in Final JJ Survey
Correct preparation of JJ	7.3	41.0
Child <2 years had diarrhea episode in past two weeks	22.7	32.4
Used JJ during recent diarrhea episode	14.0	44.1
Knows dose of JJ for child <2 years	21.4	19.0

Although the reasons for the decline in knowledge of the correct administration of JJ could be hypothesized, SC/US staff should systematically investigate them through qualitative study. It is likely that while the success of JJ demonstrations are easy to assess through re-demonstration, it is much more difficult to assess whether messages about the administration of JJ are clearly understood. The learning process is further complicated by the availability of different types of ORS and the diverse opinions of family, friends, and others about how to treat diarrhea.

CS-VII PROJECT ORGANIZATIONAL CHART

* - denotes a SCF/US management position in Siraha Field Office
The Project Manager reports to the Program Director

Contacts / Persons met

No.	Location	Name of Contact	Designation
SAVE THE CHILDREN (US), Kathmandu			
1		Min Dhoj Karki	IEC Officer
2		B.M. Devkota	Program Director
3		Chanda Rai	Assistant, P.D. & PHC
4		Usaya Manandhar	Assistant, P.D. & Education
SAVE THE CHILDREN (US), Siraha			
5	District Office	Krishna B. B. K.	Accountant
6	Ilaka # 4	Khil Nath Niraula	NFE Coordinator
7		Chola Kant Sharma	IEC Officer
8		Dhana Malla	Project Coordinator
9		Janaki Shrestha	Staff Nurse
10		Krishna Lamsal	Staff Nurse
11		Lekh Hari Dahal	Staff Nurse
12		Ram Dayal Shah	HIS Supervisor
13		Renu Rai	ANM
14	Ilaka # 5	Gopal Pd. Tamang	Field Coordinator
15		Rajesh Limbu	Staff Nurse
16		Ishwor Khattri	Deputy Field Coordinator
17		Bhusan K. Chaudhary	Staff Nurse
18		Ram Asish Roy	ANM
19		Beenita Adhikari	MCHW
20		Anita Chaudhary	MCHW
21		Bela Ghising	MCHW
22		Kalyami Shah	MCHW
HP Management Committee, Golbazaar			
23		Shiva Narayan Yadav	Chairman
24		Damodor Adhikari	Vice-Chairman
25		Uddav Adhikari	Member
ORC Management Committee, Devipur			
26		Bechee Shing	Chairman
27		Suret Dash	Vice-Chairman
28		Raj Kumar Mahato	Treasurer
29		Mohand Samsalhok	Secretary
30		Gyanmbhir Lal Chaudhari	Member
31		Tefi Lal Chaudhari	Member
32		Hast Lal Chaudhari	Member

33	Upendra Mahato	Member
34	Ram Dev Shah	Member
35	Jibchhi (CHV)	Member
36	Ram Kishan Shah	Member
HP Staff, Devipur		
37	Yogendra N. Mallik	Health Assistant (Arnama HP)
38	Govinda Yadav	AHM
39	Ray K. Shah	Peon
40	Hadisa Khatun, Phulo Devi, Bina, Chandra	CHVs
41	Sukuhi Mochi, Rampari	TBAs
ORC Management Committee, Pipra		
42	Bhikhari Saphi	Chairman
43	Suk Dev Thakur	Vice-Chairman
44	Tulashi Sardar	Secretary
45	Jaga Dev Kamait	Treasurer
46	Prakash K. Gupta	Member
47	Binod Thakur	Member
48	Phulgen Kamait	Member
49	Ram Narayan Mandal	Member
50	Bachu Das	Member
HP Staff, Pipra		
51	Ram Bilash Thakur	Health Assistant
52	Bhupendra Lal Dev	AHW
53	Tulasi Yadav	ANM
54	Bhim Bahadur Malla	VHW
55	CDO, Siraha	Durga Prasad Pokhrel
MOH, Siraha		
56	Dr. Ram Chandra Singh	DPHO
57	Dr. Suryo Narayan Yadav	DPO
58	Hari Lal Shrestha	Vector Control Asst
59	MOE, Siraha	Ram Balak Singh
60	Ministry of Local Devt, Siraha	Devi Prasad Sharma
61	Bhawani Youth Club	local NGO (Club)
62	Sunrise Youth Club	local NGO (Club)
63	Shrejana Club	local NGO (Club)
64	Indreni Youth Club	local NGO (Club)
65	John Snow, Inc., Kathmandu	Dr. Penny Lawson
66	Redd Barna, Kathmandu	Martha Levitt

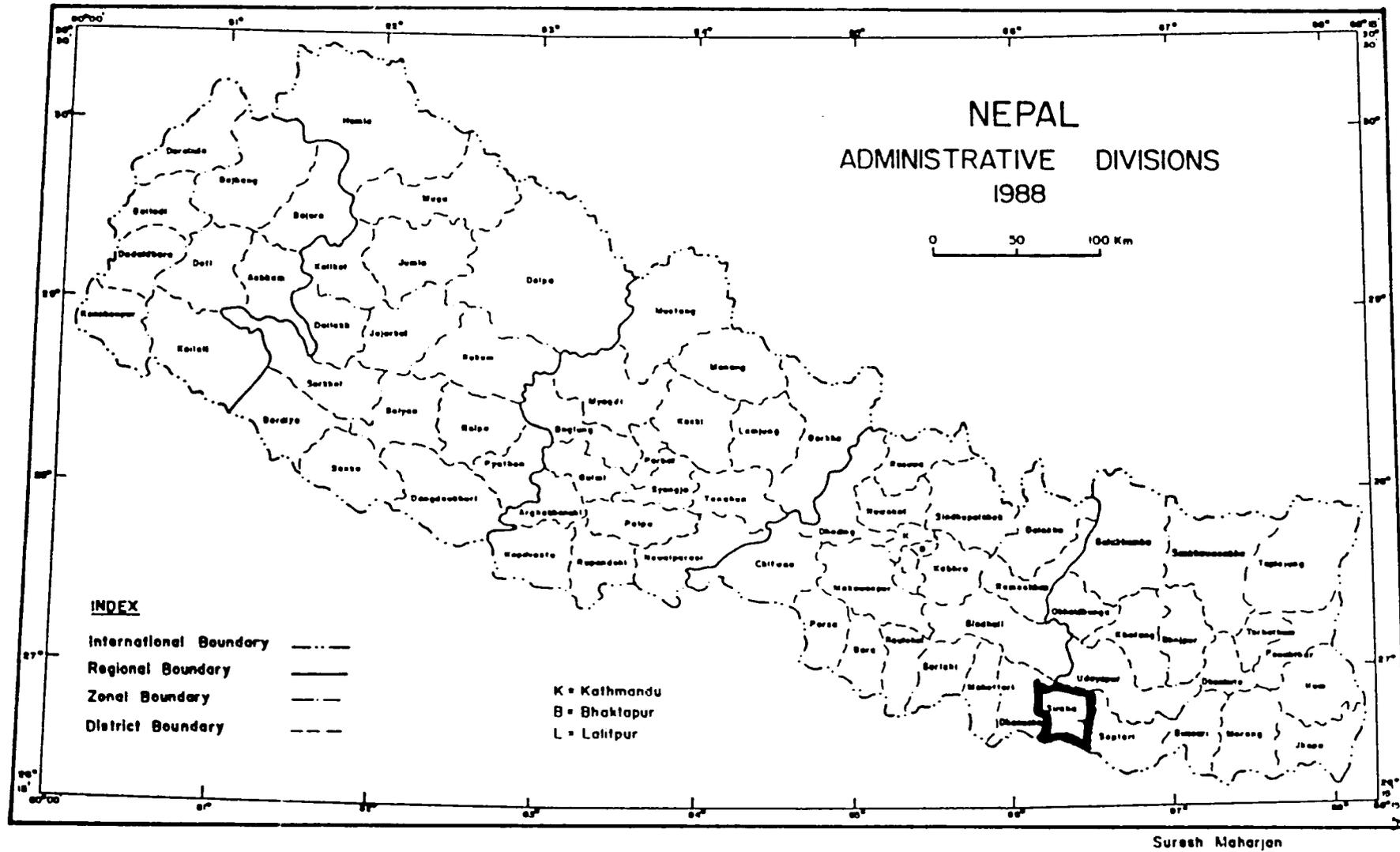
ITINERARY

Date	Group A	Group B	Group C	Group D
Monday December 12, 94	<ul style="list-style-type: none"> - Visit to Pipra ORC - Meeting with TBAs / CHVs, and Management Committee 	<ul style="list-style-type: none"> - Visit CDO, LDO, DHO, DEO in Siraha - Visit to Devipur ORC - Meeting with TBAs / CHVs, and Management Committee - Visit to NFE Class (Chandra Ayadhapur) 	N F E	<u>Vitamin A Programme and Kitchen Gardens</u>
Tuesday December 13, 94	<ul style="list-style-type: none"> - Street Drama Programme - Management Committee Meeting - Visit to Bariyarpatti HP - Visit to Mushahar Gaun (Musarneya) 	<ul style="list-style-type: none"> - Street Drama Programme - Management Committee Meeting - Visit to Kalyanpur HP - Meeting with CHVs / VHWs / TBAs 	<ul style="list-style-type: none"> - Visit to NGOs (Bhawami Youth Club, Sunrise Youth Club, Shrejana Club, Indreni Youth Club) - Home visits in Mohanor, Lallpur, Asanipur VDCs - NFE classes / women's group - DEO (Ram Balak Singh) - LDO (Devi Prasad Sharma) - Literacy test (Dhangadi) - Focused discussions with NFE-facilitators, supervisors, and graduates 	<ul style="list-style-type: none"> -Chaudhary Eye Hospital - Kitchen Gardens - District Hospital Siraha - Meetings with Farmers Groups - Meeting with DHO
Wednesday December 14, 94	<ul style="list-style-type: none"> - Visit to Nainpur HP / Clinic - Meeting with VHWs / HP-staff - Meeting with Women's Group (Chandra Ayadhapur, Panbari) - Meeting with Project Staff 	<ul style="list-style-type: none"> - Visit to Golbazaar HP - Meeting with VHWs / HP-staff - Women's Group Meeting (Bhawanipur) - Visit to Literacy Class / Club (Hanuman Nagar), meeting with club members 		
Thursday December 15, 94	<ul style="list-style-type: none"> - Meeting with community leaders in both ilaka (4 & 5) 	<ul style="list-style-type: none"> - Meeting with community leaders 		
<i>Team accompanied by *</i>	Dhana Malla	Khem Thapa, Chanda Rai	Chola K. Sharma	Renu Upadhaya, R. Neraula

* - The accompanying team changed as required

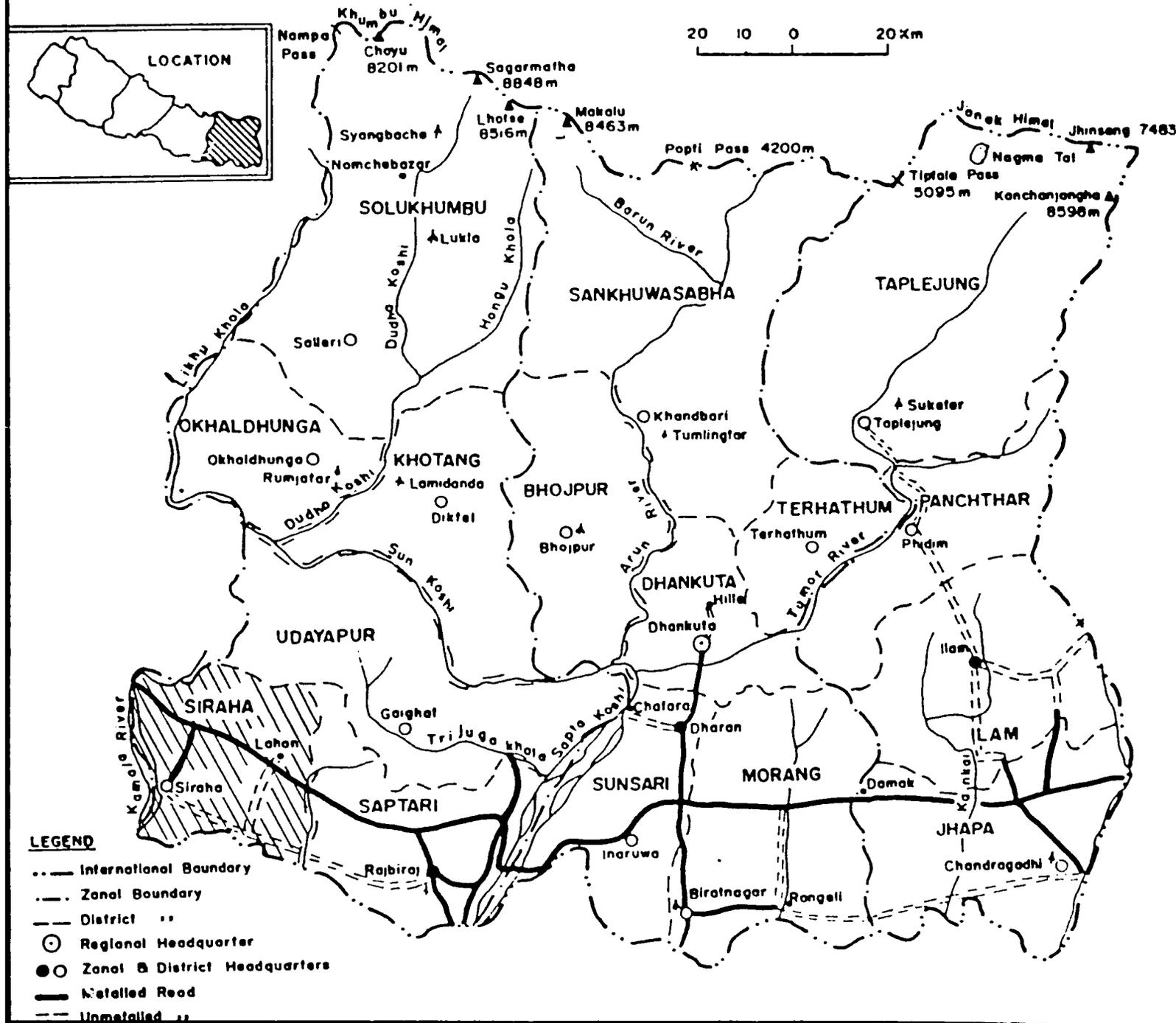
LIST OF DOCUMENTS REVIEWED

1. SCF/US, *Strengthening of Child Survival Activities in Siraha District, Kingdom of Nepal*, Project Proposal, December 1990
2. SCF/US, *CS-VII Detailed Implementation Plan*, June 1992 (sections H / I missing)
3. SCF/US, *CS-VII Quarterly Reports to US A.I.D.*
 - October - December 1991
 - January - March, April - June, July - September, October - December 1992
 - January - March, April - June, July - September, October - December 1993
 - (Reports for 1994 were no longer required by US A I D)
4. SCF/US, *Report on a Nutrition Survey*, by Jane Robertson, February 1994
5. SCF/US (Nepal), *Impact of SCF/US Nonformal Adult Education Program on Mother and Child Care*, September 1992
6. SCF/US, *Lessons Learned in the Course of a Three Year CS-VII Urban Health Program in Jakarta/Indonesia*, by N Hirschhorn MD August 1992
7. SCF/US, *Report on Sustainability of Health and Development Programs in Nepal and Bangladesh*, by N Hirschhorn MD, December 1992
8. SCF/US (Nepal), *Report of CS-VII Detailed implementation Plan Orientation Workshop*, February 1993
9. SCF/US, *Mid-Term Evaluation CS-VII Project, Siraha District, Nepal*, April 1993
10. SCF/US (Nepal), *IEC Messages and Materials Workshop Report*, May 1993
11. SCF/US, *Report on Baseline Survey*, by M. Dupar / C. Carter, May 1992
12. SCF/US (Nepal), *Report of Focus Group Discussions: Immunization, Control of Diarrheal Diseases, Acute Respiratory Infection*, by C.K.Sharma, C. Pradhan, M. Dupar, November/December 1992
13. SCF/US (Nepal), *Vitamin A Curriculum*, September 1993
14. CHVs CDD, FP, EPI, ARI Training - Lesson Plan, February 1994
15. SCF/US (Nepal), *Report of the CS-VII Final Knowledge and Practice Survey*, by M. Dupar, November/December 1993
16. USAID, *Health and Child Survival Project Questionnaire*, September 1992
17. SCF/US (Nepal), *Report on Jeevan Jal Preparation Survey*, Nov/Dec 1992
18. SCF/US (Nepal), *Report of Replanning Workshop*, April 1993



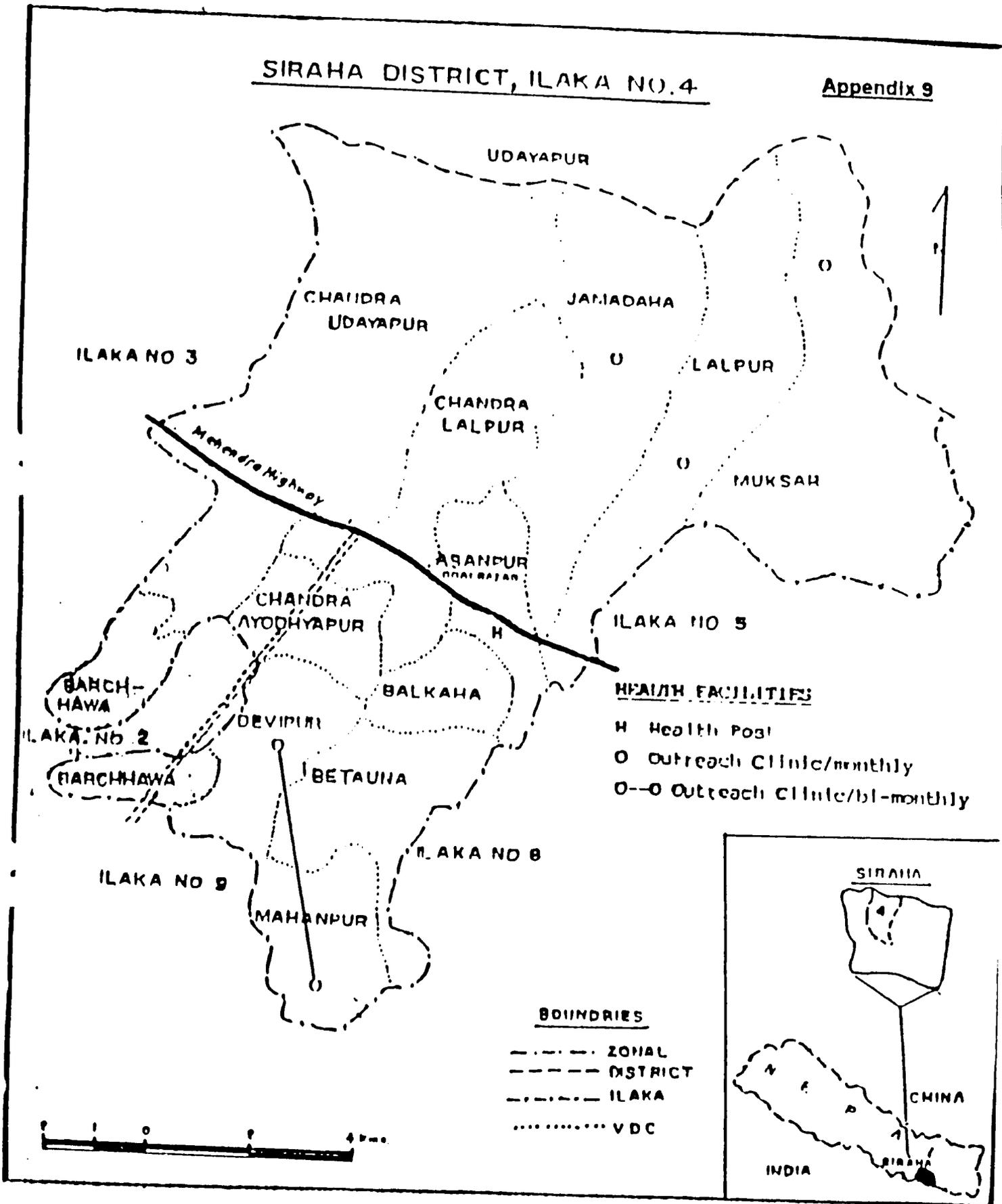
Administrative Divisions: Nepal has three levels of administrative division: 5 development regions, 14 zones and 75 districts. Each zone is composed of several districts (4 to 8 in number). Among districts, Dolpa is the largest and Bhaktapur the smallest in terms of total area covered by them. In physical location, 16 districts lie in the mountain (Himalaya) region, 39 districts in the hilly region, and 20 districts in the Tarai region.

