

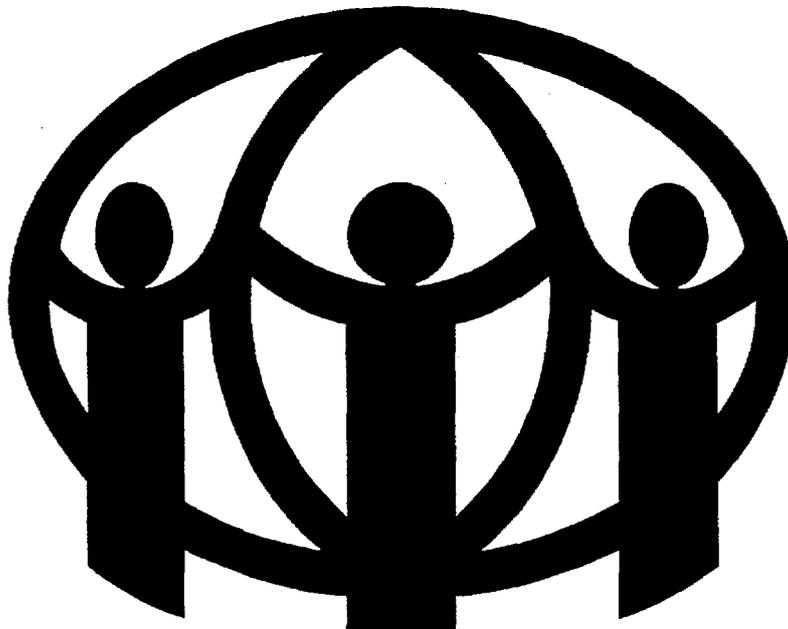
FINAL EVALUATION

for

CHILD SURVIVAL VI PROJECT

OTR-0500-A-00-0098-00

NEPAL



Submitted to:

United States Agency for International Development
Washington, D.C.

by:

Adventist Development and Relief Agency International
Silver Spring, MD

October 1993

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Silver Spring, MD

by

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October 1993

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LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
AHW	Auxiliary Health Worker
ANC	Antenatal care
ANM	Assistant Nurse Midwife
ARI	Acute Respiratory Infection
CDD	Control of Diarrheal Disease
CHV	Community Health Volunteer
CMA	Community Medicine Auxiliary
CS	Child Survival
DHO	District Health Office (in Kabhre)
DIP	Detailed Implementation Plan
DMPA	depot medroxy-progesterone acetate, Depo-Provera®
DPHO	District Public Health Officer
EPI	Expanded Program of Immunization
FP	Family Planning
FPA/N	Family Planning Association of Nepal
FR	Field Representative
HIS	Health Information System
HMG	His Majesty's Government
HP	Health Post
HPIC	Health Post In-Charge
HPSC	Health Post Support Committee
IEC	Information, Education, Communication
IGA	Income Generating Activities
JICA	Japan International Cooperation Agency
JJ	Jeevan Jal
JMA	Japan Medical Association
MCH	Maternal Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
PCS	Project Support Communications
PH	Primary Health
PHC	Primary Health Care
PP	Project Proposal
PVO	Private Voluntary Organization
SATA	Swiss Association for Technical Assistance
SHP	Sub Health Post
SMH	Scheer Memorial Hospital
TA	Technical Assistance
TBA	Traditional Birth Attendant
UMN	United Mission to Nepal
US AID	US Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception

EXECUTIVE SUMMARY

I. BACKGROUND OF PROJECT

The Child Survival (CS) Project began in 1990, as the first effort by ADRA/Nepal in Child Survival interventions. ADRA has been involved in curative care in assisting the Scheer Memorial Hospital (SMH) in Banepa for 30 years, and in bringing cardiac surgery services to Bir and Teaching Hospitals in Kathmandu. Kabhre Palanchok District was chosen as the site of the Project, because of the presence of SMH's recent re-orientation to become the district hospital and its desire to have a community outreach program to provide health services. A need for child survival services was based on a UNICEF report (1987) listing the district having one of the highest infant mortality rates in Nepal. In spite of the district being transacted by a major road from Kathmandu, many parts are very remote, and are home to ethnic groups of limited economic means. To members of some of these groups, Nepali is not a first language and they may have not yet entered the demographic transition. However, there is a growing trend of urbanization along the road, with centers of wealth and sophistication in towns like Banepa.

II. EVALUATION METHODS

This consisted of a study of Project documents, as well as published and unpublished reports and papers, review of materials in ADRA offices in Kathmandu, Banepa and in the field sites, as well as visits to each of the Project sites, and to one site where ADRA was not operating for comparison data. In country, data was collected through key informant interviews with Project staff, ADRA/Nepal support staff, villagers, Community Health Volunteer's (CHV's), Traditional Birth Attendants (TBA's), Village Health Workers (VHW's), municipality leaders, health post staff, sub-health post staff, staff of other health institutions, including SMH and Family Planning Association of Nepal (FPA/N), private practitioners, traditional healers, members of the District Health Office as well as key officials of the Ministry of Health, US AID, and Japan International Cooperation Agency (JICA). Structured and participant observations and role play of health post activities were other evaluation methods. Some observations took place at homes of CHV's and TBA's at the ward level. Focus group discussions were held with CHV's, TBA's VHW's, members of literacy classes as well as income generating classes and Health Post Support Committee's (HPSC's). Finally, analyses of data from the District Health Information System (HIS) were done. Literacy classes and health worker training were not being held during the time of the evaluation.

III. ACCOMPLISHMENTS

A. OBSTACLES

The Project has overcome an immense number of obstacles during its three year span. There were general start up problems with the new focus of child survival interventions for ADRA/Nepal, including the loss of key Project staff in its first year then starting fresh and functioning for the next two years without a designated full time director. Hence, the early development of the project cannot be traced accurately with the current in-country staff. At the start-up time, political turmoil and weak technical support affected the Project. The Project's accomplishments rank comparably with any good project that has not faced those obstacles, and this is primarily a testimony to the energy, enthusiasm and dedication of its staff.

B. GOALS AND ACTIVITIES

The ADRA/Nepal CS VI Project has the goal of strengthening the health services in the district run by the Ministry of Health. It has undertaken this with the following activities: practical refresher training of health post staff and community health workers, provision of analysis capabilities for the district HIS, implementation of an improved reporting system, initiation of literacy classes for women, income generating activities, and the establishment of an urban Primary Health Clinic in Banepa. The activities take place in 4 Health Post (HP) areas, and the municipality of Banepa.