Eastern Development Region



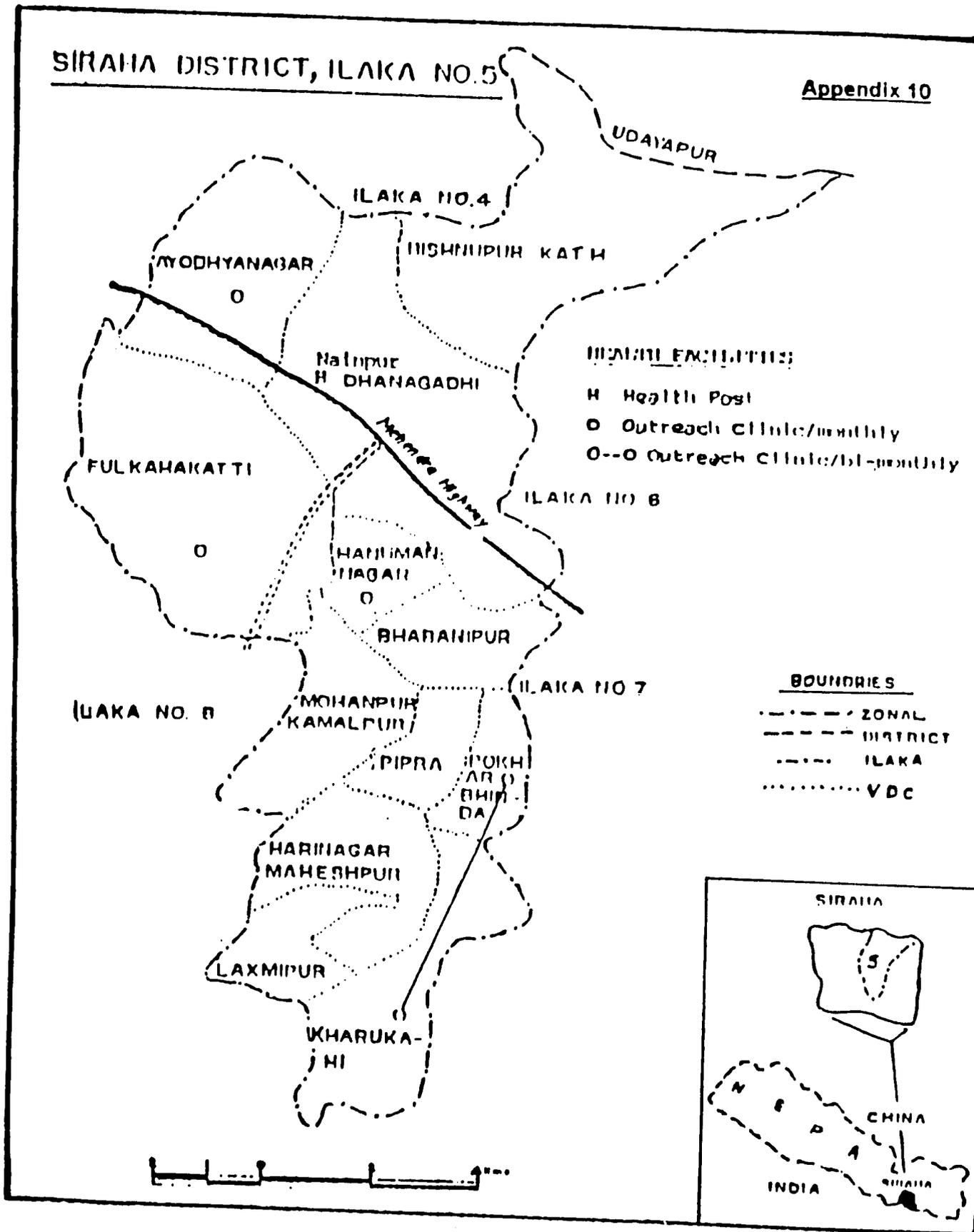
SIRAHA DISTRICT, ILAKA NO. 4

Appendix 9



SIRAHA DISTRICT, ILAKA NO.5

Appendix 10




SAVE THE CHILDREN US
Nepal Field Office

Child Survival VII Project, Siraha.

Training Activities
From Oct. 1991 to Dec. 1994

S. No.	Participants	No. of Staff	Duration in Days	Basic Refresher	Training Topics	Remarks
1.	Health Post Staff	14	3	Basic	Snake Bite	
2.	Health Post Staff	14	1	Basic	Kalajat	
3.	Health Post Staff	14	6	Basic	ARI, EPI, MH, CDD, FP Nutrition/Vit A	
4.	Health Post Staff	14	6	Refresher	ARI, EPI, MH, CDD, FP Nutrition/Vit A	
5.	Health Post Staff	14	3	Basic	First AID	
6.	Health Post Staff	14	3	Basic	HIS	
7.	Health Post Staff	14	3	Refresher	HIS	
8.	Health Post Staff	14	1	Basic	Disabled Children	
9.	Health Post Staff	14	1	Basic	Clinic Management	
10.	Health Post Staff	14	1	Basic	Drug Listing	
11.	Health Post Staff	14	1	Basic	Dental Problem and Oral Hygiene	
12.	Health Post Staff	14	1	Refresher	Dental Problem and Oral Hygiene	
13.	Health Post Staff	14	1	Basic	Gyne including STDs and AIDS Prevention	
14.	Health Post Staff	14	4	Basic	Depoprovera	
15.	Health Post Staff	14	3	Refresher	Depoprovera	
16.	Health Post Staff	2	7	Refresher	Kalajat Management Training	
17.	VHWs	24	6	Basic	ARI, EPI, MH, CDD, FP, Nutrition/Vit. A.	
18.	VHWs	24	6	Refresher	ARI, EPI, MH, CDD, FP, Nutrition/Vit. A.	
19.	VHWs	24	4	Basic	Depoprovera	
20.	VHWs	24	3	Refresher	Depoprovera	
21.	VHWs	24	5	Basic	HIS	
22.	VHWs	24	36	Refresher	HIS updating Training (one day in a month - Separately total 36 days)	Every month 1 day
23.	FCHVs	216	6	Basic	ARI, EPI, MH, CDD, FP, Nutrition/Vit A.	

S. No.	Participants	No. of Staff	Duration in Days	Basic Refresher	Training Topics	Remarks
24.	FCHVs	216	3	Refresher	ARI, EPI, MH, CDD, FP, Nutrition/Vit. A	
25.	FCHVs	216	1	Basic	Vitamin A	
26.	FCHVs	216	1	Basic	First AID	
27.	FCHVs	216	1	Basic	HIS	
28.	FCHVs	216	2	Refresher	HIS	
29.	TBAs	105	6	Basic	ARI, EPI, MH, CDD, FP, Nutrition/Vit. A	
30.	TBAs	105	1	Basic	Three Cleans	
31.	TBAs	105	1	Refresher	Three Cleans	
32.	TBAs	105	1	Basic	HIS	
33.	TBAs	105	1	Refresher	HIS	
34.	TBAs	105	1	Basic	Vit. A	
35.	TBAs	105	1	Refresher	Vit. A	
36.	TBAs	105	2	Basic/ Refresher	Recording, Reporting Delivery Practice and Sterilization	
37.	Local Club Members	13	3	Basic	First AID	
38.	Local Club Members	13	3	Basic	CDD, FP, Vit. A	
39.	School Teachers	73	2	Basic	First AID	
40.	Farmers Group	6	5	Basic	FP, CDD, MH, ARI, Vit. A	
41.	Women's Group	44	6	Basic	FP, CDD, MH, ARI, EPI, Nutrition/Vit. A	
42.	POP Group	34	6	Basic	FP, CDD, MH, ARI, EPI, Nutrition/Vit. A	
43.	NFE Facilitators	246	6	Basic	FP, CDD, MH, ARI, EPI, Nutrition/Vit. A	
44.	NFE Facilitators	246	1	Basic	JJ Preparation	
45.	NFE Facilitators	246	1	Basic	Vitamin A	
46.	MCH/ORC Mngt. Com.	13	1	Basic	FP, CDD, MH, ARI, Vit. A.	
47.	MCH/ORC Mngt. Com.	13	1	Basic	Health Program Orientation	
48.	Jeevan Jal Seller	102	1	Basic	Jeevan Jal Preparation	
49.	NFE Supervisors	18	6	Basic	ARI, CDD, FP, EPI, MH, Nutrition/Vit. A.	
50.	NFE Supervisors	18	1	Basic	JJ Preparation	
51.	NFE Supervisors	18	1	Basic	Vitamin A.	

Locality: _____ Interviewer: _____

Date: _____ Interviewee: _____

SECTION A - Interview with Health Post Staff

1.1. No. of trained CHVs: _____

1.2. When were the CHVs trained ? _____

1.3. No. of active (existing) CHVs: _____

1.4. Are CHVs geographically representative ? _____
(refer to a map) _____

If not, how did you find out ? _____

If yes, how do you know ? _____

1.5. What is the role of CHVs ? _____

1.6. Who supervises CHVs ? _____

1.7. How is the supervision carried out ? (fill in blanks)

- a. Visiting CHVs _____ times a month.
- b. Holding meetings once in a _____.
- c. Through Community Management Team _____.

1.8. Why is the meeting held with CHVs ? _____

1.9. How often are CHVs re-supplied ? _____

1.10. Where are the CHVs being re-supplied ? _____

1.11. Who re-supplies CHVs ? _____

1.12. How is the relationship between H.P. and CHVs ?

Good

Fair

Poor

Why ? _____

1.13. What are the main problems related to the CHV programme ?

1.14. How are these problems solved ?

1.15. Are refresher courses held with CHVs ?

Yes

No

a. Who arranges the workshops / trainings ? _____

b. How often ? _____

c. Where ? _____

Comments / Recommendations

SECTION B- Interview with C H Vs

2.1. When were you trained ? _____

2.2. Why were you trained ? _____

2.3. How many families do you work for ? _____

2.4. How often do you visit them ? _____

2.5. What time of the day do you visit them ? _____

2.6. Do they pay you for your services ? Yes No

2.7. Who does the household chores, such as cooking, cleaning, looking after children in your house ?

2.8. Does the Health Post (name _____) support you in your work ?
 Always Sometimes Never

Why / How ? (ask for each category)

2.9. Do VHWs (name of the VHW) visit you ? Yes No

If 'yes', how often ? _____

2.10. Do you attend meetings arranged by VHWs ? Yes No

2.11. Do you refer patients to H.P. ?

Yes No

2.12. What kind of patients do you refer ?

2.13. Have you attended further training / refresher courses ?

Yes No

If yes, on what subjects was the training held ? _____

Who trained you during these sessions ? _____

2.14. What problems do you have regarding your work as CHV ?

Comments / Recommendations

SECTION C- Interview with Community Management Team

3.1. Where are the members from (ask each member's area) ?

3.2. How was the committee formed ? _____

3.3. Why was the committee formed ? _____

3.4. Do you know the names of the CHVs trained in your area ?

3.5. What role / work does a CHV carry out ? _____

3.6. Who supervises them ? _____

3.7. Do you see any advantage of CHVs ? _____

3.8. Do you know what problems CHVs are facing ? _____

3.9. Do you assist them to solve their problems and, if so, how ?

Comments / Recommendations

Site: _____

Date: _____

1. Age of child _____ (1994 FY)

2. How many children: 0 - 11 _____
 12 - 36 _____
 37 - 59 _____
 > 59 months _____

3. Where did you deliver ? _____

4. Who delivered you ? _____

4.a. What was used to cut the umbilical cord ? _____

4.b. Who cut the cord ? _____

5. Did you experience any problems during delivery ? _____

6. Do you know about Family Planning ? _____

7. Where can you go for Family Planning ? _____

8. Do you plan to use Family Planning in the future ? _____

9. Do visit the Health Post ? _____

10. For what reasons ? _____

11. A/N Mothers (period 1 year)

S No.	Name	Address	Age	Registered A/N Dates (as registered)	Registered A/N Dates (on card)

11.a. Where was the child born ? Home _____ Others _____

11.b. Who attended your delivery ? _____

Team: _____

CLIENT SATISFACTION RANDOM CHECK
(interview each third mother attending the health post)

1. Why have you come to the health post / what is the medical problem ?

2. How long did you have to wait to be seen ? _____

3. Was the staff friendly and attentive ? _____

4. Were you satisfied with the treatment / advice or will you seek advice at another source ? _____

5. Have you always used this health post or only recently ? _____

6. Did you have to pay for medical services anywhere before, and if so, how much ?

7. What advice were you given on home care during this visit ? _____

8. Where you told to come back for follow-up and, if so, when ? _____

9. (for the team): Check the treatment corresponding to the initial medical problem

Team: _____

HEALTH POST CHECK-LIST

1. Opening Hours _____

2. Staff in attendance _____

3. Has the health post running water ? _____

4. Is the facility clean ? _____

5. Is there a functioning toilet ? _____

6. What essential drugs are available ? _____

7. Has the health post sufficient supplies of ORS/ Jeevan Jal ?

Yes _____ No _____

8. Is there an 'ORS Corner' ?

Yes _____ No _____

9. Is teaching material available ? (Kind of material / Is it displayed ?)

10. Clinic attendance during the last month

Male _____ Female _____ Children < 5yrs _____ Total _____

11. Number of deliveries carried out by ANMs during last month _____

12. Check registration book (Comments) _____

13. Check function of all technical equipment. (Comments) _____

14. How is clinical waste being disposed of (syringes, needles, dressings, etc.) ?

15. Question to Staff: "How would you diagnose and treat a child with ARTI ?"

TRAINING (Initial)

1. Number of people trained and types of training

Category	A R I		C D D		F P	
	Number of courses	Length	Number of courses	Length	Number of courses	Length
D H O						
HP-staff						
Clinic Staff						
CHVs						
TBAs						
Womens Groups						
Literacy Groups						

Comments _____

2. Did the community health committees receive training in the above ?

Yes _____ No _____

If 'no', why not ? _____

3. Which subject was best covered and why ?

4. Was the length of training adequate ?

Yes _____ No _____

If 'no', why not ? _____

Team _____

TRAINING (Refresher)

1. Number of people trained and types of training

Category	A R I		C D D		F P	
	Number of courses	Length	Number of courses	Length	Number of courses	Length
D H O						
HP-staff						
Clinic Staff						
CHVs						
TBAs						
Womens Groups						
Literacy Groups						

Comments _____

2. Did the community health committees receive training in the above ?

Yes _____ No _____

If 'no', why not ? _____

3. Which subject was best covered and why ?

4. Was the length of training adequate ?

Yes _____ No _____

If 'no', why not ? _____

Team: _____

TRAINING (On-Site)

1. Number of people trained and types of training

Category	A R I		C D D		F P	
	Number of courses	Length	Number of courses	Length	Number of courses	Length
D H O						
HP-staff						
Clinic Staff						
CHVs						
TBAs						
Womens Groups						
Literacy Groups						

Comments _____

2. Did the community health committees receive training in the above ?

Yes _____ No _____

If 'no', why not ? _____

3. Which subject was best covered and why ?

4. Was the length of training adequate ?

Yes _____ No _____

If 'no', why not ? _____

Team: _____

SUMMARY OF IEC ACTIVITIES/MATERIALS CS 7 PROGRAM SIRAHA

S.#	MATERIALS/ ACTIVITIES	WHERE (TARGET GROUP)	LANGUAGE	#
(a)	(b)	(c)	(d)	(e)
1.	Cinema Slides show:	Slides are being shown at the Cinema Halls (Golbazar, Lahan Merche...) Slides have been developed for five CS intervention i.e. ARI, EPI, MH, FP, CDD.	Nepali/Maithali	12
2.	Short film show:	Shown at 4 Cinema Halls. The test message is given from the short film (JJ relates)	Nepali	1
3.	MCH outreach Clinic Signboards	These Signboards were posted at all outreach clinic sites i.e. 6 in GBR and 7 in DNGD.	Nepali	14
4.	CHV Sign boards	Placed at the homes of the 216 CHV. (Name address and contact her for health related advice)	Nepali	216
5.	INU Paintings	All component messages paintings have been completed in SC/US working area of both Ilakas	Nepali/Maithali	
6.	EPI Clinic Notice Boards	Placed at All EPI Sites. There mentioned ... name, date and location	Nepali	108
7.	Health post Signboards	Placed at the both Health post i.e. Golbazar and Nainpur	Nepali	2
8.	Street Drama Show	CS messages were disseminate three street drama at the each and every VDC ^s ward at the basis of rotation (ARI, CD, MH, EPI, FP)	Nepali/Maithali	288 show
9.	Poster Production	Distributed at the different place and training period to the HP staff, CHV, TBA, school teacher etc (ARI, EPI, TT, MH) -KTM	Nepali/Maithali	15000
10.	Calendar with CS message	Production and distributed it to the LINGO, NGO, GO, etc. The message was in the calendar of three cleans	Maithali	2000
12.	Campaign (Miking, postimg)	Different promotional campaigns were conducted in the SC/US working areas. During the campaign CHV, TBA, ... community member were actively participated campaign were a) Jeevan Jal Campaign b) Three clean campaign c) TT Campaign d) FP Campaign e) Vitamin 'A' Campaign	Nepali/Maithali	5
13.	NFE Classes activity: (Message disseminate HM NFE class)	CS messages or CDD, ARI, EPI, MH, FP, V+a, were disseminated thru NFE class. Before implementation messages NFE/Facilitators were provided training and key messenger book, poster, etc.	Nepali/Maithali	200

(a)	(b)	(c)	(d)	(e)
14.	Production Cs message booklets	Production and distributed to the targeted groups (CDD, ARI, FP, MH, EPI, VIT 'A')	Nepali	30000
14.	Training	Provided training to the Health worker and volunteer community member about CS messages on CDD, ARI, FP, MH, EPI, VIT 'A'	Nepali	As necessary
15.	ORT Corner Establishment	ROT Corner were establishment at the each ORC Site and HP Clinic.	Nepali	14
16.	IEC Corner Establishment	IEC Corner is establishment in SC/US office	Nepali	2
17.	Health Education Session	Conducted health education session at the ward level in each and every VDC, 7 CDD, MH, EPI, ARI, FP and Vitamin 'A'	Nepali/Maithali	-
18.	EPI Jeevan Jal Service Sign Bords	Placed at the all EFI sites and ORC sites.	Nepali	216
19	Booklets, leaflets. (FP)	Production and distributed to all targeted group	Nepali	8000
20	Mobile Video Show	Showed at the different VDC to the targeted group The film's message was FP and Health related	Nepali	As required
22	Banner Production	Banner Production and placed at the market during the camp period and especial activities (i e FP camp and AIDS)	Nepali	-
23	CDD Flip Chart	Collection from CS 3 project and used in training and distributed to the CHV.	Nepali	-
24	Collection and distributed other IEC materials from the GO, INGO, NGO etc	Different IEC materials were collected from GO and INGO at the periodic basis and distributed to the targeted groups The materials were produced by TAG, JSI, FP/MCH, CDD section , USAID, world education etc	Nepali English	-

**Save the Children US
GOLBAZAR, SIRAHA**

CHVs Literacy Status - 1994/95

Ilaka # 4

S.#.	VDCs	# of CHVs	Illiterate	Literate from						Grand Total	Remark
				Formal school	CHVs test	NFE			Total		
						1991/92	1992/93	1993/94			
1	Balkawa	9	4	1	2	-	2	-	2	5	
2	Betauna	9	1	4	1	3	-	-	3	8	
3	Devipur	8	2	-	-	1	4	1	6	6	
4	Mahanour	9	2	-	2	1	2	2	5	7	
5	Barchhawa	9	2	2	-	-	2	3	5	7	
6	Chandra Ayadhyapur	9	2	2	3	2	-	-	2	7	
7	Mukshar	8	2	-	1	1	2	2	5	6	
8	Chandra Udaypur	8	1	1	1	12	4	-	5	7	
9	Chandra Lalpur	9	4	3	1	1	-	-	1	5	
10	Asanpur	9	3	4	-	-	1	1	2	6	
11	Jamadah	8	3	3	1	-	-	1	1	5	
12	Lalpur	9	3	1	3	-	-	2	2	6	
13	Total Program Ilakas	104	29	29	15	10	17	12	39	75	
		107	19		8	18	16	17	51	88	
	Total of both ilaka	211	48	50	23	28	33	29	90	163	

Total CHVs = 211

Total Literate = 163

Literate from School = 50 (30.6 %)

Literate from CHVs test = 23 (14.1 %)

Literate from NFE = 90 (55.2%)

$$\frac{163}{211} \times 100 = 77.2 \%$$

**Save the Children US
Golbazar Siraha**

CHVs Literacy Status 1994/95

S.#.	VDCs	# of CHVs	Illiterate	Literate from						Grand Total	Remark
				Formal school	CHVs test	NFE					
						1991/92	1992/93	1993/94	Total		
1	Laximpur partar	9	1	1	-	1	5	1	7	8	
2	Pipra	9	3	1	2	-	2	1	3	6	
3	Mchanpur Kamalpur	9	3	1	2	-	2	1	3	6	
4	Pokarvinda	9	1	1	-	4	2	1	7	8	
5	Bishnupur Katti	8	-	8	-	-	-	-	-	8	1 vacant
6	Phoolkaha Katti	9	2	1	2	1	-	3	4	7	
7	Dhanagadhi	9	1	6	-	1	-	1	2	8	
8	Ayadhyanagar	9	2	4	-	3	-	-	3	7	
9	Hanumanagar	9	-	2	1	3	1	2	6	9	
10	Bhawanipur	9	1	-	-	4	2	2	8	8	
11	Khaurkpyahi	9		-	4	-1	1	3	5	9	
12	Maheshpur	9	2	1	-	0	3	3	6	7	
13	Total	107	19	19	30	8	18	16	17	51	88

Save the Children US
Golbazar, Siraha
TBAs Literacy status 1994/95

S.#.	VDCs	# of CHVs	Illiterate	Literate from						Grand Total	Remark
				Formal school	CIIVs test	NFE					
						1991/92	1992/93	1993/94	Total		
1	Kharukiyahi	4	1	-	1	1	1	1	2	3	
2.	Maheshpur	3	2	-	-	-	-	1	1	1	
3.	Hanumannagar	3	3	-	-	-	-	-	-	-	
4.	Pipra	4	3	-	-	-	-	1	1	1	
5.	Bishnupuri Katti	3	3	-	-	-	-	-	-	-	
6.	Bhawanipur	3	1	-	-	-	-	2	2	2	
7.	Mohanpur kamalpur	6	3	-	-	-	-	3	3	3	
8.	Laxmipur .patar...	3	2	-	-	-	1	-	1	1	
9.	Dhangadi	6	5	-	-	-	-	1	1	1	
10.	Pokharvinda	3									
11	Phulkahakatti	11	9	-	2	-	-	-		2	
12	Aoyadhya nagar.	5	5	-	-	-	-	-	-	-	
13	Total	54	37		3	-	2	12	14	17	

S.#.	VDCs	# of CHVs	Illiterate	Literate from						Grand Total	Remark
				Formal school	CIIVs test	NFE					
						1991/92	1992/93	1993/94	Total		
1	Mahanour	3	1	-	-	-	-	2	2	2	
2	Betauna	3	3	-	-	-	-	-	-	-	
3	Devipur	3	3	-	-	-	-	-	-	-	
4	Barchawa	3	1	-	-	-	-	2	2	2	
5	Balkawa	3	3	-	-	-	-	-	-	-	
6	Mukshar	5	5	-	-	-	-	-	-	-	
7	Chandra	4	2	-	-	-	-	2	2	2	
8		2	2	-	-	-	-	-	-	-	
9	Jamadah	2	2	-	-	-	-	-	-	-	
10	Lalpur	1	-	-	-	1	-	-	1	1	
11	Asanpur 21	13	-	-	-	1	-	8	8	8	
12		-	-	-	-	-	-	-	-	-	
13	Total	54	37	-	3	-	2	12	14	17	
		51	36	-	-	1	-	14	15	15	
	Grand Total of	105	73		3	1	2	26	29	32	

Total # of TBAs = 105

Total # of literate = 32

Literate from formal school = No

Literate from TBA test = 3 (9.3%)

Literate from NFE = 29 (90.6%)

* For TBA test same from (question) was used as CIIVs test

S.#.	VDCs	# of CHVs	Illiterate	Literate from						Grand Total	Remark
				Formal school	CHVs test	NFE					
						1991/92	1992/93	1993/94	Total		
1	Mahanour	3	1	-	-	-	-	2	2	2	
2	Betauna	3	3	-	-	-	-	-	-	-	
3	Devipur	3	3	-	-	-	-	-	-	-	
4	Barchawa	3	1	-	-	-	-	2	2	2	
5	Balkawa	3	3	-	-	-	-	-	-	-	
6	Mukshar	5	5	-	-	-	-	-	-	-	
7	Chandra	4	2	-	-	-	-	2	2	2	
8		2	2	-	-	-	-	-	-	-	
9	Jamadah	2	2	-	-	-	-	-	-	-	
10	Lalpur	1	-	-	-	1	-	-	1	1	
11	Asanpur 21	13	-	-	-	1	-	8	8	8	
12		-	-	-	-	-	-	-	-	-	
13	Total	54	37	-	3	-	2	12	14	17	
		51	36	-	-	1	-	14	15	15	
	Grand Total of	105	73		3	1	2	26	29	32	

Total # of TBAs = 105

Total # of literate = 32

Literate from formal school = No

Literate from TBA test = 3 (9.3%)

Literate from NFE = 29 (90.6%)

* For TBA test same from (question) was used as CHVs test.

Appendix 15

Report of the

Child Survival 7 KPC Survey

***SAVE THE CHILDREN / US
NEPAL FIELD OFFICE***

***REPORT OF THE
CHILD SURVIVAL VII
FINAL KNOWLEDGE, PRACTICE,
AND COVERAGE SURVEY***

NOVEMBER - DECEMBER 1994

***REPORT PREPARED BY:
MARSHA DUPAR, SC/US CONSULTANT***

***CHILD SURVIVAL VII
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
GRANT No. PDC-0500-G-00-1077-00***

- *Documented* improvements in maternal health practices included: 20.6% of mothers had at least one ante natal visit (from AN cards), and 27.8% of mothers had had two or more doses of tetanus toxoid (TT). 41.6% of mothers *reported* having had an ante natal visit 38.7% of deliveries were attended by a trained traditional birth attendant, and 51.5% of mothers correctly stated the 3 cleans for a safe delivery.
- There was no change in family planning use. Only 18 (9%) of the 201 eligible couples were using any method, 11 (5.5%) of whom used a permanent method.

RECOMMENDATIONS AND LESSONS LEARNED

SC/US staff made many specific recommendations for individual project activities which are discussed in the text of the report. As these recommendations were developed it became apparent that there were a few factors that repeatedly affected project implementation. Further discussion of these factors led to the development of the following lessons learned:

- Although the key constraint to achieving established numerical objectives for utilization of health services (i.e., EPI coverage), is that SC/US is not the service provider, there remains a strong commitment to supporting the MOH as the source of health services.
- The duration of the project was too short. The project attempted to address too many child survival interventions.
- Qualitative and quantitative studies must continue to be conducted to clarify the complex socio-economic and cultural structures in the communities.
- Building a strong, cooperative project team and early establishment of links with government counterparts, other agencies, local leaders and groups, and the mothers themselves is essential.

EXECUTIVE SUMMARY

Save the Children US (SC/US) initiated a Child Survival (CS) VII project in Ilakas 4 and 5 of Siraha District in October 1991. The aim of the project is to reduce child morbidity and mortality through strengthening of the Ministry of Health's service delivery system and increasing community awareness of protective health behaviors. To assess the impact of the three year project, a final knowledge, practice, and coverage (KPC) survey was conducted from November 16-29, 1994, in all 24 Village Development Committees (VDCs) in which the project was implemented. The survey followed the standardized 30 cluster sample methodology mandated by U.S. AID of PVO CS VII projects, allowing for easy comparison with the CS VII Baseline K&P Survey conducted in February 1992.

The objective of the survey was to obtain information on the health knowledge and practices of mothers with children under two years of age. The baseline survey questionnaire was revised to reflect changes made in the project objectives following the mid-term evaluation in April 1993. SC/US has acquired additional experience with this standardized KPC survey methodology through its CS VIII project in Nuwakot District. Senior staff from Siraha, Nuwakot, and Kathmandu conducted training in the 30 cluster sample survey methodology for the survey team. The entire survey schedule was implemented in three weeks.

SURVEY FINDINGS

- An increase in income generating activities from 10.5% to 38.2%.
- Breast feeding is universal, and there were improvements in the introduction of supplemental foods.
- There was no change in the proportion of children who had experienced diarrhea in the past two weeks (32.8%). Although there were increases in mothers giving more breast milk (21.8%) and the same amount of other fluids (34.6%) during diarrhea, there was no change in giving of solid foods (3.9% gave more and 33.3% gave the same amount). 50% of mothers gave ORS during diarrhea (increased from 16.0% at baseline). There was an increase in seeking treatment for diarrhea (up to 80.8% from 53.1%) and of mothers seeking treatment, more sought treatment from health facilities (36.5%) and medical shops (27.0%). However, care is also sought from traditional healers (12.7%) and local quack doctors (41.3%).
- Among the 50 (21.0%) of children who had suffered from acute respiratory infection in the past two weeks, 84.0% of their mothers sought treatment. Care was sought from MOH health facilities (42.9%), local quack doctors (42.9%), medical shops (35.7%), and traditional healers (19.0%). 46.2% of all the mothers correctly stated three signs/symptoms of ARI that warrant treatment, and 65.1% knew that treatment was available at health facilities.
- Although 69.3% of mothers reported that they had given immunizations to their children, complete immunization coverage of 12-23 month olds (*documented* on EPI cards) increased to only 22.9% (from 10.5% baseline). More mothers (44.5%) had EPI cards, but another 24.8% reported losing them. Loss of cards increased with age of the child.
- 66.8% of mothers accurately stated that green leafy vegetables help prevent night blindness, and 55.2% reported that their 12-23 month old child had received two or more doses of vitamin A.

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
CDD	Control of Diarrheal Diseases
CHV	Community Health Volunteer
CS	Child Survival
CSSP	Child Survival Support Program
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
FP	Family Planning
HP	Health Post
IEC	Information, Education, and Communication
JJ	Jeevan Jal (Nepal's oral rehydration solution)
KPC	Knowledge and Practice
MCH	Maternal Child Health
MCHW	Maternal Child Health Worker
NFE	Nonformal Education
ORC	Outreach Clinic
ORS	Oral Rehydration Solution
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
U.S. AID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker

ACKNOWLEDGMENTS

Save the Children US wishes to acknowledge the generous cooperation of the 240 mothers who participated in the CS VII Final KPC Survey. Having met with many such mothers during the course of the project, we are well aware of their heavy workload and appreciate their willingness to make time available for the interviews.

The Child Survival VII project staff would like to thank the following persons who participated in the preparation and conduct of the CS VII Final KPC Survey:

INTERVIEWERS:

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Meena Lama	Sangita Lama	Sherkha Chouhan
Ratna Lama	Ranjana Moktan	Sarasoti Lama
Bali Lama	Karuna Lama	Usha Lama
Bashna Lama	Sushila Yadav	

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Rabindra Thapa	Bal Krishna Bhusal	Krishna Lamsal

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1.3 SCHEDULE OF ACTIVITIES IN KATHMANDU AND SIRAHA

November	Revision and preparation of survey questionnaire, obtaining population-based data for the selection of 30 random cluster sites, selecting supervisors and interviewers, determining costs and logistics of both training for and conduct of the survey.
November 16	Final preparation/printing of the survey questionnaire in Kathmandu, finalizing Maithali translations of the questionnaire and sample selection in Siraha.
November 18	Travel to the Siraha
November 19	Preparation for survey training and finalize logistics in Siraha.
November 20-22	Training of supervisors and interviewers, and field testing of questionnaires.
November 23-25	Conduct of the survey in all 24 VDCs in the project area.
November 26-27	Hand tabulation of survey results.
November 28	Data analysis with SC/US Siraha staff.
November 29	Travel to Kathmandu
December 5	Community feedback session in Siraha.
November 30 December 6	Prepare report.
December	Feedback to national level Ministry of Health, Ministry of Education, and U.S. AID/Nepal officials with the findings of the final project evaluation.

2. METHODOLOGY

2.1 THE SURVEY QUESTIONNAIRE

The questionnaire, which contains 46 questions, was designed to collect information from mothers of children under 24 months of age. The questions were based on a standardized survey format which U.S. AID requires of all PVO CS VII projects. The standardized survey instrument was developed by the staff at the PVO Child Survival Support Program (CSSP), with the assistance of U.S. and international experts for the various intervention areas. The CS VII Final KPC Survey questionnaire was adapted from the CS VII Baseline K&P Survey questionnaire. Revisions reflect changes made in the project objectives following the mid-term evaluation. Technical advice for these changes was provided by Cynthia Carter, from the PVO CSSP.

1. INTRODUCTION

1.1 BACKGROUND

Save the Children US (SC/US) initiated a Child Survival (CS) VII project in Ilakas 4 and 5 of Siraha District, Nepal, in October 1991. The target population of 103,542 persons included 14,191 children under five years of age and 21,763 women between the ages of 15-45 years. The goal of the project is to reduce infant and child mortality through two strategies: strengthening of the Ministry of Health's service delivery system and mobilization of the community. Project interventions included diarrheal disease management, immunization, vitamin A supplementation, management of acute respiratory infection (ARI), promotion of ante natal care and improved delivery services and practices, family planning and literacy training for women.

Information regarding the health knowledge and practices of mothers with children under two years of age was collected through the CS VII Baseline K&P Survey in February 1992.¹ Additional baseline information was obtained through a 100% family enrollment of the project area in December 1991 - February 1992.² During the life of the project, additional qualitative and quantitative studies were conducted to guide the implementation of the project. At mid-term, a quantitative assessment was not conducted, as the mid-term evaluation team and project staff agreed that it was too early to expect change in knowledge and practices³ Therefore, this Final KPC Survey is the first comprehensive quantitative study to document changes in mothers' knowledge and practices since the Baseline K&P Survey.

1.2 OBJECTIVES OF THE FINAL KPC SURVEY

A population based sample survey is one method of obtaining rates; that is data relative to denominators, which are an important part of a project's health information system. The data collected from a sample survey can be used for project design, management information, and evaluation purposes. By restricting the sample to mothers of children less than 24 months of age, repeat surveys can ascertain the project's ability to reach children born during the life of the project, and establish whether the project was successful in communicating to the mothers certain action messages about key Child Survival interventions. The objective of the Final KPC Survey was to provide SC/US and Siraha District staff with a quantitative assessment of the impact of the project on mothers' health knowledge and practices. Specifically, knowledge and practices regarding the following project interventions were assessed:

- breast-feeding and child feeding practices
- diarrheal diseases
- acute respiratory infection (ARI)
- immunizations
- vitamin A supplementation
- maternal care

The estimate of confidence limits for the survey results were calculated using the following formula: **95% confidence limit = p +/- z (square root of {pq/n})**
where: **p** = proportion in population found from survey; **z** = statistical certainty chosen (if 95% certainty chose, that **z** = 1.96); **q** = 1-p; and **n** = sample size.

EXAMPLE: If the proportion of children in the survey who were completely and correctly immunized is 37%, **n**=297, and **z** = 1.96:

$$95\% \text{ confidence limit} = .37 \pm 1.96 (\text{square root of } \{.37 \times .63/297\})$$

Therefore, $1.96 = .37 \pm .03$ (34% to 40%)

In other words, we are 95% sure that the actual proportion of children in the survey area who are completely and correctly immunized is between 34% and 40%.

2.3 SELECTION OF THE SAMPLE

The sample consisted of 240 women with children 0-23 months of age in 24 Village Development Committees (VDCs) in Ilakas 4 and 5, Siraha District, Nepal. Eight households were selected in each of 30 selected wards (cluster sites) following the process described in The EPI Coverage Survey training manual (WHO, Geneva, Oct. 1988).⁵ Thirty wards were randomly selected from the population data collected during the 100% family enrollment conducted by the project in December 1991 - February 1992.² The sampling interval was calculated and the first cluster was selected using a currency note to obtain a random number within the sampling interval. The remaining 30 clusters were selected moving forward from this point (Appendix E).

Population-based data is not available for the villages in the ward, so one village was randomly selected by the following method. After the survey teams reached the designated wards, they obtained the names of all of the villages in the wards. These villages were numbered. A numbered slip of paper was then drawn from the cupped hands of the supervisor by one of the interviewers. The initial household surveyed within the village was identified by the following method: The survey team went to the center of the village where they spun a bottle. Following the direction of the bottle, all houses (with a child under two years) between the village center and border were identified and serially numbered. Again, the house was selected by drawing a numbered slip of paper from the hands of the supervisor. The survey team started the interviews in the selected house and continued with the houses in a line to the border. After reaching the border, the next nearest household with a child under two years was interviewed. If two houses were equidistant from the last completed house, the next house was selected by the toss of a coin.

2.4 TRAINING OF SUPERVISORS AND INTERVIEWERS

The CS VII project staff in Siraha selected the 15 survey supervisors and hired 30 local women to attend the survey training. Interviewer qualifications included SLC pass (high school equivalent) and knowledge of spoken Maithali. The selected candidates were advised that final selection as a survey interviewer would be dependent upon demonstrated ability to conduct interviews during the training sessions.

The first two questions ask about the age of the respondent (mother) and her youngest child under 24 months of age; question 3 obtains the household address; and question 4 asks about the mother's involvement in income generating activity. Questions 5-9 deal with breast feeding and supplemental feeding practices; and question 11 asks about knowledge of foods that prevent night blindness. Questions 11-20 refer to mother's responses to diarrheal disease and management of the child with diarrhea. Questions 21-25(a and b) deal with mother's responses to ARI and management of the child with ARI. Questions 26-31(a and b) concern the immunization status and vitamin A supplementation status of the child. Questions 32-43 are about ante natal care, family planning, delivery attendant and knowledge of the "three cleans" for delivery.

As during the baseline survey, the questionnaire was originally available in English (Appendix B) and translated into Nepali. SC/US has acquired additional experience with the survey questionnaire through its CS VIII project in Nuwakot District. This has aided in preparing the most easily understood Nepali translation (Appendix A). The Maithali translation was adapted from the translation used during the CS VII baseline K&P survey. Translations for the questions that were added for the final survey were obtained locally, in Siraha, to ensure that these questions would be colloquially appropriate. Interviewers carried a written copy of the Maithali questionnaire for use with mothers who could not easily understand the Nepali. Although Maithali is widely spoken in the eastern Terai region of Nepal, it no longer exists in written form, so the written Maithali translation is a transliteration using written Nepali (Appendix C).

2.2 DETERMINATION OF SAMPLE SIZE

Sample sizes were calculated using the following formula: $n = z^2 (pq)/d^2$
 where n = sample size; z = statistical certainty chosen; p = estimated prevalence/coverage/level to be investigated, $q = 1-p$; and d = precision desired.

The value of p was defined by the coverage rate that requires the largest sample size ($p = .5$). The value d depends on the precision, or margin of error, desired (in this case $d = .10$). The statistical certainty was chosen to be 95% ($z = 1.96$). Given the above values, the needed sample size (n) determined is:

$$\begin{aligned} n &= (1.96 \times 1.96) (.5 \times .5) / (.1 \times .1) \\ n &= (3.84) (.25) / .01 \\ n &= 96 \end{aligned}$$

It takes much time to randomly select an identified individual from the survey population, and then perform this selection 96 times to identify a sample of $n = 96$. Time can be saved by doing a 30-cluster sample survey in which several individuals within each cluster are selected to reach the required sample size. However, in order to compensate for the bias which enters the survey from interviewing persons in clusters, rather than as randomly selected individuals, experience has shown that a minimum sample of 210 (7 per cluster) should be used given the values of p , d , and z above (Henderson, et.al., 1982).⁴ In general, when using a 30 cluster sample survey, the sample size used should be approximately double the value n , when $n = (z \times z) (pq)/(d \times d)$. In this case, a sample size of 240 (8 per cluster) was selected so as to ensure the minimum of 210 would be obtained

In order to ensure consent and confidentiality, a consent form was read to the mother before commencing with the survey (at end of Appendix B). The consent form advised the potential respondent that she was not obligated to participate in the survey. The consent form also assured the mother that all information would be held in confidence, and that the information would be used to help health workers plan health activities.

2.6 METHOD FOR DATA TABULATION AND ANALYSIS

A team of 20 persons, from among SC/US staff and survey supervisors and interviewers, worked in pairs to hand tabulate the data. The tabulation took two days, including cross tabulations of supplemental feeding practices and of immunization and vitamin A status by age. Each question from the survey questionnaire had one or more tables that coincided with the question. Tables consisted of frequency distribution and percent. Tabulators received a short training from SC/US staff in hand tabulation technique and were closely supervised by two senior SC/US staff and the SC/US consultant.

Due to inaccuracies, two questionnaires were dropped during tabulation, making the completed sample size 238.

2.7 COSTS

ITEM	COST (NR)	COST (US\$)
Questionnaire preparation and printing	3,900	
Photocopying of revised/added questions	1,150	
Supplies (pens, pencils, erasers, tape, etc.)	3,100	
Snacks during training and tabulation	4,100	
Travel and daily allowances for interviewers and supervisors	13,000	
Per diem for drivers and Nuwakot/Kathmandu staff	4,375	
Reproduction of report (estimated)	15,000	
Airfare to Janakpur		55
Consultant fee		1,000
Sub-Total	NR 44,625	US\$ 1,055
TOTAL	US\$ 1,900	

2.8 FEEDBACK SESSIONS

2.8.1 Discussion of Results with SC/US Siraha Field Staff

A summary of the results of the CS VII Final KPC Survey was presented for discussion to representatives of the SC/US Siraha field staff on November 28, 1994. The purpose of the discussion was to:

- share ideas regarding the factors that facilitated and limited the impact of the project as determined by the survey,
- identify the lessons learned, and
- select recommendations for further health program activities.

The training of supervisors and interviewers was conducted by senior SC/US staff from Nuwakot, Siraha, and Kathmandu. The training took place over three days, November 20-22. The training agenda appears in Appendix D.

Only the supervisors attended the first half of the first day. Though sample size and the 30-cluster sample had already been drawn for the survey, supervisors practiced calculating and selecting a sample using mock data.

Due to the nature of interviewer qualifications and brevity of the training, sessions on sample size calculations and drawing a 30-cluster sample were not thoroughly reviewed in the interest of more time for practical experience and interchange. The sessions demonstrating good and bad interview techniques were conducted by four (two teams of two) SC/US staff. After the demonstrations, the supervisors and interviewers practiced reading the questionnaire, followed by practice interviewing each other. The Maithali translation of the questionnaire was also reviewed.

The final day of training commenced with field experience. Three nearby wards, which did not fall into the survey sample, were selected as convenient and large enough field test sites. Each interviewer completed one interview, with mothers of children 0-23 months old, under supervision. All questionnaires were then checked by the survey trainers and comments marked on each interview form. The afternoon feedback session, with all interviewers and supervisors, consisted of reviewing marking errors, and discussing difficulties experienced in the field and general impression of the day's activity.

Upon completion of the training, four interviewers were dismissed from interviewer responsibilities because of inadequate skill. The list survey team members is given in Appendix F.

2.5 CONDUCT OF THE INTERVIEWS

The household interviews were conducted over three days, November 23-25. The 30 cluster sites were distributed throughout Ilakas 4 and 5 from the northern-most point in the foothills of the Himalayas to the southern-most point on the Indian border. SC/US made available two jeeps for use by the 15 survey teams. To ensure accuracy and efficiency of the interviews, most survey team were comprised of two interviewers and one supervisor. Two experienced teams of one supervisor and one interviewer were selected to enable completion of the interviews as quickly as possible. The intensive level of supervision enabled each team to complete one cluster a day, with some variation due to time required for travel to the cluster site.