- Training

Training activities included management seminars for Health Post In-Charge (HPIC) staff in the entire district (not just the targeted HP's), management and Maternal Child Health (MCH) services to Auxiliary Health Workers (AHW's) and administrative staff at the District Health Office (DHO) and HP level, refresher training to district supervisors, training and refresher training to TBA's and high risk and referral training to CHV's. The Project has attained its objectives in this activity. Participants attested to the practical nature of the training and reported it as beneficial to their work. ADRA has begun developing Information, Education, Communication (IEC) materials appropriate to its rural setting.

- Literacy Training for Women

Literacy classes were held in rural villages and Banepa. Out of 600 enrolled women 406 successfully completed the final examinations. Preference to attend literacy classes was given to TBA's and CHV's. The curriculum included a health component based on the Facts for Life publication, taught by HP personnel. Participants acquired knowledge on other development activities.

A great thirst for literacy skills was seen among village women in this district. ADRA/Nepal is meeting some of that need through this program. Banepa municipality is committed to eradicating illiteracy. Discussions with women who have completed the classes invariably centered on maintaining and enhancing those recently acquired skills. An independent consultant has recently evaluated this literacy program (Paudel 1993).

- Health Information System

Through ADRA CS's efforts the HIS has been modernized at the DHO level, but is dependent on the accuracy and timeliness of reports submitted from the periphery. Computer training and support were provided. ADRA tried to strengthen the HIS by facilitating reporting at the Village Development Committee (VDC) level. The use of this data in planning is awaited. Three 30-cluster sampling surveys have been conducted during the life of this Project. The first did not follow the USAID CS standard questionnaire guidelines, but Technical Assistance (TA) and subsequent training of Nepali individuals allowed analysis of the data, and carrying out the next two have reinforced the technique and analysis. There are no statistically significant differences in the survey results over the brief Project period.

- CHV strengthening

The CHV's were found to be a strong local resource. ADRA can take credit in motivating them through refresher training, and through the support and encouragement provided by its Field Representatives (FR's), who visit the active CHV's and help facilitate VHW activities in the VDC. The FR is the active grass-roots link with the community.

- Banepa PH Clinic

With the increased urbanization in Nepal, and the epidemiologic transition occurring, the health care of urban populations needs to be addressed. Immunization rates are thought to be lower in the urban than in the rural areas! The model Primary Health Clinic set up by the ADRA CS Project in Banepa provides MCH, FP and adult services. In the new facility it will provide Voluntary Surgical Contraceptive (VSC) services that are currently being performed elsewhere. In the Banepa urban setting CHV's have been trained. Mother's groups are active there in contrast to the rural areas

- Household Income Generation

This has recently started with an emphasis on skills' development (sewing). Participants from a wide variety of backgrounds are completing the first training program and plan to sew on consignment in their communities.

- HP, SMH and PH Clinic Referral System

This system is in the testing stages, the organizational structure exists and has resulted in faster, less costly access to care at SMH, and resultant feedback to the HP.

- HPSC

These are newly re-organized and are seen as having the potential to play a key role in the overall management of the HP.

C. ADRA/NEPAL CS INFRASTRUCTURE

The Project has hired competent staff for their various jobs, managed their activities with active supervision and significantly invested in further public health training for some individuals to take on additional responsibilities in the future. It has set up a field office and clinical facility in Banepa, and established linkages with the DHO, and other health institutions working in the district, as well as in other parts of Nepal. A field library in the Banepa office exists, which houses training materials and other resources. Transportation support is maintained.

IV. IMPACT OF PROJECT

The Project has been in operation for only three years (effectively two) and it is much too soon to gauge any quantitative impact nor would it be appropriate to try. Strengthening of government health services does not lend itself to such analysis. However, based on a qualitative basis, the Project shows credibility, both in Kabhre and in Kathmandu. It provides training that is practical in scope, and offers participants opportunities to discuss problems encountered in their work. Community perceptions are that deaths from immunizable and diarrheal diseases have declined.

V. CONCERNS

A. RELATIONSHIP BETWEEN ADRA/NEPAL AND ADRA/HQ AND THE CS PROJECT

It is the perception of ADRA/Nepal that it appears to be implementing ADRA/I-designed CS projects in Nepal. Current ADRA/Nepal staff feel they do not have the responsibility to write goals and objectives, nor draft the Project documents nor decide for the need for technical assistance. A comprehensive scheme for project monitoring is lacking. The evaluation process in relation to the goal and objectives was not clearly understood by the staff. This may be related to the poorly prepared objectives in the Project documents.

B. EFFECT OF TRAINING

There are many training programs for health workers in Nepal. However, there has been no attempt to assess the results of the training in an operational way.

C. NEED FOR A RURAL GRASS ROOTS FOCUS

A strength of the Project lies with the FR's who work in the community and try to improve the efforts of the CHV's and TBA's, and try to ensure that the VHW's carry out their routines. Supervision of the FR rarely takes place in the worksite. A valuable opportunity to increase the status and effectiveness of CHV's and TBA's is lost. Dialogue between the Project and the community at the ward level is lacking.

D. IMPROVING THE QUALITY OF THE SERVICES OFFERED AT THE HP

HP activities seem limited to writing prescriptions based on brief clinical histories. No attempts are being made to make the facility run efficiently and to minimize the time spent by busy mothers who bring their children in for preventive or curative services. Rudimentary quality assurance is lacking. No efforts are made to verify the understanding of any messages transmitted to patients. Health education is rarely given.

E. LITERACY PROGRAM

While the literacy program has created a great zeal towards learning, Paudel (1993), noted the achievement score on health was not as good as expected; and there was lack of long range planning as well as ongoing supervision and monitoring.

VI. RECOMMENDATIONS

A. CLARIFICATION AND FACILITATION

That the respective roles and responsibilities of ADRA/Nepal and ADRA/I be clarified

- to facilitate greater local (in-country) input and participation in determining clearly-defined project goals and objectives (as in Detailed Implementation Plan (DIP) and proposal preparation)
- to support their role for requesting the form, timing and duration of technical assistance
- to streamline procedures involving requests for information and assistance so that response times are minimized and timely communication is assured.

B. MANAGEMENT

That ADRA/Nepal

- prepare detailed written protocols, guidelines, procedures and work-plans to enable
 - effective, regular supervision, coordination and assessment of all personnel
 - comprehensive, systematic monitoring, documentation and evaluation of objective-oriented project activities
- enhance community participation and involvement in all aspects of the project (planning, implementation and evaluation) and specifically as related to sustainability issues
- explore and establish appropriate, proactive mechanisms to further strengthen networking relationships with the Scheer Memorial Hospital, local Non-Governmental Organizations (NGO's), USAID/Nepal, all levels of His Majesty's Government's Ministry of Health (HMG/MOH) and related ministries, key stakeholders and relevant local organizations for information-sharing, problem-solving efforts, professional support and guidance.