Teams were deployed at 8:30 AM and returned between 5:00 PM and 7:00 PM. After returning each evening the questionnaires were collected and the survey trainers reviewed many of the questionnaires for accuracy and completeness.

The supervisors of each team were responsible for the selection of the starting household and direction in each cluster. Most supervisors observed 50% of the interviews conducted by each interviewer, each day. Each questionnaire was checked for completeness before the survey team left the survey area, so that, in the case of missing or incorrect information, the mother could be visited again the same day.

was 10.2 months. The mode was 9 months. It is noteworthy that the distribution of ages is skewed to the children under one year. The effect this distribution had on findings, such as family planning use, is unknown.

Age (in months)	#	%	Cumulative %
0	15	6.3	59.5
1	10	4.2	
2	9	3.8	
3	13	5.5	
4	12	4.6	
5	7	2.9	
6	12	4.6	
7	10	4.2	
8	12	5.0	
9	23	9.7	
10	12	5.0	
11	7	2.9	
12	10	4.2	40.3
13	6	2.5	
14	17	7.2	
15	10	4.2	
16	8	3.4	
17	12	5.0	
18	5	2.1	
19	3	1.3	
20	4	1.7	
21	6	2.5	
22	9	3.8	
23	6	2.5	

3.3 INCOME GENERATION

The participation of the mothers in some kind of income generating activity has increased from 10.5% to 38.2%. The chief income generating activities reported were casual labor (13.9%), selling agricultural products (13.5%), and producing/selling livestock (12.6%).

3.4 BREAST FEEDING PRACTICES

Breast feeding continues to be universal, with 97.5% of mothers reporting breast feeding their less than 2 year old child now. Five of the six mothers not breast feeding now reported breast feeding previously. 74% mothers reported starting to breast-feed their newborn more than 8 hours after delivery.

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This discussion provided the basis for the discussion of the findings, lessons learned, and recommendations made in this survey report. Since time available for the discussion was very limited (2 1/2 hours) the ideas discussed were further expanded by SC/US staff in Kathmandu. A list of discussion participants is given in Appendix G.

2.8.2 Community Feedback Session / Siraha

A summary of the results of the CS VII Final KPC Survey were presented to the government officials, local leaders, and other community members on December 5, 1994, at the SC/US office in Golbazar, Siraha. A list of the 40 participants is presented in Appendix H.

During the session, important findings regarding the six components of the project were presented, followed by a discussion. The participants actively participated in the discussion, commenting on the achievements and shortcomings of the project and making recommendations for future health program activities. A short report of the session is presented in Appendix I.

2.8.3. Feedback to Ministry of Health and U.S. AID/Nepal Officials

SC/US has planned a presentation of the results of the CS VII Final KPC Survey for officials from the Ministry of Health and U.S. AID/Nepal in December 1994, following the final project evaluation. Copies of the survey report will be distributed to the invited officials prior to the meeting. The final evaluation team will present the findings of the evaluation, including the Final KPC Survey results. SC/US staff from Kathmandu and Siraha will support the discussion with additional comments regarding their first-hand experiences implementing the project in Siraha.

3. RESULTS

During data tabulation, two questionnaires were dropped due to errors. Unless otherwise stated, the percentages given are based on the total sample of 238 complete, accurate questionnaires.

To facilitate comparison of the final survey findings against those of the baseline survey, most of the results are presented in tables including the percentages for both surveys.

3.1 MOTHER'S AGE

The mothers' ages were clustered at five year intervals (i.e., 20, 25, and 35). The range of ages was 17-44 years; the mean was 26.5 and the mode was 25 years.

3.2 CHILD'S AGE

The children's ages were truncated (i.e., rounded down to the nearest completed month; e.g., 27 days = 0 months). The sum of the 238 children's ages was 2,429 and the mean

findings of supplemental feeding practices observed at the time of the **baseline survey** are presented in the following table:

Baseline Survey					
Are you giving child...?	Age (in months)				
	0-3	4-6	7-9	10-12	13-23
water	(2) 4.4%	16.1%	66.7%	91.2%	98.0%
bottle milk	(2) 4.4%	3.2%	14.8%	14.7%	4.0%
porridge/gruels	(0) 0.0%	9.7%	63.0%	85.3%	96.0%
fruits/fruit juices	(1) 2.2%	9.7%	29.6%	58.8%	56.4%
leafy green vegetables	(0) 0.0%	6.5%	33.3%	76.5%	91.1%
meat/fish	(0) 0.0%	6.5%	14.8%	52.9%	75.2%
legumes	(0) 0.0%	9.7%	37.0%	70.6%	88.1%
eggs/yogurt	(0) 0.0%	6.5%	18.5%	38.2%	63.4%
adding sugar	(0) 0.0%	3.2%	14.8%	35.3%	46.3%
adding fat/oil	(1) 2.2%	9.7%	18.5%	50.0%	54.5%
# of children by age group	45	31	27	34	101

There was an unexpected increase in the proportion of children 0-3 months given water, other milks, and added sugar. (It is a common practice to add sugar to other milks.) Although these increases are greater than the margin of error of the study, it is difficult to know how significant they are given the small number of children in this age group (as is shown in the tables).

3.6 *DIARRHEAL DISEASES*

There was no change in the proportion of children reported to have had of diarrhea in the two weeks before the survey (32.8%).

3.6.1 *Feeding Practices during Diarrhea*

The feeding practices of the 78 mothers who reported their child had had diarrhea are presented in the following tables alongside the findings of the baseline survey.

Amount of breast milk given was ...?	#	%	Baseline %
more than usual	17	21.8	7.4
same as usual	40	51.3	49.4
less than usual	20	25.6	43.2
stopped completely	1	1.3	0.0
child not breast-fed	0	0.0	0.0

3.5 SUPPLEMENTAL FEEDING PRACTICES

3.5.1 Knowledge of Time to Introduce Supplemental Foods

Although the proportion of mothers stating the correct age for introduction of supplemental foods (4 to 6 months) more than doubled since the baseline survey, two thirds of mothers still believe supplemental foods should be introduced after 6 months.

Time	#	%	Baseline %
4-6 months of age	65	27.3	12.1
before 4 months	12	5.0	1.3
after 6 months	158	65.4	76.6
don't know	3	1.3	10.0

3.5.2 Supplemental Feeding Practices by Age

The final survey findings of the percent of children receiving solid/semi-solid foods, by age group, is shown in the following table (mother answered "yes", she gives the food to the child, or adds it to the child's food).

Final Survey					
Are you giving child...?	Age (in months)				
	0-3	4-6	7-9	10-12	13-23
water	(10) 21.3%	51.6%	88.9%	100%	100%
other milks	(8) 17.0%	29.0%	46.7%	69.0%	64.0%
porridge/gruels	(2) 4.3%	32.3%	68.9%	96.6%	97.7%
fruits/fruit juices	(0) 0.0%	6.5%	35.6%	69.0%	67.4%
squash/mango/papaya	(1) 2.1%	6.5%	40.0%	75.9%	77.9%
leafy green vegetables	(1) 2.1%	12.9%	64.4%	93.1%	97.7%
meat/fish	(1) 2.1%	9.7%	37.8%	75.9%	80.2%
legumes	(1) 2.1%	16.1%	66.7%	96.6%	97.7%
eggs/yogurt	(1) 2.1%	9.7%	40.0%	69.0%	70.9%
adding sugar	(5) 10.6%	35.5%	51.1%	75.9%	70.9%
adding fat/oil	(2) 4.3%	25.8%	66.7%	89.7%	96.5%
# of children by age group	47	31	45	29	86

There were considerable improvements in the introduction of supplemental foods; more children were given more foods at an earlier age, compared to the baseline survey. The

none of the mothers in the baseline survey. Other sources of treatment for diarrhea were as follows:

From where was treatment sought?	#	%	Baseline %
Health post/hospital/mobile clinic	23	36.5	0.0
Private doctor	26	41.3	18.6
Relatives/friends	19	30.2	65.1
VHW	2	3.2	NA
CHV	6	9.5	4.6
TBA	2	3.2	NA
Traditional healer	8	12.7	4.6
Medical shop	17	27.0	4.6

The increase in the use of private doctors and medical shops is important because these health workers do not have standardized types and levels of training. The private doctors ("quacks") are often men who previously worked with the malaria eradication program; they are not doctors. Medical shopkeepers may or may not have attended courses that included diagnosis and treatment of diarrhea.

3.6.3. Knowledge of Signs and Symptoms of Diarrhea and Actions to Take during Diarrhea

Mothers' knowledge of the signs and symptoms of diarrhea that warrant treatment improved as follows:

Signs/symptoms that would cause mother to seek treatment for diarrhea:	#	%	Baseline %
Doesn't know	6	2.5	26.8
Vomiting	74	31.1	13.4
Fever	98	41.2	7.5
Dry mouth, sunken eyes, decreased urine output	78	32.8	12.9
Prolonged diarrhea (>14 days)	105	44.1	12.9
Blood in stool	45	18.9	5.0
Loss of appetite	45	18.9	5.4
Weakness	150	63.0	38.1
Other	37	15.6	7.1

From this data it is clear that there is a marked increase in mothers' knowledge of signs and symptoms of diarrhea that warrant seeking treatment. This is consistent with the increases in mothers' knowledge of actions to take when their child has diarrhea. The increase in knowledge of the need to give more to drink and more frequent, small foods suggests that there is a gap between the knowledge and practices regarding the actions to take during diarrhea.

Amount of other fluids given was ...?	#	%	Baseline %
more than usual	5	6.4	7.4
same as usual	27	34.6	12.3
less than usual	22	28.2	29.6
stopped completely	7	9.0	11.1
exclusively breast-fed	17	21.8	39.5

Amount of solid foods given was ...?	#	%	Baseline %
more than usual	3	3.9	6.2
same as usual	26	33.3	13.6
less than usual	28	35.9	35.8
stopped completely	6	7.7	13.5
exclusively breast-fed	15	19.2	30.9

Although mothers have adopted the practice of giving *more* breast milk during diarrhea, they did not give more fluids or solid foods. However, there is a definite increase in the proportion of mothers giving the *same* amount of fluids and solids as usual.

3.6.2. Treatment of Diarrhea

One-half (50%) of the 78 mothers who reported their child had had diarrhea, used oral rehydration solution (ORS) to treat the diarrhea, compared to 16% of mothers in the baseline survey. The percentage of mothers giving medicine increased from 33.3% in the baseline survey to 62.8% now. Treatments utilized by the 78 mothers reporting their child had diarrhea were as follows:

Treatment given:	#	%	Baseline %
None	9	11.5	34.6
ORS	39	50.0	16.0
Salt-sugar-water solution	8	10.3	8.6
Other fluids	4	5.1	1.2
Saline infusion	0	0.0	NA*
Diarrhea medicine	49	62.8	33.3
Other	15	19.2	16.0

* not asked

There was a 28% increase in the proportion of mothers who sought treatment for their child's diarrhea (from 53.1% baseline to 80.8% final). Of the 63 mothers who sought treatment 36.5% went to a MOH facility (health post/hospital/mobile clinic), compared to

From where was treatment sought?	#	%
Health post/hospital/mobile clinic	18	42.9
Private doctor	18	42.9
Relatives/friends	10	23.8
VHW	0	0.0
CHV	2	4.8
TBA	0	0.0
Traditional healer	8	19.0
Medical shop	15	35.7

Again, the use of private doctors and medical shops is important because they lack standardized training and may not prescribe appropriate medical care, whereas VHWs and CHVs are the community-based MOH workers and volunteers who have been targeted to receive training regarding prompt recognition of ARI and early referral for appropriate treatment.

3.7.2. Knowledge of Signs and Symptoms of ARI

46.2% of the 238 mothers interviewed correctly named *three* signs and symptoms of ARI that would cause them to seek treatment. Another 29.8% correctly identified *two* signs and symptoms. The knowledge of specific signs and symptoms of ARI that would cause them to seek treatment was as follows:

Signs/symptoms that would cause mother to seek treatment for ARI:	#	%
Doesn't know	26	10.9
Fast or difficult breathing	156	65.5
Chest indrawing	123	51.7
Loss of appetite	47	19.7
Fever	121	50.8
Cough	127	53.4
Other	26	10.9

3.7.3 Knowledge of Where Treatment for ARI is Available

65.1% of the 238 mothers interviewed knew that treatment for ARI was available at MOH facilities (health post/hospital/mobile clinic). Knowledge of other sources where treatment could be obtained followed closely the pattern of where treatment had actually been

Actions to take when child has diarrhea:	#	%	Baseline %
Doesn't know	3	1.3	20
Take to health post	143	60.1	45.6
Give child more to drink	46	19.3	0.0
Give child smaller, more frequent feeds	70	29.4	1.3
Withhold fluids	14	5.9	0.0
Withhold foods	8	3.4	0.4
Other	108	45.4	42.3

As with knowledge of actions to take during diarrhea, there is a marked increase in mothers' knowledge of the need to give children extra food following diarrhea:

Actions to take after child has diarrhea:	#	%	Baseline %
Doesn't know	9	3.8	54.8
Give child smaller, more frequent feeds	121	50.8	7.5
Give child more foods than usual	46	19.3	5.0
Give child foods with high calorie content	92	38.7	17.1
Other	47	19.7	15.8

3.7 ACUTE RESPIRATORY INFECTION

The proportion of mothers who reported their child had been ill with cough or difficult breathing in the past two weeks was 25.6%. To determine whether or not these children were likely to have suffered from acute respiratory infection (pneumonia) these mothers were also asked if the sick child had experienced fast, difficult breathing. Fifty mothers (21%) said yes. Thus, the prevalence of ARI was similar to the baseline data collected in November 1992 during the Jeevan Jal preparation survey (26.8%). Information regarding ARI was not obtained during the baseline K&P survey because the original ARI objective aimed to improve the knowledge and practices of VHWs and CHVs, not mothers. However, during the baseline survey it became apparent that community awareness of ARI was high; 61.9% of mothers reported that cough was the most significant child health problem in the community. Therefore, the objectives for improving the knowledge and practices of mothers were added when the detailed implementation plan was prepared in May 1992.

3.7.1 Treatment for ARI

84% of the 50 mothers reporting ARI sought treatment for their child. 42.9% of these mothers sought treatment from MOH health facilities. Other sources of treatment included:

Even greater improvements in mothers' knowledge were observed for TT immunization:

Knowledge of reason for giving TT:	#	%	Baseline %
To protect mother and newborn against tetanus	177	74.4	14.6
To protect only the mother against tetanus	22	9.2	17.1
To protect only the newborn against tetanus	7	2.9	10.5
Doesn't know	32	13.5	57.7

Knowledge of # of TT injections needed to protect the newborn:	#	%	Baseline %
One	22	9.2	6.3
Two	38	16.0	12.1
More than two	152	63.9	37.6
Doesn't know	25	10.5	43.9

3.8.3 *Child Immunization Coverage*

There was no significant change in the proportion of infants *0-3 MONTHS* who had received BCG immunization (20% at baseline and 17% at final survey), suggesting that families have not altered their practice of keeping their young infants at home.

Vaccine coverage among infants *4-11 MONTHS* showed declines in coverage of BCG, DPT1, and OPV1, and suggest declines in DPT and OPV drop-out rates:

Vaccine coverage 4-11 months:	#	%	Baseline %
BCG	43	45.3	57.5
DPT1	47	49.5	62.5
DPT3	16	16.8	18.8
DPT drop-out	-	66.0	70.0
OPV1	46	48.4	57.5
OPV3	16	16.8	17.5
OPV drop-out	-	65.2	69.6

Vaccine coverage among children *12-23 MONTHS* showed increases of .15-20% in coverage levels for all immunizations, and suggest decreases in both DPT and OPV drop-

sought by the 50 mothers with sick children. The following sources of treatment were reported:

From where is treatment for ARI available?	#	%
Health post/hospital/ mobile clinic	155	65.1
Private doctor	88	37.0
Relatives/friends	20	8.4
VHW	9	3.8
CHV	6	2.5
TBA	3	1.2
Traditional healer	65	27.3
Medical shop	42	17.6

Again, we see that private doctors (quacks), medical shops, and traditional healers are preferred sources of child health care.

3.8 IMMUNIZATION

3.8.1 History of Immunization and Retention of EPI Cards

There was no change in the proportion of mothers who reported that their child had ever received immunizations: 69.3% now compared to 73.2% of mothers in the baseline survey. However, the findings suggest that retention of EPI cards slightly improved (interviewers had to see the EPI card or the growth monitoring card).

Do you have an EPI card?	#	%	Baseline %
Yes	106	44.5	39.3
Lost	59	24.8	31.8
Never had one	73	30.7	28.9

Interviewers commented that many mothers had thrown the EPI card away after the immunizations were completed, which is consistent with an observed decrease in card retention with increasing age of the child.

3.8.2 Knowledge of Immunizations

Knowledge of the correct age to give measles vaccine increased from a baseline level of 17.6% to 39.4% of mothers in the final survey.

3.10 MATERNAL HEALTH

3.10.1 Utilization of Ante Natal Services and TT Coverage

There were marked improvements in utilization of ante natal services and tetanus toxoid (TT) coverage since the baseline survey:

Utilization of ante natal services/TT coverage:	#	%	Baseline %
Have an ante natal card	49	20.6	1.2
Lost an ante natal card	58	24.4	5.4
Had 1 or more ante natal visits (documented on card)	49	20.6	1.2
Had 1 or more ante natal visits (reported)	99	41.6	9.6
Have a TT card	71	29.8	17.2
Lost a TT card	77	32.4	11.3
Had 2 or more TT (documented on card)	66	27.7	17.6

3.10.2 Food Intake during Pregnancy

The results suggest a slight increase in intake of food during pregnancy, with some women more likely to consume the same amount of food as usual, rather than eating more food than usual:

During pregnancy the amount of food you ate was...?	#	%	Baseline %
more than usual	42	17.6	7.5
same as usual	78	32.8	23.4
less than usual	118	49.6	68.6

3.10.3 Delivery Attendant

The final survey results show no change in type of delivery attendant, but does provide new information about the utilization of trained versus untrained traditional birth attendants (TBAs). While the utilization of TBAs had not changed, the results show that among the 74.4% of deliveries attended by TBAs, nearly half (48%) are attended by trained TBAs. It was noteworthy that mothers knew whether or not the TBA had been trained, possibly due to the high visibility of TBA training and CHV/TBA meetings in the

out rates. These improvements resulted in an increase in complete coverage, with BCG + DPT3 + OPV3 + measles, from 10.5% at baseline to 22.9% now:

Vaccine coverage 12-23 months:	#	%	Baseline %
BCG	47	49.0	28.1
DPT1	47	49.0	28.9
DPT3	30	31.3	15.8
DPT drop-out	-	36.2	45.5
OPV1	47	49.0	28.1
OPV3	28	29.2	14.9
OPV drop-out	-	40.4	46.9
Measles	27	28.2	13.2
Complete coverage	22	22.9	10.5

The slight difference between polio and DPT drop-out rates may be insignificant or may reflect the project staff's observation that polio vaccine supply was less adequate than the DPT vaccine supply.

3.9 VITAMIN A

3.9.1 Knowledge of Foods with High Vitamin A Content

66.8% of mothers accurately stated that green leafy vegetables help prevent night blindness. Yellow fruits (37.4%) and fish/meat (37.4%) were also reported to be helpful.

3.9.2 Vitamin A Coverage

In accordance with MOH policy, there are no home-based records of vitamin A capsule distribution. 55.2% (53/96) of mothers reported that their 12-23 month old child had received two or more doses of vitamin A.

Heeding this recommendation, the focus of the nutrition intervention was shifted to include:

- Promotion of adequate feeding practices during and after illness.
- Promotion of foods high in vitamin A content and support for the MOH's new vitamin A supplementation program.
- Assessment of the impact of recent crop failures on the nutritional status of children.

In spite of dropping the objective regarding weaning foods and less focus on growth monitoring, weighing of infants and children continued to be done during the maternal child health (MCH) clinics. In most communities weighing was considered to be an essential MCH clinic activity. MOH staff and community members received some training about the charting of weights on the "Road-to-Health" cards and were assisted with providing some basic advice and encouragement to the families of malnourished children. Although comprehensive efforts to improve supplemental feeding practices were not undertaken, the final survey shows definite improvements in these practices. However, the unexpected increase in the giving of water, other milks and added sugar to infants 0-3 months is worrisome and needs to be further investigated.

The MOH in Siraha District received considerable assistance from the National Vitamin A Program Technical Advisory Group (TAG) and SC/US during the first two vitamin A capsule distribution campaigns in 1993. During these campaigns reported coverage rates were high (over 90%). National level staff assisted district staff with the training of health workers and volunteers, capsule supply, and supervision. SC/US supported the campaigns with promotional activities, training, and supervision. However, as the national effort moved into its second year, the TAG was phasing out its participation and the District Health Office (DHO) is assuming responsibility for the vitamin A capsule distribution campaigns. In the most recent campaign (October 1994), SC/US staff observed that coverage levels had dropped due to inadequate coordination during planning, training, and capsule distribution. The report of coverage is pending from the DHO.

4.1.2 Achievements

Nutrition / Vitamin A Objectives	Achievements
Conduct a study of the impact of recent crop failures on food availability and distribution within households and the nutritional status of children under 5 years to determine the need for food aid intervention.	Post-harvest (Feb 1994) and pre-harvest (Aug 1994) nutrition surveys showed chronic malnutrition and no indication for food aid intervention.
60% of children 12-23 months will have received 2 doses of vitamin A.	55.2% had received 2 doses (reported, not documented).

4.1.3 Recommendations

SC/US staff recommend that vitamin A activities continue to focus on both prevention of vitamin A deficiency and regular vitamin A supplementation.

- The final survey showed increased knowledge of some foods that are high in vitamin A content, but further education about the diversity of such foods should be promoted

10/1

communities. Few mothers (5.0%) seek out health professionals for assistance at the time of delivery.

Who cut and tied the cord?:	#	%	Baseline %
Yourself	9	3.8	6.6
Family member	37	15.6	22.6
Untrained TBA	92	38.7	NA*
TBA	NA	NA	68.2
Trained TBA	85	35.7	NA
Health professional	12	5.0	1.2

* not asked

3.10.4 Knowledge of the 3 Cleans for Delivery

51.3% of mothers correctly stated the 3 cleans for a safe delivery (clean hands, clean surface, and clean cord tie and cutting tools). Another 23.9% correctly stated 2 of the 3 cleans. Only 5% of mothers did not know what needs to be clean at the time of delivery.

3.11 FAMILY PLANNING

The utilization of family planning had not changed. Only 18 women (9.0%), of the 201 women who were not and did not want to be pregnant in the next two years, were utilizing a family planning method. The contraceptive prevalence, by type, was as follows:

Family planning method:	#	% (of 201 eligible)	Baseline % (of 169 eligible)
Vasectomy/laparoscopy/ mini-lap	11	5.5	9.5
Depo-provera injections	3	1.5	1.2
Pills	2	1.0	0.0
Condoms	2	1.0	0.0
Total	18	9.0	10.7

4. DISCUSSION AND RECOMMENDATIONS

4.1 NUTRITION/ VITAMIN A

4.1.1 Discussion

Following the mid-term evaluation, the project staff dropped the objective regarding appropriate weaning foods (see Appendix J for list of revised project objectives). "The [mid-term] evaluation team believed effective nutrition interventions were so difficult to achieve, that perhaps the project could better focus on improving nutrition through promotion of treatment for ARI, ORT use during diarrhea, and measles immunization."³

fluids and 3.9% more foods). The only significant improvement was an increase in the giving of more breast milk during diarrhea (from 7.4% to 21.8%).

4.2.2 Achievements

CDD Objectives	Achievements
60% of families with a child <2 years will know how to prepare Jeevan Jal correctly.	41% demonstrated correct preparation *
60% of families with a child <2 years will know how to give Jeevan Jal correctly.	19% of families knew how to give correctly to a child <2 years *
25% of children <2 years with diarrhea will be treated with JJ.	50% were treated with JJ
25% of children <2 years will receive more fluids during diarrhea.	21.8% more breast milk 6.4% more other fluids
25% of children <2 years will receive more foods during diarrhea.	3.9% more foods
25% of children <2 years will receive more foods after diarrhea.	Not asked - knowledge of need to give small, frequent feeds was 50.8%.
90% of mothers with a child <2 years will have access to JJ.	88% had access to JJ *

* Findings from the Jeevan Jal Preparation Final Survey (Appendix K)

4.2.3 Recommendations

SC/US staff believe that these successes were achieved through the diverse ways that families, and particularly women, were encouraged to adopt the beneficial practices:

- JJ campaigns during which highly motivated CHVs demonstrated preparation of JJ in their villages and taught women appropriate management of diarrhea. These activities were supported by placement of signs marking the CHVs' homes, where JJ was available for sale. Other local leaders and TBAs who expressed interest were included as sources for education about the management of diarrhea and as sales agents for JJ.
- JJ promotion and education about the management of diarrhea through the non-formal education (NFE) program. During these promotional campaigns, each NFE participant was given the opportunity to correctly demonstrate the preparation of JJ and discuss the appropriate management of diarrhea. The impact of JJ promotion in the NFE classes was well documented in a study of the impact of the NFE program on health behaviors: 99% of NFE program graduates demonstrated correct preparation of JJ, compared to 55% of illiterates and 74% of other literates.⁶
- Street dramas, wall paintings, and posters supported these campaigns.
- These promotional activities were backed up by refresher training in diarrhea management for MOH health workers and volunteers and support for the conduct of MCH clinics where ORT corners were maintained.
- The project has coordinated with the DHO and health post staff, CHVs, and community leaders to initiate and maintain two health post MCH clinics and 13 outreach MCH clinics every month.

through IEC activities. Additionally, the post-harvest Nutrition Survey and Focus Group Discussions identified the need to teach families ways to maintain the nutrient value of their food during food processing and cooking.

- Establishing kitchen gardens may be an appropriate mechanism for increasing mothers' knowledge of vitamin-rich foods and improve access to vegetables and fruits. However, promotion of kitchen gardens would need to be supported by irrigation systems since many communities in the project area have insufficient water for gardens.
- SC/US should work closely with the DHO to support planning, training, and supervision for the vitamin A capsule distribution campaigns. Promotion of the campaigns should continue to ensure that families remain motivated to seek vitamin A supplementation for their children.
- Further efforts to maintain a household- or community-based record of vitamin A supplementation should be explored through discussion with the DHO, TAG, and other agencies that have initiated vitamin A capsule distribution campaigns. This would facilitate programming; i.e., allow for calculation of coverage, as well as improve efforts to target individual children for supplementation.

Regarding the introduction of supplemental foods at the recommended age, further study is needed to identify the factors influencing healthy feeding practices. Special attention should be given to exclusive breast-feeding for the first three months. Identifying households or mothers who can be used as role models for other families may create greater acceptance of appropriate feeding practices.

4.2 MANAGEMENT OF DIARRHEAL DISEASES

4.2.1 Discussion

The incidence of diarrhea has not changed since the baseline survey. However, several outbreaks of diarrhea were observed during the 1994 rainy season. These findings point to the difficulty encountered by health programs that aim to reduce diarrhea morbidity and mortality. The SC/US staff unanimously pointed to the lack of clean drinking water and sanitation facilities as being the key causes for these endemic and epidemic levels of diarrheal diseases. Efforts to prevent morbidity through promotion of adequate personal and environmental hygiene have little impact when clean drinking water is unavailable.

The final survey shows that mothers' knowledge and practices regarding diarrhea and its treatment have improved markedly, particularly with regard to the use of ORS, knowledge of the actions to take when their child has diarrhea, knowledge of the signs and symptoms of diarrhea that would cause a mother to seek treatment, and the practice of seeking treatment (especially from trained health workers). These findings are further supported by the findings of the final Jeevan Jal preparation survey in which 41% of households with a child less than 2 years had a family member who demonstrated correct preparation of JJ and 88% of households reported that ORS was available (Appendix K). However, the final JJ preparation survey showed no change in knowledge of how to give JJ.

The findings regarding feeding practices during diarrhea were less encouraging, perhaps due to a gap between the knowledge of beneficial feeding practices and the actual practices during the child's illness. Although there were increases in mothers' knowledge of the need to give more fluids and foods during diarrhea, few actually did so (6.4% more

The project has been somewhat successful in improving this situation through:

- Availability of ARI treatment at MCH clinics where support for essential drugs are provided.
- Promotion of ARI messages through CHVs, TBAs, mothers' groups, NFE classes, clinic management committees, street dramas, posters, wall paintings, etc.
- Technical training for MOH staff and volunteers to encourage appropriate treatment.

4.3.2 Achievements

Objectives	Achievements
25% of mothers with a child <2 years will know signs of ARI.	46.2% know 3 signs Another 29.8% know 2 signs
25% of mothers with a child <2 years will seek treatment for ARI.	84% mothers sought treatment for their child with ARI Of these, 42.9% sought care from MOH health facilities
80% of mothers with a child <2 years will know where treatment for ARI is available.	65.1% know ARI treatment is available from MOH health facility Other known sources: - 37% private doctors (quacks) - 27.3% traditional healers - 17.6% medical shops - 7.1% VHWs/CHVs/TBAs

4.3.3 Recommendations

SC/US staff recommend that the health program staff continue to collaborate with MOH personnel, SC/US field staff, and community members to promote ARI messages and support availability of appropriate ARI treatment. During the discussion of the ARI survey results it was noted that the successes achieved are the result of the committed teamwork of the project and MOH staff, supported by the entire SC/US Siraha field staff.

The survey results point to the need to collaborate with local private doctors (quacks), medical shopkeepers, and traditional healers to ensure appropriate treatment for ARI. Ways to establish communication with these local practitioners must be sought, so that the strengths and weaknesses of their treatment recommendations can be addressed, where necessary. Again, qualitative investigation may reveal how the attitudes and beliefs of the practitioners, their clients, and the health workers influence patterns of utilization and adoption of specific treatments.

The lack of appropriate antibiotics will continue to dictate what treatments are available, so solutions must be negotiated. Only once these drugs are available can appropriate treatment protocols be promoted and utilized.

Although most mothers reported that JJ is available near their homes, most medical shopkeepers and quacks promote more expensive types of ORS that are brought in from India. This situation is significant because these packets of ORS require different volumes of water for preparation, making it difficult to ensure that families know how to prepare ORS correctly.

The SC/US staff made the following recommendations for future programming:

- Ensure access to clean drinking water.
- Continue/expand the SC/US latrine promotion program. Investigate opportunities to support this program as a private sector activity, thereby improving access to sanitation and improving economic opportunity for local families.
- Continue to coordinate with MOH officials to improve JJ supply and distribution.
- Continue the JJ campaigns through CHVs and NFE classes and expand these promotional/educational campaigns to include other community groups. Identify and implement more effective ways of teaching how to give JJ.
- Continue to support the availability of appropriate referral services through training of health workers and support for MCH clinics.
- Conduct a qualitative study on child feeding practices during and after diarrhea to identify factors that support and inhibit the adoption of appropriate feeding practices. Utilize these findings to identify and test appropriate strategies for changing feeding practices.
- Investigate the practices of medical shopkeepers, local quack doctors, and traditional healers. Initiate activities with these groups to reduce the use of medicines and promote safe, appropriate treatments for diarrhea.
- Although the reasons for the lack of increase in knowledge of the correct administration of JJ could be hypothesized, SC/US staff should systematically investigate them through qualitative study. It is likely that while the success of JJ demonstrations are easy to assess through re-demonstration, it is much more difficult to assess whether messages about the administration of JJ are clearly understood. The learning process is further complicated by the availability of different types of ORS and the diverse opinions of family, friends, and others about how to treat diarrhea.

4.3 ACUTE RESPIRATORY INFECTION

4.3.1 Discussion

It is significant that many mothers seek treatment for ARI from MOH health facilities because there is a chronic shortage of antibiotics. Project staff were not surprised that families seek a medicinal treatment for ARI because receiving medicines is the outcome desired by caretakers when they visit a health worker, even when medicines are not indicated. Therefore, families presenting their sick children to the health post, quack, or medical shop often receive an antibiotic (or a prescription for one), even if the appropriate antibiotic is unavailable. Efforts to improve compliance with ARI treatment protocols at the MOH facilities has been met with some resistance, partly due to unavailability of the appropriate drugs. This is a complex situation matching community demand, the medical culture, and the lack of appropriate drugs against the child's health.

4.4.2 Achievements

Immunization Objectives	Achievements
60% of children 12-23 months will have documented complete immunization with BCG, polio, DPT, and measles.	22.9% had documented complete coverage
50% of women 15-45 years will have received at least two doses of TT.	27.7% had documented 2 or more doses of TT Another 32.4% reported losing their TT card

4.4.3 Recommendations

SC/US has a strong commitment to improving health services through the MOH system. Coordination with the DHO should be maintained to facilitate availability of viable vaccine and immunization cards, technical updates for health workers and volunteers, and strengthening of supervision. Ideally, the number of EPI clinic sites should be increased. SC/US could support the VHWs by placing a helper at each site (to help with records, advise mothers when to return, etc.). EPI clinic sites should be promoted so that mothers know where and when immunizations are available.

Project staff have observed that taking MOH staff and volunteers to visit other health projects has encouraged them to improve their work, as have awards for health workers and volunteers who perform their work well. These activities should be continued.

As with other project interventions, immunization messages should continue to be widely disseminated through NFE classes, CHVs, mothers' groups, street drama, posters, etc. Since TBAs can have a significant impact on immunization coverage, through early referral to EPI clinics, the vital role of the MCHWs in supervising/supporting the TBAs and CHVs should be maintained.

While efforts should focus on building demand for TT at MCH clinics, occasional TT campaigns will continue to increase knowledge of the importance of TT vaccination and initiate TT vaccination among all women 15-45 (in accordance with the MOH objective of 5 lifetime doses for women of child bearing age).

If immunization services improve, it may become necessary to look in greater detail at what factors influence the decision to obtain immunizations (through qualitative study). Findings should then be used to develop appropriate strategies for increasing knowledge of immunization and improving complete immunization coverage. One area of interest for such study is with regard to immunization cards. Although there were small improvements in card retention, most mothers have not yet adopted the practice of keeping these cards.

4.4 IMMUNIZATION

4.4.1 Discussion

There was little change in immunization coverage among children under 12 months. The survey findings indicate that families continue to first seek immunization for the infant after 3 months of age and are unlikely to complete the immunizations during the child's first year. The complete immunization coverage of 12-23 month old children for BCG, polio, DPT, and measles increased from 10.5% to 22.9%. This finding reflects only documented coverage, the interviewers had to look at the EPI or growth monitoring card. The proportion of mothers who had their child's EPI card increased from 39.3% to 44.5%. Although it is likely that the actual complete immunization coverage rate is higher, a review of a sample of the EPI registers - maintained by the VHWs during EPI clinics - showed a complete coverage rate of only 29% among children 12-23 months.⁷

Documented TT coverage (2 or more doses for women 15-45 years) increased by 10% to 27.7% in the final survey. Reported loss of TT cards was 52% of the 148 mothers who said they had ever had a card.

These small increases, while encouraging, point to the constraints to achieving greater coverage when SC/US is not the service provider. Examples of problems constraining access to viable, timely vaccines include:

- Inadequate supply of viable vaccine due to restructuring of the MOH, lack of transport to the district, lack of transport within the district, and lack of kerosene to maintain the cold chain.
- Supply was also disrupted following the severe flooding in 1993, as personnel and vaccines were routed to areas of the Terai needing emergency assistance.
- Reduction in the scheduled number of EPI delivery sites from 120 to 48 each month, to "... reduce vaccine wastage in the district". This reduction occurred at the end of 1993, as the project entered its third and final year.
- Failure of the VHW to attend the scheduled EPI clinics or transfer of the VHWs.
- Lack of adequate supervision of EPI clinics, partly because they are all scheduled to occur on the same few days of the month.
- Lack of EPI and TT cards.

SC/US has provided considerable logistic support for EPI activities, i.e., coordinating with the DHO to obtain vaccine from the Biratnagar facility, supplying kerosene for the refrigerators, paying travel expenses for health workers who attend extra outreach clinics, hiring local VHWs temporarily to fill the vacancies of transferred VHWs, etc. VHWs have received training to improve their EPI-related work, particularly to strengthen their record keeping.

These attempts to improve availability of immunizations, have been set against efforts taken to increase knowledge of and demand for immunizations. Improvements in knowledge of immunization were greater for TT than for measles. Only 39.4% of mothers knew when to give measles vaccine. However, nearly three-quarters of mothers knew that TT vaccines protect both mother and baby from tetanus, and over 95% knew they needed 2 or more doses of TT to protect the newborn. SC/US should look at possible reasons for this difference in knowledge of child versus TT immunizations.

4.5.3 Recommendations

Recommendations for ongoing maternal health activities include:

- Increasing the number and location of MCH clinic sites.
- Improving the quality of services through technical training, supervision, and support.
- Collaboration with the SC/US productivity sector to facilitate income generating activities for women. There is an underlying assumption that access to cash will help women to improve their diets.
- Increasing the number of ANMs.
- Continue with what worked well (as discussed above).

4.6 FAMILY PLANNING

4.6.1 Discussion

SC/US staff were disappointed but not surprised by the lack of improvement in use of family planning methods. It is felt that the main barriers to increasing contraceptive prevalence are attitudinal. A lively discussion was held regarding the cultural barriers to family planning promotion and use. Myths about the side effects of contraceptives, attitudes about desired family size, sex preferences, and cultural prohibitions against vasectomy were mentioned as some of the reasons for not using contraceptives. It was acknowledged that several of these factors result from a lack of knowledge about family planning methods and their benefits.

The lack of trained family planning providers and supplies was also discussed. All agreed that couples are unlikely to seek contraceptives from providers who are unskilled in family planning counseling techniques.

4.6.2 Achievements

Family Planning Objectives	Achievements
20% of eligible couples will use temporary or permanent methods of contraception.	9% of eligible couples are using

4.6.3 Recommendations

Due to the diversity and complexity of barriers to family planning acceptance and continuation, a variety of recommendations were suggested:

- Conduct a qualitative study of attitudes and behaviors that influence decisions regarding family planning utilization. Use the results to identify appropriate family planning messages and initiate promotional activities. The study may also be designed to influence prioritizing of which family planning methods are introduced first, i.e., if there is a large demand for permanent methods consider conducting voluntary surgical contraception camps before establishing ongoing VSC services.
- Identify local family planning users and use their influence to promote family planning.
- Coordinate with the DHO, and other agencies (CRS, Red Cross, FPAN, etc.) to establish an effective contraceptive supply and distribution system. Consider multiple systems to avoid dependence on the MOH.

4.5 MATERNAL HEALTH

4.5.1 Discussion

The maternal health interventions aimed to improve demand for and availability of ante natal, natal, and post natal services. The observed increases in utilization and knowledge of beneficial behaviors is likely to be the result of the coordinated maternal health activities

- Improved access to better ante natal care at the health post and outreach MCH clinics.
- Promotion of pregnancy and delivery care through CHVs, mothers' groups, and TBAs, under the supervision and support of the MCHWs.
- The complementary activities of the safe birth kit project.
- The 3 cleans campaign, during which TBAs and CHVs gathered groups of women (with a child under 2 years) in each ward to discuss safe delivery practices. The CHVs and TBAs were given posters and sample safe birth kits to demonstrate what needs to be clean at the time of delivery. These meetings were supported by street drama and miking. The TBAs and CHVs who gathered the largest groups of women were awarded small prizes for their good work.
- Technical training for TBAs, CHVs, MCHWs, and ANMs.
- Promotion of maternal health through NFE classes, outreach clinic and health post management committees.

Project staff commented that to a great extent the maternal health intervention did not depend on MOH personnel or availability of supplies for equipment. It was noted that this lack of dependency on the MOH enabled the project to have greater impact.

Further improvements in maternal health service utilization will depend on increasing the number and locations of MCH clinics. Lack of access to professionally trained ANMs has been hampered by the reduction in number of ANMs posted to each health post, from two to one. However, it is unclear whether this situation has had much impact on choice of delivery attendant. Local custom inhibits women from leaving their homes for delivery, and the ANMs do not travel far to attend home births.

4.5.2 Achievements

Maternal Health Objectives	Achievements
30% of pregnant women will have an ante natal visit.	20.6% had an ante natal visit (documented) Another 24.4% reported losing their ante natal card 41.6% had an ante natal visit (reported)
40% of mothers with a child <2 years will know the three cleans for a safe delivery.	51.3% knew the 3 cleans

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- Conduct a needs assessment for family planning services delivered by the MOH to identify possible areas for support.
- Collaborate with other agencies to provide appropriate training in family planning counseling. Levels of technical training will on the type of provider; e.g., ANM versus shopkeeper.

The final recommendation addressed the need to expand family planning programming beyond the health sector and develop integrated population programming. Most SC/US staff are familiar with the individual, social, and even global results of population growth, and are beginning to identify the ways in which multi-sectoral collaboration can create a greater impact on the communities knowledge and practices. This process should be facilitated through training for SC/US staff in population issues, including formulation of an integrated approach to population programming. To be most successful, a needs assessment should be done to identify the strengths and weaknesses of the staff with regard to population programming, including their own gender biases and sensitivity to discussing family planning.

5. *LESSONS LEARNED*

During discussions of the final KPC survey results, project staff commented on the following lessons that they learned during the course of the project:

- The key constraint to achieving established numerical objectives for utilization of health services (i.e., EPI coverage), is that SC/US is not the service provider. Although project staff (and many government health workers) have been frustrated in their efforts to improve service delivery, they remain committed to supporting the MOH as the source of health services and do not recommend the establishment of a parallel service delivery system.
- The duration of the project was too short. The project attempted to address too many child survival interventions and may have had greater impact if there had been a focus on fewer prioritized, achievable interventions.
- The communities in the project area are very diverse with regard to socio-economic status and cultural practices. There must be a strong, sustained commitment to finding out what the situation is through rapid quantitative assessments and **qualitative** studies.
- The project's achievements have resulted from the high levels of commitment and effort shared by the SC/US staff, MOH personnel, and the communities. The need to establish effective links with government counterparts, other agencies, local leaders and groups, and the mothers themselves early in the life of the project should not be underestimated. Similarly, the project experienced delays in staffing and changes in staffing that delayed or temporarily disrupted project implementation.

आमाको दूध/पोषण

५. तपाईंले (बच्चाको नाम) लाई अझै आफ्नो दूध छाउदै हुनुहुन्छ ?

१. छ

(प्रश्न नं. ७ मा जानुहोस्)

२. छैन

६. के तपाईंले (बच्चाको नाम) लाई पहिले पनि आफ्नो दूध छाउनु भयो ?

१. छ

२. छैन

(प्रश्न नं. ८ मा जानुहोस्)

७. बच्चा जन्मिएपछि सबभन्दा पहिले (बच्चाको नाम) लाई कहिले आफ्नो दूध खुवाउनु भयो ?

१. बच्चा जन्मिएको एक घण्टा भित्र

२. बच्चा जन्मिएको एक देखि आठ घण्टा भित्र

३. बच्चा जन्मिएको आठ घण्टा भन्दा पछि

४. सम्झना छैन

८. बच्चालाई आमाको दूध बाहेक ठोस खानेकुरा (अन्न) कहिलेबाट शुरु गर्नु पर्दछ ?