C. SPECIFIC RECOMMENDATIONS

- Training activities should be related to learning objectives that are in some sense measurable. Some output or outcome needs to be assessed, both at the conclusion of the training and with follow-up at periodic intervals to assess some impact indicators to see if the training has had any effect.
- Operate the Banepa PH Clinic as a model urban health service delivery center and clarify its role with SMH, DHO and NGO's.
- Make appropriate recommendations on a job description of HP personnel to the HMG/MOH, based on a work analysis conducted in the four HP's.
- Expand opportunities for income generating activities in coordination with HMG agencies including Ministry of Local Development, Women's Development Division, Production Credit for Rural Women's Activity.
- Create a Project Resource Center that would house international public health and development-related publications (books, periodicals, reports, monographs, etc.), health educational materials (videos, slides, flip charts) and audio-visual equipment.
- Consider acting upon the recommendations of the external evaluation of the literacy program.

FORWARD

This document was prepared by the team leader after extensive discussions with the team, and presentation of the outline to the entire Project staff, on two different occasions. The observations listed in the supplementary questions and issues are those of individual team members and represent their input from places visited, discussions held, and documents reviewed.

The team wishes to thank the officials of His Majesty's Government of Nepal, the staff of the various facilities in Kabhre Palanchok District and villagers, all of whom shared with us the wonderful hospitality of Nepal, and allowed us to observe and question. The evaluation took place during one of Nepal's most devastating monsoons, but conditions did not hinder the team from carrying out its mission, a testimony to the ADRA CS Project staff who were untiring in facilitating this evaluation in every way possible.

Members of the team were privileged to walk to remote villages with some of the Project staff, and to stay in Project staff homes or other facilities. Villagers shared their hospitality with the team and were very kind in answering questions we posed as they took time from their busy harvesting schedules. The greatest resource of Nepal lies in the self respect of the rural peasant.

The team leader takes this opportunity to thank the members of the team who persevered in difficult circumstances, worked together to complete the tasks, and offered constructive input at all phases of the evaluation. The evaluation team (including 3 physicians and one nurse), with its compound eyes represented by such diverse backgrounds, and different points of view, functioned as a sophisticated organism.

EVALUATION

Introduction

This evaluation represents a synthesis by the entire evaluation team. It has also had considerable input from the Project staff themselves, as the findings and recommendations were presented, discussed, clarified, and modified over a two day workshop at the end of the in-country period.

ADRA/Nepal has worked in a variety of health related projects. SMH, a Seventh Day Adventist supported hospital has functioned for over 30 years as the major referral hospital in Kabhre District, and in the neighboring districts of Ramechhap, Sindu Palchok, and Dolakha. ADRA/Nepal wished to join forces with SMH in a community outreach effort, combining the clinical competence of SMH with ADRA's

commitment to public health. SMH had become recognized as the district hospital for Kabhre Palanchok district. It was discovered in 1987 that the IMR in this district was one of the highest for the Central Region. Coupling this need for services with ADRA's skills, and SMH's clinical track record appeared to provide a good opportunity for improving health in this region. US AID awarded the CS VI grant, which added resources to those already committed by ADRA.

BACKGROUND

- Historical background

Nepal was isolated from the outside world until 1951. Rudimentary health services were begun after that, with a focus on vertical programs such as malaria control, eradication of smallpox, and family planning activities funded by major donors. NGO's provided curative services in several areas as exemplified by SMH in Banepa. In the 1970's attempts were made to integrate the vertical programs of the MOH, and this has occurred with partial success. After the Alma Ata declaration of PHC in 1978, and the response of Selective PHC, the concept of CS interventions were enunciated in the 1980's. US AID committed itself to funding NGO efforts to implement these. They have come to comprise provision of immunizations, control of diarrheal diseases, acute lower respiratory infections, continuation of breast feeding, and emphasizing birth spacing. The importance of female literacy as a proximate determinate for child health was recognized in the 1980's. The important effect of socioeconomic status on health and the relevance of factors outside the biomedical model as they apply to populations has been termed the health transition. This multi-factorial process and a secular trend has resulted in the improvement of health status indicators, but Nepal still ranks near the bottom of nations in health status. ADRA/Nepal joined these efforts in 1990, when it was awarded the CS VI grant to support its own funding sources in the provision of CS interventions. Democracy was reinstated after 1990, and popular elections for the national government were held in 1991 and for village government in 1992.

- Kabhre Palanchok District

This district, comprising 1446 square km, lies in the Central Development Region, east of Kathmandu. The population is estimated to be 325,000. It is organized into 93 Village Development Committees, and two municipalities. Each VDC has an elected chairman. The smallest administrative division is the ward, there are 9 in a VDC, each with an elected member. The district name reflects two Goddesses who once stayed here. Here after, it is referred to as Kabhre District. The district is transacted by the Arniko Highway, linking Kathmandu with the Tibetan Region of the People's Republic of China. There are now feeder roads off this main thoroughfare linking nearby villages, but many villages in the district lie several days walk from the road. Kabhre District lies in the hills of Nepal, with

representation from the Tamang, Hill Hindu Castes, and Newar ethnic groups. Although Nepali, an Indo-European language is the lingua franca, it is not the native tongue for many people in the district, and some do not speak it at all. The religion of the hills, based on animism and shamanism predominates, is termed Hinduism by many, with Buddhism finding expression amongst Newar and Tamang. Most homes are accessible only by foot trail, and have no electricity nor running water. Mini-hydel electricity is supplied to towns along the road. Kerosene is a fuel source near the road, while most people harvest local forest resources for heat energy for cooking. The economy is based on subsistence agriculture, but commerce in the form of tourist resorts, and carpet factories is found along the road. The new Kathmandu University, has situated some facilities near the main road. Most landholdings are small, the extended family is the basic stakeholder. Imports are consumer goods, while exports are cotton textiles, carpets and some agricultural products.

Health services exist in many forms in addition to the dharmi jhankri or traditional healer. Those supported by HMG begin with the CHV, based in the ward. Current health plans call for a Sub Health Post staffed by auxiliaries, including a local MCH worker, to exist in every VDC, and a Primary Health Center staffed by a doctor and having 4 beds in each of 205 electoral constituencies in the country. There are some 12 health posts in the district, as well as two PH Centers. Each district is to have a hospital to act as a referral center for the above mentioned facilities. SMH has been designated the District Hospital in Kabhre. Many NGO's provide health services in the district, including the Red Cross, FPA/N, Lions Club and Helen Keller International. In addition, there are private practitioners and there are plans for at least two private hospitals near or on the road.

A report was published on maternal mortality in Kabhre District, which looked at causes of maternal deaths, and estimated the maternal mortality ratio to be 1210 per 100,000, which is considerably higher than the figure of 850 quoted for Nepal in official publications. Recommendations for action were given there. (Rijal 1991).