१. चार देखि छ महिना भित्र ठोस खान दिन थाल्ने

२. चार महिना अघिदेखि ठोस खाना दिन थाल्ने

३. छ महिना वा त्यो भन्दा पछि ठोस खाना दिन थाल्ने

४. थाहा छैन

९.क. तपाईंले (बच्चाको नाम) लाई पानी खानु दिनुहुन्छ ?

१. छ

२. छैन

३. थाहा छैन

९.ख. तपाईंले (बच्चाको नाम) लाई अन्य दूध जस्तै गाईको दूध वा भैसीको दूध वा बाख्राको दूध वा बालाको दूध खुवाउनु हुन्छ ?

१. छ

२. छैन

३. थाहा छैन

CS VII FINAL KPC SURVEY QUESTIONNAIRE
(NEPALI)

संकेत नम्बर

सेभ द चिल्डेन (यू. एस.)
बाल बचाउ आधारभूत स्वास्थ्य सर्वेक्षण

प्रश्नावली

दुई वर्ष भन्दा कम उमेरको (०-२३ महिना) नानी भएको (१५-४५ वर्षको) मामानाई सोधिने प्रश्नहरू ।

बन्तरबार्ता मिति.....	दोस्रो बन्तरबार्ता मिति
बन्तरबार्ता लिने व्यक्तिको नाम :	
सुपरिवेक्षकको नाम :	

१. मामाको नाम र उमेर

नाम : उमेर (वर्षमा) :

२. दुई वर्ष मुनिका बालकको नाम र उमेर

नाम :

जन्म मिति:// उमेर (महिनामा)

३. गाँउको नाम : वार्ड नं.:

गाँउ विकास समिति:

घरघुठी नम्बर :

४. के तपाईं नगद आम्दानी हुने कुनै काम गर्नु हुन्छ ?
(एक भन्दा बढी उत्तर आए सबै उल्लेख गर्नुस्)

क. छैन (गर्दिन)

ख. सिनाई बुनाई, हस्तकला

ग. कृषि उत्पादन बेच्ने (उखु, सुर्ति, चामल)

घ. ज्यालादारीमा काम गर्ने

ङ. पसल धाप्ने

च. नोकरी

छ. भेडा, बाख्रा, सुँगुर, कुखुरा पाल्ने/बेच्ने

ज. अन्य (उल्लेख गर्नु होस)

<input type="checkbox"/>

.....

९.झ. तपाईंले (बच्चाको नाम) लाई फुल वा दही खाउनु हुन्छ ?

१. छ
२. छैन
३. थाहा छैन

९.ञ. तपाईंले (बच्चाको नाम) लाई खानामा मह वा चिनी वा सख्खर हालेर दिने गर्नु हुन्छ ?

१. छ
२. छैन
३. थाहा छैन

९.त. तपाईंले (बच्चाको नाम) लाई खानामा घिउ अथवा चिल्लो चिज मिसाउनु हुन्छ ?

१. छ
२. छैन
३. थाहा छैन

१०. रतन्धोबाट बचाउने भिटामिन "ए" कुन खानेकुरामा पाइन्छ ? (एकभन्दा बढि उत्तर दिए पनि हुन्छ)

१. अण्डाको पहेलो भाग
२. हरियो सागपात
३. पहेलो फलफूल
४. माछा/मासु
५. आमाको दूध
६. थाहा छैन
७. अन्य उत्तर

झाडा पखाला

११. तपाईंको (बच्चाको नाम) लाई आजभन्दा १५ दिन भित्र पखाला लागेको थियो ?

१. थियो
२. थिएन
३. थाहा छैन
- प्रश्न नं. १८ सोधनुस्
- प्रश्न नं. १८ सोधनुस्

९.ग. तपाईले (बच्चाको नाम) लाई अन्नवाट बनेको खानेकुरा खान दिनुहुन्छ ?
(जस्तै : दूध भात, लिटो, जाउलो, सर्वोत्तम पिठो)

१. छ
२. छैन
३. थाहा छैन

९.घ. तपाईले (बच्चाको नाम) लाई फलफूल वा फलफूलको रस खाउँदै हुनुहुन्छ ?

१. छ
२. छैन
३. थाहा छैन

९.ङ. के तपाई (बच्चाको नाम) लाई फर्सी, आँप वा मेवा खान दिने गर्नु हुन्छ ?

१. दिन्छु
२. दिन्न
३. थाहा छैन

९.च. तपाईले (बच्चाको नाम) लाई हरियो तरकारी सागपात खाउनु हुन्छ ?

१. छ
२. छैन
३. थाहा छैन

९.छ. तपाईले (बच्चाको नाम) लाई मासु माछा खाउनु हुन्छ ?

१. छ
२. छैन
३. थाहा छैन

९.ज. तपाईले (बच्चाको नाम) लाई दाल, गेडागुडी, बदाम खाउनु हुन्छ ?

१. छ
२. छैन
३. थाहा छैन

१२. तपाईंको (बच्चाको नाम) लाई पखाला लाग्दा आफ्नो दूध (अन्तरवार्ता लिनेले तल लेखेको सबै पढ्नुहोस्)

१. सधैं भन्दा बढी खुवाउनु भयो ?
२. सधैं जति नै खुवाउनु भयो ?
३. सधैं भन्दा कम खुवाउनु भयो ?
४. खुवाउन पुरै बन्द गर्नुभयो ?
५. यो बच्चालाई आफ्नो दूध खुवाउने गरेको छैन

१३. तपाईंको (बच्चाको नाम) लाई पखाला लागेको बेला उसलाई आफ्नो दूध बाहेक अरु केही झोल खानेकुरा (अन्तरवार्ता लिनेले सबै पढ्नुहोस्)

१. सधैं भन्दा बढी खुवाउनु भयो ?
२. सधैं जति नै खुवाउनु भयो ?
३. सधैं भन्दा कम खुवाउनु भयो ?
४. खुवाउन पुरै बन्द गर्नुभयो ?
५. आफ्नो दूध मात्र खुवाउने गरेको

१४. तपाईंको (बच्चाको नाम) लाई पखाला लागेको बेला हरू खानेकुरा अन्तरवार्ता लिनेले तल लेखेको सबै पढ्नुहोस्)

१. सधैं भन्दा बढी खुवाउनु भयो ?
२. सधैं जति नै खुवाउनु भयो ?
३. सधैं भन्दा कम खुवाउनु भयो ?
४. खुवाउन पुरै बन्द गर्नुभयो ?
५. आफ्नो दूध मात्र खुवाउने गरेको

१५. तपाईंको (बच्चाको नाम) लाई पखाला लाग्दा तपाईंले कुनै उपचार गर्नुभयो ? (सबै जवाफ लेख्नुहोस्)

- क. केही गरेको छैन
- ख. जीवन जल
- ग. नुन चिनी पानी
- घ. अन्य झोल (उल्लेख गर्नुस)
- ङ. नसाबाट दिइएको - सेलाइन पानी
- च. पखाला रोक्ने औषधीहरू
- छ. अन्य (उल्लेख गर्नुहोस्)

२४. (बच्चाको नाम) लाई त्यसरी खोकी लाग्ने र सास फेर्न गान्हो भई विरामी परेको बेला कसबाट उपचार गराउनु भयो ? (एक भन्दा बढी उत्तर दिए पनि हुन्छ)

- क. अस्पताल/हेल्य पोष्ट/घुम्तीक्लिनिक
- ख. प्राइभेट डाक्टर
- ग. नातेदार/साथी
- घ. ग्रामीन स्वास्थ्य कार्यकर्ता
- ङ. महिला स्वास्थ्य स्वयं सेविका
- च. सुडेनी
- छ. धामी झाक्री
- ज. औषधी पसल
- झ. सामुदायीक अगुवा
- ञ. अन्य (उल्लेख गर्नुहोस्)

२५. (बच्चाको नाम) लाई स्वास प्रश्वास रोग लागेको बेला कस्तो-कस्तो लक्षण देखा परेमा तपाईं बच्चालाई स्वास्थ्य संस्थामा उपचारका लागि लैजानु हुन्छ ? (एक भन्दा बढी उत्तर दिए पनि हुन्छ)

- क. थाहा छैन
- ख. छिटोछिटो वा गान्होसग मास फेरेमा
- ग. कोखा हानेमा
- घ. खाना रुञ्ज छोडेमा
- ङ. ज्वरो आएमा
- च. खोकी लागेमा
- छ. अन्य (उल्लेख गर्नुहोस्)

खोप

२६. (बच्चाको नाम) लाई कुनै किसिमको खोप दिनु भएको छ ?

१. छ
२. छैन
३. थाहा छैन

२७. बच्चाको उमेर कति हुँदा दादुरा खोप दिनु पर्छ ?

१. महिनामा लेख्नु होस्
२. थाहा छैन

- ग. नानीलाई सधैको भन्दा बढी पिउनु दिन्छु
- घ. नानीलाई थोरै खानेकुरा घरीघरी दिन्छु
- ङ. झोल कुरा दिन्न
- च. खानेकुरा दिन्न
- छ. अन्य (उल्लेख गर्नुहोस्)

२०. तपाईंले (बच्चाको नाम) लाई पखाला रोकिएपछि के के कुरा गर्नुहुन्छ ?
(सबै उत्तर लेख्नुहोस्)

- क. याहा छैन
- ख. बच्चालाई थोरै खाना धेरै पटक खुवाउनु पर्दछ
- ग. सधैको भन्दा बढी खाना खुवाउनु पर्दछ
- घ. बढी शक्ति दिने खानेकुरा खुवाउनु पर्दछ
- छ. अन्य (उल्लेख गर्नुहोस्)

स्वास प्रश्वास सम्बन्धी रोग

२१. तपाईंको (बच्चाको नाम) लाई गत दुई हप्ता भित्रमा खोकी वा सास फेर्न गान्हो हुने रोग लागेको थियो ?

१. थियो
२. थिएन प्रश्न नं. २५ मा जाने

२२. यसरी विरामी हुंदा तपाईंको (बच्चाको नाम) ले छिटोछिटो र गान्हो गरी सास फेरेको थियो ?

१. थियो
२. थिएन प्रश्न नं. २५ मा जाने
३. याहा छैन प्रश्न नं. २५ मा जाने

२३. (बच्चाको नाम) यसरी विरामी भएको बेलामा तपाईंले कुनै उपचार गर्नु भयो ?

१. गरें
२. गरिन प्रश्न नं. २५ मा जाने

२८. गर्भवति आमालाई धनुषटंकार विरूद्ध खोप दिन किन जरुरी छ ?

१. आमा र नवजात शिशु (भर्खर जन्मिएको) दुवैलाई धनुषटंकारबाट बचाउन
२. आमालाई मात्र धनुषटंकार रोगबाट बचाउन
३. बच्चालाई मात्र धनुषटंकारबाट बचाउन
४. अन्य (उल्लेख गर्ने)
५. थाहा छैन

२९. नवजात शिशुलाई धनुषटंकारबाट बचाउन गर्भवती आमाले कतिवटा धनुषटंकार विरूद्ध सुई लिनु जरुरी छ ?

१. एउटा
२. दुईवटा
३. दुईवटा भन्दा बढी
४. एउटा पनि लगाउनु पर्दैन
५. थाहा छैन

३०. तपाईंसंग (बच्चाको नाम) खोप कार्ड छ :

१. छ (कार्डहेनुं होस्)
२. हरायो प्रश्न नं. ३२ मा जाने
३. कहिल्यै थिएन प्रश्न नं. ३२ मा जाने

३१. खोप कार्ड हेरेर सबै खोपहरू दिएको मिति तल लेख्नु होस्:

खोप	मात्रा		
	पहिलो	दोस्रो	तेस्रो
डि.पि.टी.			
पोलियो			
वि.सि.जी.			
दादुरा			

२५.(ख). (बच्चाको नाम) लाई खोकी लाग्ने र सास फेर्न गाढो भई विरामी भए उपचारको लागि काहां लैजाने गर्नु हुन्छ ?

(क) अस्पताल/हेल्थ पोष्ट/घुम्ती लिकनिक

(ख) प्राईभेट डाक्टर

(ग) नातेदार/साथी

(घ) ग्रामीण स्वास्थ्य कार्यकर्ता

(ङ) महिला स्वास्थ्य स्वयं सेविका

(च) सुडेनी

(छ) धामी भाक्री

(ज) औषधि पसल

(झ) सामुदायिक अगुवा

(ञ) अन्य (उल्लेख गर्नास)

३१.(ख) खोप कार्ड हेरेर भिटामिन 'ए' दिएको रेकर्ड छ भने तलको तालिकामा सार्नु होस्:

मात्रा	मिति
पहिलो	
दोश्रो	
तेश्रो	
चौथो	

खोप कार्डमा भिटामिन 'ए' सम्बन्धी रेकर्ड गर्ने स्थान नभएको

३१.(ग). तपाईंले बच्चालाई भिटामिन 'ए' कति पटक खुवाउनु भयो ?

- (१) एक पटक
- (२) दुई पटक
- (३) तिन/बढी पटक
- (४) थाहा छैन
- (५) कहिले पनि नदिएको

आमाको स्वास्थ्य

३२. तपाईंसँग मातृस्वास्थ्य कार्ड (गर्भवती हुँदा जचाएको कार्ड) छ ?

- | | | |
|----|-------------|--|
| १. | छ | (कार्डहेर्नु होस) <input type="checkbox"/> |
| २. | हरायो | प्रश्न नं. ३४ मा जाने <input type="checkbox"/> |
| ३. | कहिल्यै छैन | प्रश्न नं. ३४ मा जाने <input type="checkbox"/> |

३३. प्रश्नकर्ताले मातृस्वास्थ्य कार्ड हेरेर कति पटक पूर्व प्रसूति सेवा (गर्भवती जाँच) लिन गएको छिन लेख्ने ।

- | | | |
|----|----------------------|----------------------|
| १. | एक | <input type="text"/> |
| २. | दुई वा दुई भन्दा बढी | <input type="text"/> |
| ३. | छैन | <input type="text"/> |

३४. तपाईंसँग टि.टि. खोप कार्ड छ ?

- | | | |
|----|-------------|--|
| १. | छ | (कार्डहेर्नु होम) <input type="text"/> |
| २. | हरायो | <input type="text"/> |
| ३. | कहिल्यै छैन | <input type="text"/> |

३५. प्रश्नकर्ताले टि.टि. खोप कार्ड वा नभए मातृस्वास्थ्य कार्ड हेरेर कति पटक टि.टि. खोप लगाएको छिन लेख्ने ।

- | | | |
|----|------------------------|----------------------|
| १. | एक | <input type="text"/> |
| २. | दुई | <input type="text"/> |
| ३. | तीन | <input type="text"/> |
| ४. | चार | <input type="text"/> |
| ५. | पाँच वा पाँच भन्दा बढी | <input type="text"/> |
| ६. | छैन | <input type="text"/> |

३६. के तपाईं अहिले गर्भवती हुनुहुन्छ ?

- | | | |
|----|-----|--|
| १. | छ | प्रश्न नं. ४० मा जाने <input type="checkbox"/> |
| २. | छैन | <input type="checkbox"/> |

३७. के तपाईं दुई वर्ष भित्रमा अर्को बच्चा जन्माउन चाहनु हुन्छ ?

- | | | |
|----|----------|--|
| १. | छ | प्रश्न नं. ४० मा जाने <input type="checkbox"/> |
| २. | छैन | <input type="checkbox"/> |
| ३. | थाहा छैन | <input type="checkbox"/> |

४३. बच्चा जन्मिने बेलामा के-के कुरा सफा हुनु जरूरी छ ?

१. सुत्केरी गराउने व्यक्तिको हात
२. सुत्केरी हुने ठाउँको भुई
३. नाल बाधने/काट्ने औजार/धागो
४. अन्य (उल्लेख गर्ने)
५. पाहा छैन

३८. के तपाई अहिले गर्भ रोक्ने परिवार नियोजनको कुनै उपाय प्रयोग गर्दै हुनुहुन्छ ?

१. छ

२. छैन

प्रश्न नं. ४० मा जाने

३९. हाल गर्भ रोक्ने परिवार नियोजनको कुन उपाय तपाईले वा तपाईको श्रीमानले प्रयोग गर्दै हुनुहुन्छ ?

१. ल्याप्रोस्कोपी/मिनील्याप/भेसेन्टोमी

२. (डिपो) तीन महिने सुई

३. खाने चक्की

४. कण्डम

५. अन्य (उल्लेख गर्ने)

४०. तपाईको (बच्चाको नाम) गर्भ रहेको बेलामा तपाई प्रसूती पूर्व जाँचका लागि कुनै पनि स्वास्थ्य संस्था (जस्तै स्वास्थ्य चौकी/घुम्ती क्लिनिक/अस्पताल जानु भएको थियो ?

१. थियो

२. थिएन

४१. (बच्चाको नाम) गर्भ रहेको बेलामा तपाईले कति मात्रामा खानेकुरा खानु भएको थियो ? (उत्तरहरू आभालाई पढेर सुनाउनु होस्)

१. सधैं भन्दा बढी

२. सधैं जतिकै

३. सधैं भन्दा कम

४. थाहा छैन

४२. (बच्चाको नाम) जन्माउदा बच्चाको नाल कसले काट्यो ?

१. तपाई आफैले

२. परिवारको कुनै सदस्यले

३. तालिम नपाएको सुडेनीले

४. स्वास्थ्य कार्यकर्ताले (डाक्टर, नर्स आदि)

५. तालिम पाएको सुडेनीले

६. अन्य (उल्लेख गर्ने)

७. थाहा छैन

◀ स्वीकृती फारम ▶

अन्तरवार्ता दिने आमालाई पठेर सुनाउने

मेरो नाम हो र म सेभ द् चिल्ड्रेनको लागि काम गर्दछु । म तपाईंसंग तपाईंको र तपाईंको बच्चाको स्वास्थ्यबारे केही कुरा सोध्न चाहान्छु । यो जानकारीहरु खाली स्वास्थ्य कार्यत्रमलाई प्रभावकारी पार्नको लागि मात्र हो ।

यदि तपाईंलाई यो अध्ययनबारे थप कुरा जान्न वा सर्वेक्षणको नतिजा थाहा पाउन मन लाग्यो भने सेभ द् चिल्ड्रेन कार्यालय, गोलबजार/ धनगडी, सिराहामा सम्पर्क राख्नु होला ।

के म अब तपाईंलाई केही प्रश्नहरु सोध्न सक्छु ?

हुन्छ

हुदैन

- 9.f. Are you giving (name of child) leafy green vegetables?
1. yes []
 2. no []
 3. doesn't know []
- 9.g. Are you giving (name of child) meat or fish?
1. yes []
 2. no []
 3. doesn't know []
- 9.h. Are you giving (name of child) lentils, peanuts, beans?
1. yes []
 2. no []
 3. doesn't know []
- 9.i. Are you giving (name of child) eggs or yogurt?
1. yes []
 2. no []
 3. doesn't know []
- 9.j. Are you adding honey or sugar to (name of child)'s meals?
1. yes []
 2. no []
 3. doesn't know []
- 9.k. Are you adding fat (lard) or oil to (name of child)'s meals?
1. yes []
 2. no []
 3. doesn't know []
10. Which foods contain vitamin A to prevent "night blindness"?
(multiple answers possible, record all answers)
- a. egg yolks []
 - b. green leafy vegetables []
 - c. yellow type fruits []
 - d. meat/fish []
 - e. breast milk []
 - f. doesn't know []
 - g. other (specify) _____ []

DIARRHEAL DISEASES

11. Has (name of child) had diarrhea during the last two weeks?
1. yes []
 2. no [] go to 18
 3. doesn't know [] go to 18

BREAST FEEDING/NUTRITION

- 5 Are you breast feeding (name of child)?
1. yes [] go to 7
 2. no []
- 6 Have you ever breast fed (name of child)?
1. yes []
 2. no [] go to 8
- 7 After the delivery, when did you breast feed for the first time (name of child)?
1. during the first hour after delivery []
 2. from 1 to 8 hours after delivery []
 3. more than 8 hours after delivery []
 4. do not remember []
- 8 When should a mother start adding foods to breast feeding?
1. start adding between 4 and 6 months []
 2. start adding earlier than 4 months []
 3. start adding 6 months or later []
 4. doesn't know []
- 9 a Are you giving (name of child) water (or herbal teas)?
1. yes []
 2. no []
 3. doesn't know []
- 9 b Are you giving (name of child) bottle milk?
1. yes []
 2. no []
 3. doesn't know []
- 9 c Are you giving (name of child) semisolid foods such as gruels, porridge or semolina?
1. yes []
 2. no []
 3. doesn't know []
- 9 d Are you giving (name of child) fruits or juices?
1. yes []
 2. no []
 3. doesn't know []
- 9 e Are you giving (name of child) squash, mango, or papaya?
1. yes []
 2. no []
 3. doesn't know []

- 17 From whom did you seek advice or treatment for the diarrhea of (name of child)?
(multiple answers possible; record all answers)
- a. health post/hospital/mobile clinic []
 - b. private doctor []
 - c. relatives/friends []
 - d. village health worker []
 - e. community health volunteer []
 - f. traditional birth attendant []
 - g. traditional healer []
 - h. medical shop (pharmacy) []
 - i. local leader []
 - j. other (specify) _____ []
- 18 What signs/symptoms would cause you to seek advice or treatment for (name of the child)'s diarrhea? (multiple answers possible; record all answers)
- a. doesn't know []
 - b. vomiting []
 - c. fever []
 - d. dry mouth, sunken eyes, decreased urine output (dehydration) []
 - e. diarrhea of prolonged duration (at least 14 days) []
 - f. blood in stool []
 - g. loss of appetite []
 - h. weakness or tiredness []
 - i. other (specify) _____ []
19. What are important actions you should take if (name of child) has diarrhea?
(multiple answers possible; record all answers)
- a. doesn't know []
 - b. take the child to the health post []
 - c. give the child more to drink than usual []
 - d. give the child smaller more frequent feeds []
 - e. withhold fluids []
 - f. withhold foods []
 - g. other (specify) _____ []
20. What are important actions a mother should take when a child is recovering from diarrhea? (multiple answers possible; record all answers)
- a. doesn't know []
 - b. give the child smaller more frequent feeds []
 - c. give more foods than usual []
 - d. give foods with high caloric content []
 - e. other (specify) _____ []

12

12. During (name of child)'s diarrhea did you breast feed?
(read the choices to the mother)
- 1. more than usual []
 - 2. same as usual []
 - 3. less than usual []
 - 4. stopped completely []
 - 5. child not breast fed []
13. During diarrhea, did you provide (name of child) with fluids other than breast-milk?
(read the choices to the mother)
- 1. more than usual []
 - 2. same as usual []
 - 3. less than usual []
 - 4. stopped completely []
 - 5. exclusively breast feeding []
14. During diarrhea, did you provide (name of child) with solid/semisolid foods?
(read the choices to the mother)
- 1. more than usual []
 - 2. same as usual []
 - 3. less than usual []
 - 4. stopped completely []
 - 5. exclusively breast feeding []
15. When (name of child) had diarrhea, what treatments, if any, did you use?
(multiple answers possible; record all answers)
- a. nothing []
 - b. ORS sachet []
 - c. sugar-salt solution []
 - d. other fluids []
 - e. saline infusion []
 - f. anti-diarrhea medicine or antibiotics []
 - g. other (specify) _____ []
16. When (name of child) had diarrhea, did you seek advice or treatment for the diarrhea?
- 1. yes []
 - 2. no [] go to 18

25.b. Where would you go for treatment when (name of child) is sick with difficult breathing and coughing?