- History of the Project

The Project began in 1990, with a Project Paper and DIP written by ADRA/I staff, coupled with input from short term consultants, some of whom were public health students at Loma Linda University. The goal, as stated in the Project Proposal was to improve maternal and child health in three rural ilakha and one urban area in the Kabhre District through training, follow-up supervision and monitoring of the local health system. The objectives stated there (Appendix 2) were focussed on promoting child survival health services in Kabhre Palanchok District. The health targets mentioned there were extremely ambitious, especially considering that the Project was not involved in the provision of any health services. The DIP contained another specific statement of objectives, listed in Appendix 3. The actual implementation

plan from that document is summarized in Appendix 4. In the spring of 1990, before the Project was really underway, a relatively peaceful political revolution in Nepal occurred resulting in the beginning of a democratic process.

By the time of the First Annual Report in October 1991, the Project Director had resigned, and this event was preceded or succeeded by the departure of the remaining Project staff including the program coordinator and the field coordinator. In that report, a confusing objective was clarified, another HP site was added, as was a literacy component, and family planning activities centered in the Banepa clinic together with changes in the staffing pattern. Delays, to be expected in such a start up project, included not completing the baseline survey. When a 30-cluster sampling survey was finally done, a customized questionnaire and not the standardized US AID Child Survival Questionnaire was administered.

The Mid-Term Review was done in August 1992. It recognized "the unique part of program in Nepal is that it has not tried to establish a new and independent work, but is attempting to strengthen already existing activities (by means of available resources: training personnel and programs available in country)." A repeat survey was done using the standard questionnaire in April 1992. The additional HP area was added as JICA withdrew its support from the facility it had previously established. The evaluators wanted the training input to have some impact, and advised that ADRA CS collaborate with DPHO to establish a strategy to see how government targets for the district could be reached. They asked that the final evaluation show an increased coverage. It was noted that SMH had not been able to commit staff nor space to the training center because of their limitations. They recommended that an ADRA representative from ADRA regional (Division) office should be included as an observer in the final evaluation and that the objectives be revised.

The Second Annual Report in October 1992 reported a change in goal and objectives to be those recognized in this evaluation, and listed below. AIDS education was added as this district was determined be supplying commercial sex workers to India. ARI, breast feeding, ANC and FP were added to CS interventions listed in the DIP and there was a greater emphasis on 'At risk' mothers and children, and use of referrals. The referral system was developed using a form that facilitated feedback to and from SMH.

Leadership of the Project was provided by the ADRA/Nepal country director and short term external consultants provided TA. Earlier in 1993, the in-country Senior Advisor post was filled, and this seasoned individual began providing needed ongoing assistance. Attempts to fill the CS Director post were not successful. Currently, leadership is vested in a management committee composed of Project staff. The Education/Field Coordinator went on leave for further training abroad, and the

Administrative/Fiscal Officer is due to depart soon as well. This summer, a third survey was completed in spite of the difficulties imposed by the heavy monsoon rains. An independent evaluation of the literacy program was done during the summer of 1993. There has been a reorganization of the MOH during this period. It is too early to judge the effect of this change, but it will decrease health post staffing. At the time of the field visits for the Final Evaluation, preparations were being made for the next phase following renewal of US AID funding as a CS IX Project. The Third Annual Report was being prepared, and ADRA/I was sending TA to help prepare the DIP for the new project.

GOALS AND OBJECTIVES

- Goals

Improve health of mothers and children by helping the local MOH strengthen its delivery of services through education/training and collaborate with MOH in development of CS program in four Kabhre district health post areas

- Objectives

I. Establish a District training center in conjunction with SMH

- A. Provide 6 management seminars/workshops for in charge staff of the three targeted health posts
- B. Give continuing education for various levels of health post staff: "at-risk identification and management" "health messages"; "AIDS"; "CS interventions"; Family Planning"; "Health Information System"; and other topics as requested by MOH
- C. Train TBA's and CHV's in cooperation with MOH and DPHO in Banepa and four health post areas
 1. Banepa-14 new TBA's, 12 new CHV's
 2. Dapcha-refresher training. for CHV's; 90 plus 15 new TBA's
 3. Nala-refresher training for 15 TBA, 12 CHV
 4. Khopasi refresher training for 17 TBA, new training. for 20 CHV's refresher for 108 CHV
 5. Panchkhal-24 TBA's refresher training for 190 CHV
- D. Train DPHO leaders/staff-CS Management (4 sessions minimum) plus training of HIS work of MOH representatives

- E. Conduct three workshop for NGO's MOH representatives relevant to CS: AIDS education, EPI INFO Computer Software for data management, HIS
 - F. Evaluation CS services for efficiency and effectiveness in management and outcomes (50% improvement)
 - G. Third year conduct field training and clinical training at SMH/Banepa PHC clinic monthly
- II. Enhance knowledge level of women through literacy/health classes for training for 450 women, 15 years of age and above. Follow-up of interested women for establishment of mother's club and further training as CHV's and TBA's
- III. Organize/activate mothers groups for CS/Safe Motherhood goals
- A. Banepa 12 mothers groups
 - B. Dapcha 40 mothers groups
 - C. Panchkhal 40 mothers groups
 - D. Khopasi 50 mothers groups
 - E. Nala 25 mothers groups
- IV. Collaborate with the MOH Kabhre District to make the present HIS more meaningful, efficient and effective:
- A. HP and Banepa clinic will use growth cards and ANC-FP cards for mothers and children under 5
 - B. Mothers will receive immunization cards for infant/child
 - C. Health post registration summaries will be monitored for accuracy and summative data and analyzed as part of CS Project and Kabhre District Data
 - D. Conduct at least two cluster surveys per year, share analysis with DPHO/MOH and use in planning
 - E. Do a data base in Banepa and 4 health post areas for baseline data (use standard CS questionnaire of Johns Hopkins), repeat at end of project
 - F. Assist VDC to maintain accurate/complete data on births/deaths
 - G. Train minimum of 15 Nepali individuals to conduct surveys, use questionnaires, do sampling; and train CS computer staff to utilize EPI INFO computer program for analysis
 - H. Conduct EPI INFO computer Data Management Workshop for CS program staff, MOH representatives, and NGO representatives
 - I. Conduct HIS Workshop for CS program staff, MOH representatives, NGO representatives

- J. Provide feedback to DPHO, Health Post staff and VDC
- V. Written standards for CS interventions for use in field training and monitoring, based on WHO CS objectives

Evaluation of interventions will be done by DPHO staff counterparts of CS project staff using MOH goals for measurement of achievement (recognition is given to very high expectations for the government and that time frame of project may not permit expected achievement). Minimum achievement will be 50% of stated goals by October 1993.
- VI. Activate government trained CHV's who, with CS project trained CHV's will provide local areas of the CS project with FP supplies and referrals
 - A. Referrals for ANC and child primary care. Early maternal case-finding and encouragement to obtain ANC. Assistance with reporting births to the VDC. Health education on the 14 health messages, attendance and leadership in Mother's clubs (40% for active CHV's)
 - B. Provide continuing education monthly for CHV's and TBA's using ANM's, VHW's and HPIC.

IMPLEMENTATION METHODS

The details as provided by the documents are listed in Appendix 4. The Project's objectives, in their detail as stated above taken from the Project documents, really represent activities, rather than being a statement of planned outcomes in measurable terms. The implementation methods of the Project can then be described as providing training, setting up a computerized HIS at the district level, setting up and operating an urban clinic in Banepa and working through Project field representatives to strengthen the CHV's.

PURPOSE OF EVALUATION

The evaluation was designed to: 1) document activities carried out by ADRA/NEPAL to promote sustainability of effective CS interventions; 2) assess whether PVO carried these activities out in competent manner; 3) identify any lessons learned; 4) draw conclusions about applicability and relevance of lessons learned in sustainability; 5) prepare recommendations and suggests for improving impact of CS interventions in future programming. The scope of work is listed in Appendix 1.

EVALUATION METHODS

The evaluation team represented a balanced range of experience, cultures and viewpoints. It included a high level MOH official, a Nepali representative from the Project, an US AID official, an evaluator born, raised and educated in India, currently in an US academic position, representing a broad range of international health experience on his first visit to Nepal, and a North American with Nepali language fluency as well as clinical, administrative and teaching experience in health in rural Nepal spanning 24 years.

DESCRIPTION OF DATA COLLECTION

Data collection consisted of study of Project documents, as well as published and unpublished reports and papers, review of materials in ADRA offices in Kathmandu, Banepa and in the field sites, as well as visits to each of the Project sites, and to one site where ADRA was not operating for comparison data. In country, key informant interviews were held with Project staff, ADRA/I support staff, villagers, CHV's, TBA's, VHW's, community leaders, municipality leaders, health post staff, sub-health post staff, staff of other health institutions, including SMH and FPA/N, private practitioners, traditional healers and members of the District Health Office as well as key officials of the Ministry of Health, US AID, JICA. Structured and participant observations and role play of health post activities were other evaluation methods. Some observations took place at homes of CHV's and TBA's at the ward level. Focus group discussions were held with CHV's, TBA's VHW's, members of literacy classes as well as income generating classes and HPSC's. Finally, analyses were done using data from the district HIS. All individual field notes were transcribed, printed, and shared amongst the evaluators and the Project staff. Literacy classes and training were not being held during the time of the evaluation.

EVALUATION SITES SELECTION PROCESSES

Visits were made to each of the four health post sites, and within them to Sub Health Posts where they were operating, and to other health facilities in the area, as well as to the Banepa PH Clinic, and to Scheer Memorial Hospital. For comparison, a visit was made to a health post that was not one of those where ADRA was active. Visits were made to people's homes in villages, including those where CHV's, and TBA's lived. Appropriate Ministry of Health and USAID Mission visits were made in Kathmandu. Many of the Project activities were not functioning at the time of the evaluation, including training, and literacy classes but visits were made to interview participants in one of these. Details of the itinerary and individuals interviewed are listed in Appendices 5 and 6.

SUSTAINABILITY ISSUES

CHILD SURVIVAL GUIDELINES

Many of the questions in these guidelines pertain to sustainability, which is taken to mean whether activities undertaken by this Project can be supported by the people to whom the services are provided and by in country organizations supported by Nepalis. Nepalis will sustain health care activities of their own choosing in their own fashion and in their time. It is laudable to have services provided by external agencies such as US AID and ADRA, especially those in this Project that strengthen the HMG health services delivery system. It is not appropriate to expect these services to be entirely supported by Nepalese in the short time period considered in these questions, but it is reasonable to ask local communities and institutions to begin to consider supporting those activities they consider valuable. Nepal's per capita GNP, and its per capita consumption of global resources is a minuscule fraction of that of the donor countries. It is unrealistic to expect the people of this country to bear the economic burden of the interventions designed and provided by external agencies. It is with this perspective that answers to the following are provided.

A. Sustainability Status

1. At what point does AID funding for CS project activities end?

The ADRA Nepal Child Survival program started in October 1990, continued for a period of 3 years, with the funding period being up to September 30, 1993.

2. When does ADRA plan to cease CS project activities?

To date the Project activities are continued with funding from ADRA and USAID. With the newly approved ADRA CS IX project supported by US AID it has been agreed with HMG of Nepal to begin the second phase of the program for an additional period of 3 years, starting in October 1993 ending in September 1996.

3. How have major project responsibilities and control been phased over to local institutions?

The construction of a three story building by ADRA/Nepal in Banepa municipality for the Project is nearing completion with the intention of establishing a primary health care clinic there, a FP/MCH training Center, and offices for the local field staff. ADRA/Nepal is committed to continuing the CS Project activities begun with CS VI after AID funding ends. SMH has

in principle agreed to have a role in this process as it is eager to support a referral base in the district, and an urban facility in Banepa to reduce the outpatient load on the hospital. The activities on the child survival program will hopefully be carried on in the future with significant support by the people of Kabhre Palanchok District.

B. Estimated recurrent costs and projected revenues

1. Identify key CS activities that project management of ADRA perceives as most effective and would like to see sustained?

ADRA feels the following activities are most effective and would like to see them sustained: Training programs/workshops for health personnel, including CHV's and TBA's, Community development activities including female literacy and income-generation, Health Information System, and Family Planning activities.

2. What expenditures will continue to be needed (i.e. recurrent costs) if these key CS activities are to continue for at least 3 years after CS funding ends?

With the assurance of funding from USAID for the next 3 years (1993-6), the major activities of the just completed project will be continued. (For details, please see document "Fy 1993 Child Survival Extension Application (Extension of CS VI Project # OTR-0500-A-00-0098-00)."

The budget shown there is \$806,016 for the three year extension.

3. What is total amount off money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for 3 years after CS funding ends?

For year one, it is \$295,100, for year 2, \$259,095, and for year 3, \$251,821.

4. Are these costs reasonable given the environment in which the project operates (e.g. local capacity to absorb cost per beneficiary)

Yes, they are reasonable, even though ADRA/CS VI has underspent its budget. The Project has not had the absorptive capacity due to problems of leadership in the start up period, that should not continue into the CS IX time frame.

5. What are projected revenues in US dollars that appear likely to fund some CS activities for at least 3 years after AID CS funding ends?

At present the only source for revenues is from the registration fees for patients at Banepa PH Clinic (projected revenue \$200-300/year). However, with the completion of the PH Clinic with the hostel facilities to be established there, revenue will accrue from hostel fees, and from the rental of the apartment there to doctors who will work with the Project.