- a. health post/hospital/mobile clinic []
- b. private doctor []
- c. relatives/friends []
- d. village health worker []
- e. community health volunteer []
- f. traditional birth attendant []
- g. traditional healer []
- h. medical shop (pharmacy) []
- i. local leader []
- j. other (specify) _____ []

IMMUNIZATIONS

26. Has (name of child) ever received any immunizations?

- 1. yes []
- 2. no []
- 3. doesn't know []

27. At what age should (name of child) receive measles vaccine?

- 1. specify in months []
- 2. doesn't know []

28. Can you tell me the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine?

- 1. to protect both mother/newborn against tetanus []
- 2. to protect only the woman against tetanus []
- 3. to protect only the newborn against tetanus []
- 4. other (specify) _____ []
- 5. doesn't know []

29. How many tetanus toxoid injections does a pregnant woman need to protect the newborn infant from tetanus ?

- 1. one []
- 2. two []
- 3. more than two []
- 4. none []
- 5. doesn't know []

30. Do you have an immunization card for (name of child)?

- 1. yes [] (must see card)
- 2. lost it [] go to 31.c.
- 3. never had one [] go to 31.c.

ACUTE RESPIRATORY INFECTION

21. Has (name of child) been ill with cough or difficult breathing in the last 2 weeks?
- 1. yes []
 - 2. no [] go to 25
22. Did (name of child) experience rapid (fast) difficult breathing (dyspnea) when ill?
- 1. yes []
 - 2. no [] go to 25
 - 3. doesn't know [] go to 25
23. Did you seek treatment when (name of child) was ill with respiratory problems?
- 1. yes []
 - 2. no [] go to 25
24. From whom did you seek treatment for (name of child) when ill with difficult breathing and/or cough? (multiple answers possible; record all answers)
- a. health post/hospital/mobile clinic []
 - b. private doctor []
 - c. relatives/friends []
 - d. village health worker []
 - e. community health volunteer []
 - f. traditional birth attendant []
 - g. traditional healer []
 - h. medical shop (pharmacy) []
 - i. local leader []
 - j. other (specify) _____ []
- 25.a. What are the signs/symptoms of respiratory infection that would cause you to take (name of child) to a health facility? (multiple answer possible; record all answers)
- a. don't know []
 - b. fast or difficult breathing []
 - c. chest indrawing []
 - d. loss of appetite []
 - e. fever []
 - f. cough []
 - g. other (specify) _____ []

35	Look at the ante natal card and TT card and record the number of TT injections:
1.	one []
2.	two []
3.	three []
4.	four []
5.	five or more []
6.	none []

36. Are you pregnant now?
1. yes [] go to 40
 2. no []

37. Do you want to have another child in the next two years?
1. yes [] go to 40
 2. no []
 3. doesn't know []

38. Are you currently using any method to avoid/postpone getting pregnant?
1. yes []
 2. no [] go to 40

39. What is the main method you or your husband are using now to avoid/postpone getting pregnant?
1. laparoscopy/tubal ligation/vasectomy []
 2. Depo injection []
 3. pill []
 4. condom []
 5. other []

40. When you were pregnant with (name of child) did you visit any health site (health post/mobile clinic/hospital) for pregnancy/prenatal care?
1. yes []
 2. no []

41. During (name of child)'s pregnancy, was the amount of food you ate
(read choices to the mother)
1. more than usual? []
 2. same as usual? []
 3. less than usual? []
 4. doesn't know []

31.a. Look at the vaccination card and record the dates of all the immunizations in the space below:

Vaccine	Doses		
	First	Second	Third
DPT			
Polio			
BCG			
Measles			

31.b. Look at the EPI card and record the dates of all doses of vitamin A in the space below:

Doses	Date
1st	
2nd	
3rd	
4th	

31.c. How many times has (child's name) received a vitamin A capsule?

1. one
2. two
3. three or more
4. doesn't know/none

MATERNAL CARE

32. Do you have a card that records your ante natal visits?

1. Yes [] (must see card)
2. lost it [] go to 34
3. no [] go to 34

33. Look at the ante natal card and record the number of ante natal visits in the space below:

1. one []
2. two or more []
3. none []

34. Do you have a TT (immunization) card?

1. yes [] (must see card)
2. lost []
3. no []

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CS VII FINAL KPC SURVEY QUESTIONNAIRE
(MATHALI)

(अपस्त्रिया)

- प्रश्न :- ४. अहाँ नराद अप्पानो, होववाला कौनो काम करे दिमें ?
- प्रश्न :- ५. अहाँ (बच्चाके नाम) के अप्पानो अप्पन दुध पिबावने दिमें ?
- प्रश्न :- ६. अहाँ (बच्चाके नाम) के पहिले अप्पन दुध पिबने कालिये ?
- प्रश्न :- ७. बच्चा जन्मलाके बाद, सबस पहिले (बच्चाके नाम) अहाँ अप्पन दुध कते देर (समय) बाद पिअओलिये ?
- प्रश्न :- ८. बच्चाके माँ के दुध बोहेक अउरी होस खाएवला चिज कौहेअ स फिमक चाहे ?
- प्रश्न :- ९. अहाँ (बच्चाके नाम) के पानो पिअलाओ दे दिमें ?
- (क) अहाँ (बच्चाके नाम) के अप्पन दुध बोहेक गार्ड भैया, बकरी, अउर कौनवाला बस्त (पाउडर) दुध पिअवने दिमें ?
- (ख) अहाँ (बच्चाके नाम) के अप्पन स पानो खाएवाला चिज खाइए दे दिमें जैना (दुधमास, हलुसा, खेचर), सनीतम पिहो, ब रौद
- (ग) अहाँ (बच्चाके नाम) के फलफूल अथवा फलफूल के रस दे दिमें ? (जैना, आम, लताम, केरा, कदर, सेठ, फुलला, लिज) आदि
- (घ) अहाँ (बच्चाके नाम) के कदिमा, आम, अरुनमा खाइला दे दिमें ?
- (च) अहाँ (बच्चाके नाम) के होरमा तरकार, सागपात, खुवावे दिमें ?
- (छ) अहाँ (बच्चाके नाम) के माउस, माद, खुवावे दिमें ?
- (ज) अहाँ (बच्चाके नाम) के सख्ख, जौडागुड, कदाम, खगावे दिमें ?
- (झ) अहाँ (बच्चाके नाम) के अउडा अथवा दही खुवावे दिमें ?
- (ञ) अहाँ (बच्चाके नाम) के खामोस मौध, चिनी, सख्खर (गुड) खाइ दे दिमें ?
- (ट) अहाँ (बच्चाके नाम) के खातासे पि अउर कौन कौन अथवा कौन कौन चिज गिलब दिमें ?

प्रश्न (क) रौन) स बचाव के शैल मिश्रित 'र' कौन कौन खाइवाला चिज सयमे पडल जाईके ?

प्रश्न ११ :- अहाँ (बच्चाके नाम) के आरुस १५ डिग्री अउरमे माद परवाला (पेटकर) लागल है ?

प्रश्न १२ :- अहाँ (बच्चाके नाम) के माद परवाला (पेटकर) लागल है त अप्पन दुध (अहाँवाला खोले तलाके सयमे पेटे सनाउने)

42. At the delivery of (name of child), who tied and cut the cord?
- 1. yourself []
 - 2. family member []
 - 3. untrained traditional birth attendant []
 - 4. health professional (physician, nurse or midwife) []
 - 5. trained birth attendant []
 - 6. other (specify) _____ []
 - 7. doesn't know []

43. During the birth what things need to be clean? (multiple answers; record all answers)
- a. hands of person who delivers []
 - b. floor []
 - c. cord tie/cutting tools/thread []
 - d. others (specify) _____ []
 - e. don't know []

1- सब दिन स कैस) पिबे द दलिये
 2- सवादेन जातवे पिचावे दलिये वीतवे पिचावेत रट गलिये
 3- स्व दिन स कम कम पिबलिये
 4- पिमाव परे काद कु दालिये
 5- ये बच्चाडे अपन दुध नै पिचावेत रट गलिये
 प्रश्न 92 :- अहाँ (बच्चाडे नाम) के फाद्य परबला (पेयकर) लामन
 कोन कोन (रसदार) खाइवाला चिज (अनारवाला खिरे
 ले सबे परबेस

1- सवादेन स कैस) सुबलिये
 2- सवादि जेऊ नै सुबलिये
 3- स्व दिन स कम सुबलिये
 4- सुबउगाई परे काद कु दलिये
 5- अपन दुध मात्रे पिचावेत रट गलिये

प्रश्न 93 :- अहाँ (बच्चाडे नाम) के फाद्य परबला (पेयकर) लामन
 कोन कोन (रसदार) खाइवाला चिज (अनारवाला खिरे) सबे परबेस

1- स्व दिन स कैस) सुबलिये
 2- सवादि जेऊ नै सुबलिये
 3- स्व दिन स कम सुबलिये
 4- सुबउगाई परे काद कु दलिये
 5- अपन दुध मात्रे पिचावेत रट गलिये

प्रश्न 94 :- अहाँ (बच्चाडे नाम) के फाद्य परबला (पेयकर) लामन
 कोन कोन (रसदार) खाइवाला चिज (अनारवाला खिरे) सबे परबेस

प्रश्न 95 :- अहाँ (बच्चाडे नाम) के फाद्य परबला (पेयकर) लामन
 कोन कोन (रसदार) खाइवाला चिज (अनारवाला खिरे) सबे परबेस

प्रश्न 96 :- अहाँ (बच्चाडे नाम) के फाद्य परबला (पेयकर) लामन
 कोन कोन (रसदार) खाइवाला चिज (अनारवाला खिरे) सबे परबेस

प्रश्न 97 :- अहाँ (बच्चाडे नाम) के फाद्य परबला (पेयकर) लामन
 कोन कोन (रसदार) खाइवाला चिज (अनारवाला खिरे) सबे परबेस

प्रश्न ३४. इनका संगम दि.दि. खोप कार्ड में है।

प्रश्न ३५. प्रश्न क्र. वाला दि.दि. खोप कार्ड (या नई मूल्य पर मातृ स्वास्थ्य कार्ड देखें) को कलेक्टर के दि.दि. ले जाने दें, लिखें।

प्रश्न ३६. अरबन आटा गर्भवती दि.दि. ?

प्रश्न ३६. कि अटा रोकने में अरबन आटा जल्दी जल्दी टैप चार्ट दि.दि. ?

प्रश्न ३८. कि अटा अरबन आटा गर्भ रोकने लीला परिवार नियोजन के द्वारा साधन (उपाय) प्रयोग कर रहा दि.दि. ?

प्रश्न ३९. अरबन आटा रोकने लीला परिवार नियोजन के द्वारा साधन (उपाय) अटा या अरबन आटा प्रयोग कर रहा दि.दि. ?

प्रश्न ४०. अटा के (बच्चा के नाम) गर्भ में रहने का दि.दि. गर्भवती जांच के लीला द्वारा अरबन आटा / अटा नियंत्रण या अरबन आटा रोकने दि.दि. ?

प्रश्न ४१. (बच्चा के नाम) गर्भ में रहने का दि.दि. अरबन आटा रोकने वाला दि.दि. अरबन आटा रोकने दि.दि. ?

प्रश्न ४२. (बच्चा के नाम) जन्म देलापुर बच्चा के (नाम) पुत्र) नाम के कारण है।

प्रश्न ४३. बच्चा जन्म के वर में अरबन आटा / अटा रोकने साधन (उपाय) अरबन आटा रोकने दि.दि. ?

प्रश्न नं० २६(क) बच्चा के उमर कौनसे बँलाफ्त बाहरा (माइके) के खाप दिअ परे हँ।

प्रश्न ~~२६(ख)~~ २७ :- गर्भवती माइके रिटनस (धनुषाडर) के खाप कबिला दिअ परे हँ।

प्रश्न २८ :- अरुबर जन्मल बच्चा के धनुषाडर (रिजिस्ट्रि) से बँचवले बिल गर्भवती माइके कौनसे रिटनस (धनुषाडर) के विरोंधमे सुझा लैनाई जाइत हँ।

अरु ३० अहा सजमे (बच्चाके नाम) के खाप खाई अइह।

प्रश्न ३१(क) खाप कार्ड देरवले सवखाप मे डेल मिनि लिख लिख।

३१(ख) खाप कार्ड देरवले मिनिमि 'ए' डेल रैकड हँ न मिनाके तालिकामे साइ।

खाप कार्डमे मिनिमि 'ए' अरुके स्थान मे

३१(ग) अहा (बच्चाके नाम) के मिनिमि 'ए' अने बेर सु उचैदिये।

प्रश्न ३२ अहा सजमे मातु स्वास्थ्य कार्ड (गर्भवती अरु वैरमे गन्थाइला कार्ड) अइह।

प्रश्न ३३ अरु कनवारा मातु स्वास्थ्य कार्ड देरव हँ कुँ बँच पूर्व प्रसूति सेवा लिख गैल हँ, लिख।

TRAINING AGENDA (continued)

DAY 2: MONDAY, NOVEMBER 21, 1994

TIME	ACTIVITY	RESPONSIBLE PERSON
10:00 - 10:20	Marking the answers	Lamsal
10:20 - 11:20	Age reporting	Bhusal, Ravindra
11:20 - 12:00	Bad interviewing technique	Ravindra, Durga
12:00 - 12:15	Tea Break	
12:25 - 1:00	Good interviewing technique	Naramaya, Renu
1:00 - 2:00	Practice reading the questionnaire	All participants
2:00 - 2:30	Discussion	Ravindra, Naramaya
2:30 - 2:45	Tea Break	
2:45 - 4:30	Interviewing practice	All participants
4:45 - 5:00	Day 3 schedule	Ravindra

DAY 3: TUESDAY, NOVEMBER 22, 1994

TIME	ACTIVITY	RESPONSIBLE PERSON
10:00 - 12:00	Field practice	All
12:00 - 1:00	Review of questionnaire	Facilitators and supervisors
1:00 - 3:00	Feedback about field practice	Ravindra, Naramaya, Dhana, Lamsal
3:00 - 3:15	Tea Break	
3:15 - 4:15	Teams, sites, logistics	Ravindra, Naramaya, Dhana
4:15 - 5:00	Role of supervisors and interviewers	Dhana, Naramaya

**CS VII FINAL KPC SURVEY
TRAINING AGENDA**

DAY 1: SUNDAY, NOVEMBER 20TH

TIME	ACTIVITY	RESPONSIBLE PERSON
10:00 - 10:15	Purpose and objectives of survey	Dhana, Naramaya
10:15 - 10:30	Time frame	Dhana
10:30 - 11:15	Sampling methodology	Ravindra
11:15 - 12:00	Tea Break	
12:00 - 12:30	Starting point method	Naramaya
12:30 - 1:30	Purpose of each question	Ravindra, Dhana, Naramaya
1:30 - 1:45	Marking the answers	Ravindra
1:45 - 2:00	Tea Break	

The above sessions were attended by the survey supervisors only. The remaining sessions were attended by the supervisors and interviewers.

DAY 1: SUNDAY, NOVEMBER 20, 1994 (CONTINUED)

TIME	ACTIVITY	RESPONSIBLE PERSON
2:00 - 2:30	Introduction/Welcome	Ravindra, Khem
2:30 - 2:40	Purpose of survey	Chola
2:40 - 2:50	Time frame	Bhusal
2:50 - 3:00	Administrative arrangements	Dhana
3:00 - 3:30	Sampling methodology	Ravindra
3:30 - 4:00	Starting point method	Ravindra
4:00 - 5:00	Purpose of each question	Krishna, Bhusal, Dhana

SR#.	VOC	Ward #	Popn	Cum Popn	
		31	526	12704	
		32	786	13490	
		33	1082	14572	
		34	1622	1622	(5)
		35	653	16847	
		36	620	17467	
5	Chandra A. Pur	37	1172	18539	(6)
		38	630	19269	
		39	328	19597	
		40	472	20069	
		41	227	20296	
		42	421	20696	
		43	360	21077	
		44	384	21461	
		45	377	21838	(7)
6.	Chandralaym	46	741	22579	
		47	698	23277	
		48	264	23541	
		49	257	23798	
		50	171	23939	
		51	431	24370	
		52	937	25307	(8)
		53	155	25462	
		54	528	26030	
7	Chandrayya Pur	55	372	26402	
		56	778	27178	
		57	315	27493	
		58	337	27830	
		59	662	28492	
		60	492	28984	(9) 151

**CS VII FINAL K&P SURVEY
POPULATION DATA USED FOR SAMPLING**

SR#	VDC	House #	Popn	Cum Popn
1.	Lalpur	1	876	876 ①
		2	430	1306
		3	238	1544
		4	464	2008
		5	372	2400
		6	393	2793
		7	146	2939
		8	281	3220
		9	68	3288
2	MURRAY	10	292	3580
		11	298	3878
		12	185	4063
		13	235	4298 ②
		14	247	4545
		15	455	5000
		16	554	5554
		17	338	5892
		18	345	6236
3	Jandaha	19	300	6737
		20	220	7156
		21	221	7378
		22	637	8015 ③
		23	485	8500
		24	441	8941
		25	338	9279
		26	348	9627
		27	579	10146

SPT#	v De	Ward	Popn	Cum. Popn	
11	Maharour	91	407	40777	
		92	525	41302	
		93	577	41816	
		94	571	42357	
		95	506	42863	(13)
		96	748	43611	
		97	716	44327	
		98	365	44692	
		99	209	45001	
		12.	Balkandi	100	275
101	355			45831	
102	777			46608	(14)
103	441			46749	
104	621			77370	
105	534			77904	
106	720			48324	
107	277			48601	
108	525			49166	
13	Bismipur Katti	109	980	50146	(15)
		110	853	50999	
		111	2061	53060	(16)
		112	1137	53797	
		113	757	55948	
		114	485	56433	(17)
		115	850	57283	
		116	703	57986 X	
14	Ayadhnanagar	117	752	58738	
		118	366	59104	
		119	376	59480	
				59856	(18)

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SRT#	VDe	Ward	Popn	Cum. Popn.	
		61	670	29654	
		62	286	29940	
		63	524	30464	
8	Borchhanda	64	281	30745	
		65	200	30945	
		66	296	31241	
		67	393	31634	
		68	214	31948	
		69	321	32269	(10)
		70	328	32597	
		71	359	32956	
		72	408	33364	
9	Deipur	73	414	33778	
		74	265	34043	
		75	320	34363	
		76	101	34464	
		77	126	34591	
		78	374	35065	
		79	399	35464	(11)
		80	281	35745	
		81	458	36203	
10	Betama	82	415	36618	
		83	472	37090	
		84	458	37548	
		85	357	37906	
		86	495	38402	
		87	384	38786	
		88	486	39272	(12)
		89	648	39920	

18.	Blawampur	154	508	80093	
		155	264	80357	
		156	576	807000	(24)
		157	458	81331	
		158	544	81875	
		159	481	82356	
		160	379	82735	
		161	666	83401	
		162	369	83770	
19	Mohampur	163	345	841600	(25)
		164	570	84685	
		165	352	85037	
		166	439	85476	
		167	446	85922	
		168	420	86342	
		169	506	86848	
		170	470	87318	
		171	520	878000	(26)
20	Pepra	172	298	88136	
		173	305	88441	
		174	353	88794	
		175	213	89007	
		176	299	89306	
		177	326	89632	
		178	357	89983	
		179	310	90293	
		180	431	90724	
		181	360	910000	(27)
21	Pokharbinda	182	284	91368	
		183	408	91776	
		184	342	92118	
		185	285	92403	
		186	245	92648	
		187	371	93019	
		188	324	93343	
		189	417	93760	