6. Identify costs which are not likely to be sustainable

Costs not likely to be sustainable include: child survival personnel salaries, administrative (overhead) costs, those training programs offered only through CS, maintenance costs for the computer at DHO.

7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other CS projects or to AID's support of these projects?

The following lessons have been learned:

The critical need and significance of working collaboratively with the Ministry of Health and the community.

The importance of networking with governmental agencies and NGO's That financial self-reliance be recognized as only one factor in the overarching concern for program sustainability.

In certain countries (as in Nepal), the issue of sustainability appears to be irrelevant (and probably premature) in light of the major, continuing dependence of the government on external funding.

C. Sustainability Plan

1. Identify number and position of project staff interviewed and indicate extent of their involvement in project design, implementation and/or monitoring/evaluation.

The Country Director of ADRA Nepal, Senior Advisor, Administrative/Fiscal Officer, Education/Field Coordinator (current acting individual and the person on study leave), Public Health Nurse, PH Clinic -Medical Officer, Community Development Officer, Field Representatives and PH Clinic nurses, altogether numbering 10 in total were interviewed, all being Project staff. They directly implement activities, giving some attention to objective oriented actions and to monitoring and evaluation.

Country Director ADRA/Nepal, who functions as the Acting Director of CS VI

He has a significant involvement in implementation and monitoring of the Project, but apparently not as much in the design.

Senior Technical Advisor

She apparently has a strong involvement in implementation and monitoring of the Project, but states she does not have in the design.

Education/Field Coordinator

The current individual is acting in this capacity while the previous appointee is pursuing training abroad. He has a strong involvement in implementation and monitoring.

Public Health Nurse

She has a significant involvement in implementation and monitoring.

Administrative/Fiscal Officer

He has a role in monitoring the Project.

Field Representatives

They number four and have a strong role in implementation but are minimally involved in Project design. The CS field staff were found to be busy with activities and were conscientious in their performance but were not adequately guided to keep track of the objectives for which their activities were being performed nor to measure the level of their attainment. They are enthusiastic and energetic.

Community Development Officer

He has a strong involvement in implementation and monitoring.

Information Advisor in the DHO

He has a role in implementation, monitoring, and evaluation.

Banepa PH Clinic Staff

These include the doctor, two staff nurses, and support staff, and have an involvement in implementing the urban health activities.

2. Briefly describe project's plan for sustainability as laid out in DIP or other relevant AID reports

The DIP sustainability plan includes: assessment meetings with representatives of target ilakha (HPSC's) as the main approach toward achieving and maintaining public support, and the charging of user fees at the Banepa PH Clinic.

3. Describe what sustainability-promoting activities were actually carried out by ADRA over the lifetime of the project?

The collection of user fees at the Banepa PH Clinic and at HP's was actually carried out by ADRA CS VI. As well, HPSC's were reinstated in the Project HP sites and have been meeting regularly. These are the beginnings of sustainability-promoting activities.

4. Indicate what aspects of the sustainability plan ADRA implemented satisfactorily and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of ADRA's sustainability effort?

ADRA satisfactorily implemented the sustainability plan it proposed to do.

Activities that were unplanned, but formed an important aspect of ADRA's sustainability effort included: charging fees to participants taking the income generation activities classes. In addition, ADRA/Nepal was instrumental in getting two buildings constructed for the future of the Project, namely the Banepa facility which will house the PH Clinic, the Project offices, and housing for some Project staff, as well the Dapcha HP.

5. Did any counterpart institutions (MOH), development agencies, local NGO's, etc. during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If yes, have these commitments been met?

There were no financial commitments made to sustain Project benefits listed in the proposal or DIP, to be carried out by counterpart institutions.

However, ADRA/Nepal did successfully obtain considerable outside support during the Project, which benefited it immensely. The Banepa PHC clinic will be managed jointly by SMH, the municipality and the community and the DHO in the future. The current PH Clinic's rent was paid by the municipality of Banepa for the first year. HMG MOH funded 2 ANM's to work in the PH

Clinic for 1 1/2 years and provided medicines and equipment. FPA/N allowed use of its operation theater for minilaps until the Banepa PHC clinic facility is completed. ADRA/Nepal has built this new facility in Banepa, that will be occupied soon, and will lessen the requirement for leasing space and utilizing FPA/N facilities for family planning in Kathmandu. ADRA/Nepal paid for the land on which to build the Banepa PH facility. Funders from Germany and Walla Walla Washington paid for the Banepa PH Facility. The DHO of the MOH is providing necessary vaccines and needed drugs, FP contraceptives, and micronutrient such as vitamin A capsules, and iron/folate tablets to all the health facilities where ADRA/CS is working. SMH has participated in the refresher training of HPIC and made the CS referral system a priority. A new HP has been constructed in Dapcha utilizing community donated land, ADRA/Japan donated materials and volunteer labor, to lessen the requirement for leasing space in the town. Local NGO's such as the Red Cross, FPA/N, and Jaycees are providing the physical facility of an operation theater in the Banepa PH Clinic. They are also supporting FP clinical training and running of literacy classes. The Ministry of Education is encouraging literacy programs and the local municipality is committed to eradicate illiteracy in Banepa in three years. Finally, JICA and the JMA has built and equipped a new PH Center in Khopasi.

A proposal was submitted to UNICEF for support in its literacy program just before the flood but no action has been taken yet. ADRA would have carried out training and received funds for this activity, budgeted at \$17,620.

6. What are reasons given for success or failure of counterpart institutions to keep their commitment?

Not applicable.

D. Monitoring and Evaluation of Sustainability

1. List the indicators the project has used to track any achievements in sustainability outputs and/or outcomes

None are available although the Project staff are sensitive to this concern.

2. Do these indicators show any accomplishments in sustainability?

See the response to 1.

3. What qualitative data does ADRA have indicating a change in the sustainability potential of project benefits?

The qualitative data includes:

- increasing support and collaboration from the Banepa Municipality and Scheer Memorial Hospital.
 - closer working relations with the MOH at all levels, particularly at the District Public Health Office
 - greater community support and involvement in Project activities. For example, the important management role played by the Health Post Supporting Committees (HPSC) augurs well for availability of better services at the Health Post level.
 - recent trends suggest that the MOH may be requesting NGO's to play a larger role in the delivery of health care services.
4. Identify in-country agencies which worked with ADRA on the design, implementation, or analysis of the mid-term and this final evaluation?

Ministry of Education, Ministry of Health (including the Regional Training Center), District Education Office, District Public Health Office (including the NGO Coordinating Committee), Banepa Municipality Office

Scheer Memorial Hospital

John Snow International, Save the Children (USA), UNICEF, The Red Cross, Helen Keller Institute, Japan International Cooperation Agency
Family Planning Association of Nepal (FPA/N), United Mission of Nepal (UMN), Health Development Project (Institute of Medicine), World Education, Nepal Women's Association

5. Did ADRA receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP? Did ADRA carry out those recommendations? If not, why not?

ADRA/Nepal staff are not aware of any feedback on recommendations regarding sustainability made by technical reviewers of proposal/DIP.

6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

See the response to 5.

E. Community Participation

1. Identify community leaders interviewed and indicate which group(s) they represent.

Community leaders such as the mayor, deputy mayor of the municipality of Banepa, HPSC members (comprising VDC chairman, vice-chairman, and social workers who helped in construction of Khopasi HP (old building) were interviewed, the complete list is in the Appendix 6.

2. Which CS activities do community leaders perceive as being effective at meeting current health needs?

In discussions with community leaders, EPI services seem to be at least partly responsible for a perceived notion that less deaths occur from immunizable diseases. Furthermore, they report that there are fewer children dying from diarrheal deaths, which they partly attribute to the provision of ORS, much of which is supplied by CHV's. Those away from the road that are close to HP's find the services adequate, but those who are near the road often travel as far away as Kathmandu to obtain care.

The community on the whole has a positive and supportive attitude toward the CHV's as a local PHC contact or change agent, for immunization services. The CHV's and TBA's role for maternal care and referrals and as a motivating tool for FP services is appreciated.

3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective CS project activities?

The ADRA FR's role is to motivate and to instill a strong sense of service to VHW's and to participate in mother's groups. The CHV's lack of resupply of nominal drugs, like paracetamol, ORS packets, and minor first aid supplies is seen as a major concern. They feel it should be regularly replenished by the government or by some other mechanism. It is also felt that PVO staffs should establish direct supervisory relation with VHW's

Project activities that enable the communities to better meet their basic needs and increase their abilities to sustain effect CS project activities include: support to CHV's and VHW's, IGA's and literacy classes.

4. How did communities participate in the design, implementation and/or evaluation of CS activities?

The policy of MOH for better management of a HP, includes the Health Post Support Committee, formulated at the level of the HP, which includes as members representatives from the concerned VDC's as well as local social workers, distinguished persons of the community and the HPIC as member

secretary. They are to be responsible to work for better service delivery, improvement of drug supply, maintenance of staffing, mobilization of local resources, etc. However this committee is not active in many HP's and wherever it exists it is not functioning very well. In the four ADRA supported HP's, the HPSC have been re-instituted in the last 4 months after a lapse of several years in which political activities took precedence and there were no elections for local government. The committee has approximately 15 members, including the VDC chairman, vice-chairman, and 5 local social workers. The objective of this HPSC is to improve the relationship and coordination between HP and VDC's. Every month the HPSC should meet to discuss HP activities, logistics and supplies, manpower, better service delivery, support to HP, improvement in services, as well as to monitor the role and activities of CHV, TBA, and traditional healers. Their activities currently include writing concerned government authorities at the district and regional level regarding fulfillment of the HP staffing pattern, mobilizing user's fee activities, scheduling immunization activities, and overseeing the operation of the HP's.

The HPSC is the major vehicle for communities to be involved in the CS activities. Through the field representatives, the Project is aware of their concerns.

Where there are Sub Health Posts, the Village Development Committee is responsible for donating the premises, and paying for the salary of a peon.

5. What is the number of functioning health committees in the project area? How often has each met during the past 6 months? Please comment on whether committee members seem representative of their communities.

There are four functioning health committees in the Project area, but each has only met once or twice in the last 6 months. VDC elections were only held in 1992, so there were no opportunities to activate the committees before then. Heavy monsoon flooding this year has made regular participation difficult. Committee members seem to represent the elite in their communities as is typical in Nepali bureaucracies.

6. What are the most significant issues currently being addressed by these health committees?

The most significant issues that are supposed to be addressed by HPSC include: writing to concerned government authorities (district and regional level) about the fulfillment of HP staffing; making recommendations to keep

the good personnel from being transferred; initiating drug schemes; mobilizing user's fee programs; attempting to display the VHW's field program, EPI schedule in VDC's; and encouraging continuing training to CHV and TBA's. Other capabilities include: evaluation of the performance of CHV, TBA, VHW's; making recommendations for CHV's and TBA's to enter literacy programs; and to improve the HP physical facilities and acquire land for the construction of new facilities. At this early stage, the issues addressed by the health committees are more related to trying to obtain greater inputs from the CS project. Problems they see as particularly acute include the lack of drugs and supplies for running the HP's. The Kusa Devi community is particularly aware of the lack of a decent physical facility for its sub health post, and the lack of resources to pay a peon.

7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

The major resource that a community in the Project area has contributed is the land and some labor for the construction of the new Dapcha HP.

8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

The HPSC have been successful in mobilizing resources in Dapcha because they perceived the existing HP structure as being inadequate. It is also a relatively wealthy community with road access.

F. Ability and willingness of counterpart institutions to sustain activities

1. Please identify persons interviewed and indicate their organization and relationship to the CS project.
 - Dr. Vigna, Chief Medical Officer of SMH, which runs the designated district hospital, and a referral center. SMH is a Seventh Day Adventist supported institution, as is ADRA/CS.
 - Rambhakta Kokh-Shrestha, Mayor Banepa Municipality
 - Ganga Saagar Shrestha, DPHO of Kabhre District
 - Japan Med. Assoc. (JMA) staff Midori Kitahara, and Y. Takamatsu, Coordinator: Nepal Primary Health Care Project
2. What linkages exist between the CS project and the activities of key health development agencies (local/municipal/district/provincial/state level)? Do these linkages involve any financial exchange?

ADRA/Nepal

ADRA/Nepal has supported the CS Project financially, and has mobilized support for CS project activities through building construction, as noted above in C:5.

SMH

SMH has agreed to coordinate services with ADRA/CS, act as a referral center and provide faculty for some of the training programs. Dr. Vigna oversees the provision of curative services to the people of Kabhre Palanchok District and other neighboring districts. He expressed his view that due to ADRA CS activities, SMH has been linked with HP personnel, that is referral linkages are two way, with HPIC gaining self respect as they can refer to SMH and the referred patient gets reduced registration charge and faster access to SMH. PH Centers at Banepa and Khopasi can function as a mechanism to reduce the patient load to SMH and serve as a screening center, and do post operative dressings. CHV's can be trained to do minor surgical dressings.

DHO

The DHO has supported the Project financially as noted above in C:5. Besides staffing and supervising the posts, they provide drugs and supplies to the HP's, and carry out reporting for the HIS. They are eager to establish an appropriate urban PHC clinic at Banepa that provides immunization, FP activities, and maternal care. They operate under a limited budget.

JICA and JMA has supported the Project financially as noted above in C:5.