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SR#	VDC	Hand #	Pop. ^	Cum. Pop?
15.	Dhangadhi	121	357	60200
		122	245	60445
		123	427	60872
		124	367	61239
		125	190	61429
		126	350	61779
		127	1089	62868
		128	1915	64783 (19)
		129	578	65301
		130	746	66047
		131	936	66983 (20)
16.	Falkahakatti	132	709	67692
		133	865	68557
		134	650	69207
		135	564	69771
		136	634	70405 (21)
		137	801	71206
		138	462	71668
		139	993	72661
		140	1163	73824 (22)
		141	463	74287
		142	980	75267
17.	Harumanagar	143	392	75659
		144	810	76469
		145	277	76746
		146	335	77081 (23)
		147	106	77187
		148	450	77637
		149	378	78015
		150	329	78344
		151	536	78880
		152	280	79160
		153	425	79585

CS VII FINAL KPC SURVEY TEAM**INTERVIEWERS:**

Punam Kumari Dhakal	Anita Lama	Bashna Lama
Shanti Kumari Yonjan	Lalita Yonjan	Sushila Yadav
Laxmi Lama	Nisu Yadav	Sherkha Chouhan
Man Kumari Lama	Ratna Shyamboo	Sarasoti Lama
Parbati Choudhari	Samsa Lama	Usha Lama
Meena Lama	Sangita Lama	Samiti Lama
Ratna Lama	Ranjana Moktan	Binda Singh
Bali Lama	Karuna Lama	Gita Lama
Basanti Lama		Himala Shyamboo

SUPERVISORS:

Durga Regmi	Bal Krishna Bhusal	Tej Lal Lama
Chola Kant Sharma	Lekh Hari Dahal	Arjun Thapaliya
Arun Kumar Mahato	Rajesh Limbu	Ram Dayal Shah
Renu Upadhya	Radhika Ghimire	Janaki Shrestha
Krishna Lamsal	Ram Asis Roy	Renu Rai

TRAINING FACILITATORS:

Dhana Malla	Naramaya Limbu	Chola Kant Sharma
Krishna Lamsal	Rabindra Thapa	Bal Krishna Bhusal

DATA TABULATION:

Naramaya Limbu	Dhana Malla	Chola Kant Sharma
Durga Regmi	Lekh Hari Dahal	Basana Lama
Rajesh Limbu	Sarmila Bardewa	Arjun Thapaliya
Arun Kumar Mahato	Punam Dhakal	Ram Dayal Shah
Renu Upadhya	Hari Prasad Koirala	Janaki Shrestha
Krishna Lamsal	Ram Asis Roy	Renu Rai
Bal Krishna Bhusal	Chandra Kala Rana	Radhika Ghimire
Nisu Yadav	Bharat Shrestha	Ram Asis Roy

TECHNICAL SUPPORT / COORDINATION:

Chanda Rai, SC/US: preparation of questionnaire and survey report, and overall coordination

Cynthia Carter, PVO Child Survival Support Program, Johns Hopkins University, Baltimore, MD, USA: recommendations for final survey questionnaire

Marsha Dupar, SC/US consultant: data tabulation/analysis, preparation of report

SR#	VDC	Hard	Pop ^	Cum. Pop.?	-
22.	maheshpur	190	316	94076	
		191	488	94564	(28)
		192	436	95000	
		193	246	95246	
		194	385	95631	
		195	326	95957	
		196	442	96399	
		197	250	96649	
		198	322	96971	
		199	339	97310	
23	Laxmipur	200	497	97807	
		201	603	98410	(29)
		202	401	98811	
		203	249	99060	
		204	410	99470	
		205	323	99793	
		206	360	100153	
		207	415	100568	
		208	287	100855	
		209	550	101405	(30)
24	Khukhariyai	210	359	101764	
		211	494	102258	
		212	363	102621	
		213	365	102986	
		214	308	103294	
		215	443	103737	
		216	260	103997	

**CS VII FINAL KPC SURVEY
PARTICIPANTS AT COMMUNITY FEEDBACK SESSION
SCUS OFFICE, GOLBAZAR, SIRAHA
DECEMBER 5, 1994**

Name	Designation
Mr. Durga Prasad Pokhrel	Chief District Officer (CDO), Siraha
Dr. Surya Narayan Yadav	Chief, District Health Office (DHO), Siraha
Mr. Ram Chandra Singh	Public Health Officer, DHO, Siraha
Mr. Hari Lal Shrestha	Vector Controller, DHO, Siraha
Mr. Udav Bahadur Adhikari	Secretary, Environmental Committee, Golbazar
Mr. Ram Nath Yadav	Chairman, Environmental Committee, Golbazar
Mr. Shambhu Kattel	Manager, Gramin Bekash Bank, Golbazar
Mr. Kumud Prasad Sharma	Headmaster, Asanpur High School
Mr. Nelamber Singh	Headmaster, Laxmipur Patar High School
Mr. Yadav	Teacher, Mahanaur High School
Mr. Ram Bilash Thakur	Health Post In-charge, Sukhipur Health Post
Mr. Yogendra Narayan Mallik	Health Post In-charge, Arnama Health Post
Mr. Rasam Lal Choudhari	Health Post In-charge, Chhowapath Health Post
Mr. Surya Man Lama	VDC Chairman, Asanpur
Mr. Hari Lal Choudhari	VDC Chairman, Mahanaur
Mr. Shyam Sundar Pal	VDC Chairman, Betauna
Mr. Jas Lal Lama	VDC Chairman, Chandra Ayodhanagar
Mr. Pushpa Lal Pakhrin	VDC Chairman, Jamdaha
Mr. Ram Sarup Mahato	VDC Chairman, Lalpur
Mr. Yalamber Singh	VDC Chairman, Laxmipur Patar
Mr. Brama Dev Yadav	VDC Chairman, Barchhawa
Mr. Shiba Narayan Yadav	Chairman, HP Management Committee, Golbazar
Mr. Hasta Lal Chaudhari	Member, ORC Management Committee, Devipur
Mr. Raj Kumar Singh	Member, ORC Management Committee, Phulkahakatti
Mr. Sobit Prasad Shah	Chairman, ORC Management Committee, Bhawanipur
Mr. Nil Kantha Shah	Chairman, Laligurash Youth Club, Muksar
Mr. Lila Nath Shrestha	Chairman, Srijana Youth Club Chohorba
Mr. Nab Raj Lama	Chairman, Indrauli Youth Club, Jamdaha
Mr. Shyam Lama	Chairman, Mahaboudha Youth Club, Dhangadi
Mr. Surya Narayan Singh	Chairman, Sunrise Youth Club, Hanumannagar
Mr. Maheshore Kamti	Chairman, Pokharbinda Youth Club
Mr. Ramji Shah	Chairman, Bhawanipur Youth Club
Mr. Ram Adhin Yadav	Muksar

**CS VII FINAL KPC SURVEY
SC/US STAFF PARTICIPATING IN DISCUSSION OF RESULTS
SC OFFICE / GOLBAZAR
NOVEMBER 28, 1994**

<i>NAME</i>	<i>DESIGNATION</i>	<i>SITE</i>
Mr. Khem Thapa	District Program Coordinator	Siraha
Ms. Dhana Malla	Project Coordinator	GRR
Ms. Durga Regmi	Women Development Coordinator	GBR
Mr. Bal Krishna Bhusal	Training Coordinator	GBR
Mr. Chola Kant Sharma	IEC Coordinator	GBR
Mr. Govinda Pun	Accounts Officer	GBR
Mr. Arun Mahatq	Economic Development Officer	DNGD
Mr. Krishna Lamsal	Assistant Training Coordinator	DNGD
Mr. Krishna Bahadur B. K.	Accountant	GBR
Ms. Janaki Shrestha	Staff Nurse	GBR
Mr. Ram Dayal Shah	HIS Supervisor	GBR
Ms. Renu Rai	Auxiliary Nurse Midwife	GBR
Ms. Kalyani Shah	Maternal Child Health Worker	GBR
Ms. Bela Ghising	Maternal Child Health Worker	GBR
Mr. Ram Asis Roy	Auxiliary Health Worker	DNGD
Mr. Lekh Hari Dahal	Health Post Coordinator	Dhangadi
Mr. Rajesh Limbu	Health Post Coordinator	Armana
Ms. Radhika Ghimire	Health Post Coordinator	Charapath
Mr. Hari Prasad Koirala	Health Post Coordinator	Nainpur
Ms. Chandra Kala Rana	Health Post Coordinator	Golbazar
Ms. Renu Upadhya	Women Development Coordinator	GBR
Ms. Anita Dahal	Women Development Coordinator	DHGD
Mr. Ishor Khattri	Education Coordinator	GBR
Mr. Gopal Tamang	Field Coordinator	DNGD
Ms. Sharmila Bardewa	Staff Nurse	GBR
Ms. Naryani Joshi	Women Development Assistant	GBR
Mr. Mithilesh Jha	J.T.	GBR
Mr. Nageshore Yadav	Overseer	GBR

**CS VII FINAL KPC SURVEY
REPORT OF COMMUNITY FEEDBACK SESSION
SC/US OFFICE / GOLBAZAR
DECEMBER 5, 1994**

The findings of the Child Survival VII Final KPC Survey were presented in a community feedback session at the SC/US Office, Golbazar, Siraha, on December 5, 1994. Forty participants, representing the Siraha District Offices, VDCs, and community organizations attended the meeting (Appendix H). SC/US was pleased to welcome the Chief District Officer, Mr. Durga Prasad Pokhrel, and others to the meeting.

Ms. Dhana Malla, SC/US CS VII Project Coordinator, explained the purpose of the meeting to the participants and then presented the key findings of the Final KPC Survey. Ten minutes were allocated for discussion of each of the project's six components. The following issues were discussed.

Since the advice of local quack doctors is often sought by families for treatment of childhood illnesses such as diarrhea and ARI, a lengthy discussion was held regarding how to ensure safe, appropriate treatment for the communities' children. The following recommendations were given:

- The MOH should consider the role of the quack doctors and seek solutions for ensuring that they are providing appropriate health care.
- International non governmental organizations like SC/US should organize trainings for these local quack doctors as a pilot project.
- The CDO mandated the VDC chairmen to identify the local quack doctors in their respective VDCs and attempt to supervise their activities. The help of the CDO should be sought when necessary.

During the discussion of Jeevan Jal preparation, the VDC chairmen from the northern VDCs stressed the lack of clean drinking water facilities and requested assistance with developing such facilities. The VDC Chairman from Jamdaha stated that teaching JJ preparation and use will not solve the diarrhea problem; it can only be solved if clean drinking water is made available.

Although the availability of clean drinking water was stated to be the most significant way to reduce the prevalence of diarrhea, the CDO commented that he was surprised to learn of the success of the project in educating illiterate mothers about diarrhea and the preparation of JJ. The lack of availability of JJ in local medical shops was discussed as a barrier to increasing the use of JJ. The DHO and VDC Chairman agreed to promote JJ among medical shopkeepers, to better serve the communities.

Regarding the lack of improvement in immunization coverage, the VDC Chairmen commented that families are not willing or able to store the EPI cards in their homes. They stated that it is the habit of people to lose documents such as citizenship cards, land holding deeds, etc. Additionally, it is the habit of families to discard the EPI cards after immunizations are complete, as these cards are not required for any purpose; i.e., entrance

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**CHILD SURVIVAL VII
PROJECT OBJECTIVES**

**DETAILED IMPLEMENTATION PLAN
MAY 1992**

**REVISED IMPLEMENTATION PLAN
APRIL 1993**

IMMUNIZATION

60% of children 12-23 months will be completely immunized with BCG, polio, DPT, and measles.

60 % of children 12-23 months will have *documented* complete immunization with BCG, polio, DPT, and measles. *(SAME) **

50% of women 15-45 years will have received 2 doses TT.

50% of women 15-45 years will have *documentation of at least 2 doses TT. (SAME)*

CONTROL OF DIARRHEAL DISEASE

50% of mothers with child <2 years will correctly name three causes of diarrhea.

(DROPPED)

60% of families with child <2 years will know how to prepare and administer Jeevan Jal (ORS) correctly.

60% of families with child <2 years will know how to prepare and give Jeevan Jal (ORS) correctly. *(SAME)*

40% of children <2 years with diarrhea will be treated with JJ (ORS) and receive more food and fluids during and after diarrhea episode.

25% of children <2 years with diarrhea will be treated with JJ (ORS) and receive more food and fluids during and after diarrhea episode. *(REVISED)*

90% of mothers with child <2 years will have access to JJ (ORS) *(NEW)*

NUTRITION

40% of mothers with child <2 years will give appropriate weaning foods.

(DROPPED)

A study of the impact of recent crop failures on household food availability distribution of food within the household and the nutritional status of children under 5 years will be conducted. If indicated SC will begin or work with other agencies to begin measures to ensure an adequate food supply. (NEW)

* Changes in objectives are noted in *italics*.

into school. With further discussion, it was recognized that the cards are important for ensuring that all of the vaccinations are given, not just for SC/US's record keeping. The CS VII Project Coordinator asked the VDC Chairmen and DHO officials to encourage mothers to keep the EPI cards for the benefit of their children.

Lack of regular availability of vaccines was discussed. The DHO officials requested that the VDC Chairmen take a more active role in supervising the EPI sites and the work of the Village Health Workers. There is a policy that VHWs obtain the signature of the VDC Chairmen prior to collecting their salary. Some VDC Chairmen were unaware of this policy and will check with the VHWs in their VDCs.

Regarding the maternal health interventions, the participants were pleased with the increase in attendance at ante natal clinic. Some VDC Chairmen requested that outreach clinics be conducted in their VDCs.

A lengthy discussion was held regarding family planning. The participants were shocked at the low level of temporary contraceptive use. They believe that the contraceptive prevalence is higher and that the reason for the low reported usage is the cultural norm of not discussing family planning. They suggested that more private interviews need to be held to find out if women are using family planning. It was also stated that family planning use may be low in spite of increased awareness of the benefits family planning. The following recommendations were made for future family planning activities:

- Promotion of depo-provera and maintenance of regular supply
- Condom promotion
- Make other FP methods available; i.e., Norplant, IUDs
- Select FP motivators from the same community
- Promote training in FP counseling
- Maintain effective follow up of FP users

In concluding the session Dr. Yadav, the DHO, expressed his appreciation for the assistance that SC/US has given the MOH. He added that there are still problems to be faced, e.g., supply and distribution of FP commodities and vaccines. Finally, he remarked that the results of the project were impressive and requested that similar support be maintained in the future.

Mr. Gopal Tamang, SC/US Ilaka In-charge/Dhangadi, extended thanks to the participants. Mr. Durga Prasad Pokhrel, CDO, expressed his surprise that such improvements are being made in Siraha District, and commented that the findings of the final survey are exciting, impressive, and informative. He closed the session, thanking all participants for attending and SC/US for organizing the meeting.

**SAVE THE CHILDREN / US
CHILD SURVIVAL VII
SUMMARY OF JEEVAN JAL PREPARATION FINAL SURVEY FINDINGS
NOVEMBER 1994**

The Save the Children/US Child Survival VII project aims to reduce infant and child morbidity and mortality due to diarrheal diseases through improved access to MOH health services and improved knowledge and practices regarding the management of diarrhea at the household level. Appropriate management of diarrhea in the household depends on knowledge of the preparation and administration of Jeevan Jal (JJ), the Nepali oral rehydration solution. Therefore, the following project objective was selected:

60% of families with a child <2 years will know how to prepare and give Jeevan Jal correctly.

In November 1992, project staff conducted a baseline survey of JJ preparation and found that only 7.3% of the 210 households interviewed had a family member who could correctly prepare JJ. Among these same households, 21.4% had a family member who knew the correct dose of JJ for a child under two years (1/2 glass after each stool), while 23.6% knew the correct dose of JJ for a child over two years (1 glass after each stool).

In November 1994, a 30 cluster sample survey was conducted to assess the impact of the project on knowledge of JJ preparation and administration. A total of 210 households with a child under 2 years were interviewed (7 per cluster). If available, the youngest child's caretaker was interviewed. The caretakers or other household members were asked if they knew how to prepare JJ, those who did were then asked to demonstrate doing so. These 162 respondents were also asked about the administration of JJ.

FINDINGS

I. FINDINGS ABOUT JJ PREPARATION

162 (77.1%) of the 210 households interviewed had a household member who stated that they could prepare JJ. In 131 of these households the respondent was the caretaker; while in 31 households the respondent was another member. Correct preparation was defined as: washed hands, used clean pot, used clean drinking water, used six tea glasses of water, used one packet of JJ, and mixed thoroughly.

The following table shows that just over half of the respondents who thought they could prepare JJ correctly actually gave a correct demonstration. Therefore, 41.0% of all of the 210 households sampled had a family member who knew how to prepare JJ correctly.

**DETAILED IMPLEMENTATION PLAN
MAY 1992**

**REVISED IMPLEMENTATION PLAN
APRIL 1993**

VITAMIN A

60% of children 12-23 months will have received 2 doses of vitamin A.

60% of children 12-23 months will have received 2 doses of vitamin A. *(SAME: Vitamin A is distributed to children 6-59 months every 6 months).*

60% of lactating mothers of children 0-12 months will have received one dose of vitamin A.

DROPPED

FAMILY PLANNING

20% of eligible couples will use temporary or permanent methods of contraception.

20% of eligible couples will use temporary or permanent methods of contraception. *(SAME)*

MATERNAL CARE

25% of women will eat more during pregnancy.

(DROPPED)

30% of pregnant women will have an ante natal checkup.

30% of pregnant women will have an ante natal checkup. *(SAME)*

40% of mothers with a child <2 years will know the three cleans for a safe delivery.

40% of mothers with a child <2 years will know the three cleans for a safe delivery. *(SAME)*

ACUTE RESPIRATORY INFECTION

25% of mothers with a child <2 years will seek advice or treatment from health workers when their child has difficult respirations.

25% of mothers with child <2 years will know signs of ARJ and seek advice or treatment. *(SAME)*

80% of mothers with a child <2 years will know where treatment for ARJ is available. (NEW)

LITERACY

80% of CHVs and 50% of trained TBAs and mothers' group members will have basic literacy skills.

70% of CHVs and 20% of trained TBAs will have basic literacy skills. *(REVISED)*

HEALTH INFORMATION SYSTEM

60% of VHW registers will be up to date. *(NEW)*

4. FINDINGS ABOUT SOURCES OF INFORMATION ABOUT JJ

In the 210 households surveyed, information about JJ was obtained from:

Source	Number of HHs	Percent of HHs
CHV	49	23.3
Health post/hospital	42	20.1
Radio/street drama	26	12.3
VHW	6	2.9

To increase families' knowledge and improve their practices regarding the management of diarrhea, the project conducted JJ campaigns. During these campaigns highly motivated CHVs demonstrated the preparation of JJ in their villages and taught women about the appropriate management of diarrhea. These activities were supported by placement of signs marking the CHVs' homes, where JJ was available for sale. Other local leaders and TBAs who expressed interest were included as sources for education about the management of diarrhea and as sales agents for JJ.

DISCUSSION AND RECOMMENDATIONS

The findings of the final survey compared to the baseline survey indicate that while knowledge of JJ preparation and use of JJ during diarrhea episodes has increased, knowledge of how to give JJ has remained the same.

Indicator	% of HHs in Baseline JJ Survey	% of HHs in Final JJ Survey
Correct preparation of JJ	7.3	41.0
Child <2 years had diarrhea episode in past two weeks	22.7	32.4
Used JJ during recent diarrhea episode	14.0	44.1
Knows dose of JJ for child <2 years	21.4	19.0

The methods used to promote knowledge of JJ preparation and use of JJ during diarrhea are fully described in the report of the Final KPC Survey. As stated in the report, these activities should be continued, so that the achievements are sustained. Recommendations for additional future activities are also given.

Although the reasons for the lack of increase in knowledge of the correct administration of JJ could be hypothesized, SC/US staff should systematically investigate them through qualitative study. It is likely that while the success of JJ demonstrations are easy to assess through re-demonstration, it is much more difficult to assess whether messages about the administration of JJ are clearly understood. The learning process is further complicated by the availability of different types of ORS and the diverse opinions of family, friends, and others about how to treat diarrhea.

Criteria	Number of Respondents Correct	% of 162 Respondents Correct	% of 210 Households with Respondent Correct
Washed hands	133	82.1	63.3
Used clean pot	146	90.1	69.5
Used clean drinking water	156	96.3	74.3
Used six tea glasses water	134	82.7	63.8
Used one packet JJ	154	95.1	73.3
Mixed JJ thoroughly	155	95.7	73.8
All criteria	86	53.1	41.0

Only 86 respondents covered the pot without prompting (53.1% of 210 households).

2. FINDINGS ABOUT JJ ADMINISTRATION

After preparing the JJ, the respondents were asked about how to give JJ:

Criteria	Number of Respondents Correct	% of 162 Respondents Correct	% of 210 Households with Respondent Correct
1/2 glass JJ after each stool for a child <2 years	40	24.7	19.0
1 glass JJ after each stool for a child >2 years	27	16.7	12.9
As desired	107	66.1	51.0

Only 75 respondents correctly stated the length of time that JJ can be stored (24 hours). This was 35.7% of the 210 households interviewed.

3. FINDINGS ABOUT USE OF JJ DURING DIARRHEA

Of the 210 households interviewed, 68 reported that the child under two years had had diarrhea during the past two weeks (32.4%). In 30 (44.1%) of these households the child with diarrhea was given JJ. 137 households (65.2%) reported that a medical shop is the nearest place to get JJ. Another 15% stated that the CHVs home is the nearest place. 185 households (88.0%) stated that JJ is available when needed.