The new Khopasi PH Center to be completed under JMA funding and JICA's management and will be supported by JICA from 1993 to May 1995. HMG will meet the cost of local manpower, 13 in number, and other expenses will be born by the funder. There are plans to raise funds from user fees, but even after adjusting for this it is unclear how the predicted deficit of Rs 700,000 annually will be raised after JICA support ends. They plan to cooperate with ADRA/CS in health activities in the Khopasi area.

UNICEF

Linkages are being pursued as noted in C:5 for support for the literacy program.

Banepa Municipality

The major is concerned about developing a phased in mechanism to run the PH Clinic after ADRA's withdrawal. In this electoral constituency there are no other health institutions even at the rural area so he suggests the government make an effort to establish one. He is aware of the progressive immunization coverage by ADRA CS efforts at PH Clinic, and is very positive about CHV's roles in urban Banepa and is committed to eradicate illiteracy in Banepa in the coming 3 years.

3. What are the key local institutions ADRA expects to take part in sustaining project activities?

These include the DHO, SMH, and Banepa Municipality.

4. Which CS project activities do MOH personnel and other staff in key local institutions perceive as being effective?

The Project activities perceived as effective to produce human resource development (knowledge, skill, capability to use the skill) to manage the CS activities and to improve the information system are: training and management workshops, health information workshop training, literacy programs, PH Clinic services, IEC activities (drama, videos, booklets, brochures) and motivation to CHV's.

5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGO's? Did they teach them to train CHV's or manage CS activities once AID funding terminates?

The health and district level health staffs could be made more effective to train CHV's with additional support from the Project in the form of training and workshops. They are currently doing so with the CHV Program basic and refresher training conducted by the Director of the Central Region Health Service.

6. What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain activities once CS funding ends?

The current ability of MOH to sustain CS activities in the ongoing form has been definitely enhanced by the above Project inputs from ADRA CS VI project. It needs to be more focussed in terms of sustainability of the ADRA CS IX project period (1993-6), since MOH resources are limited. SMH will continue to provide the curative services at the hospital level.

7. Are there any project activities that counterpart organizations perceive as effective?

The improvement of the existing human resource is taken as the most important outcome of the ADRA CS Project by the MOH. SMH and the municipality of Banepa perceives the establishment of a PH Clinic offering FP and MCH services as well as the training center at Banepa as most effective.

G. Project expenditures

1. Pipeline analysis of project expenditures,

See Appendix 5 for pipeline analysis of Project expenditures. Note the following there:

Column A: Project expenditures for the period indicated

Column B: Original budget (1990)

Column C: Revised budget (1992)

C-A : Difference between Columns A and C.

2. Budget comparisons for planned expenditures identified in DIP with actual expenditures at the end of the project. Were there some categories of expenditures much higher or lower than originally planned?

See Appendix 5 for pipeline analysis of Project expenditures.

3. Did project handle finances in a competent manner?

Yes, the project handled finances in a competent manner. However, 44% of the budgeted funds were unspent as of August 31, 1993.

Included as Appendix 6 is the Financial Audit for the period September 1, 1990 - September 30, 1992 by a USAID-approved firm (KB Chitracar and Co). The report also includes a Fund Accountability Statement, and an evaluation of the System of Internal Control and, Compliance with Agreement Terms, Applicable Laws and Regulations. Their overall assessment is consistent with our observations.

Arrangements are being made to complete a similar audit of the final year (1992-3).

4. Are there any lessons to be learned regarding project expenditures that might be helpful to AID support strategy

Budget considerations must be taken into account as early as possible in the Project planning process and should closely relate to program activities. Local input in budgetary issues has an important part in Project planning. The costs of program activities versus support staff should be appropriately balanced. Financial management support should be provided at Project commencement and in a regular, timely manner.

5. Budget management

Was the rate of expenditures reasonable per project budget?

Yes.

If there were shifts, can ADRA justify them?

No major shifts were noted except relevant adjustments as a result of the revised Project objectives.

Did the project reach its objective with the funds provided? Is the budget underspent or overspent?

This question regarding reaching the objective can only be answered in the context of all the evaluation findings. The evaluation team feels that it has. The budget is underspent (44%) as of August 31, 1993. However, as indicated in the comments in the attached Schedule, certain items of expenditure are yet to be debited.

H. Attempts to Increase Efficiency

1. What strategies did ADRA implement to reduce costs, increase productivity, or make the project more efficient?

Some cost reductions have occurred by cost-sharing overhead/administrative expenses with ADRA/Nepal as well as through close collaborative ties with the District Public Health Office, Scheer Memorial Hospital and other NGO's.

Project productivity and efficiency has been enhanced through the emphasis on training programs for health personnel, formation of mothers' groups and health post supporting committees, professional in-service training for ADRA Project staff (in Nepal and abroad), monthly/quarterly and annual reviews of Project work, and work-plan exercises (begun in June 1993) to coordinate field activities.

2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

During the life of this Project, the program encountered the following setbacks: major re-organization of the HMG health infrastructure took place on two separate occasions (1991 and the second, taking place at the time of the evaluation); there were political disturbances (strikes, "Democracy"-related activities), natural disasters, and frequent changes in MOH/DPHO staffing; there was inadequate Project leadership particularly during the first year (1990-1); the position of Project Director continues to remain unfilled at present.

3. Are there any lessons learned regarding attempts to increase efficiency that might be applicable to other PVO CS projects or to AID's support of these projects?

see response to 1.

I. Cost Recovery Attempts

1. What specific cost-recovery mechanisms did ADRA implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

There were none, other than registration fees for patients at the Banepa PHC. They were implemented by the Project.

2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

The amount is negligible (\$ 200-300) and represents less than 1% of project costs but is cost effective to implement.

3. What effect did any cost recovery activity have on ADRA's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

There was no apparent effect.

4. Is the community ready to bear part of the cost of preventive services and to promote health?

Although there is increasing support for preventive/promotive activities, the community still expects the government/ADRA et. al. to continue to provide these services free of cost.

5. What specific cost recovery mechanisms have been implemented to offset project expenditures? Were the costs reasonable? Was cost per potential beneficiary appropriate?

Not relevant

6. Identify costs which are not likely to be sustainable?

Discussed earlier under B 6.

7. What are the reasons for the success or failure of the household income generating activities of this projects?

Refer to J

8. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO CS projects or to AID's support strategy?

No, as cost recovery is not a part of the strategy of this Project.

J. Household Income Generation

1. Did the project implement any household income generating activities?

The household income generation program has started at the Khopasi PH Center area in the last 7 months. Three groups of a total of 69 women are attending cutting and sewing classes. They are still learning so have not started generating any tangible income but are sewing clothes for their own use.

2. Estimate the dollar amount of income added to a family or household's annual income, as a result of the income-generating activity of the project?

Since the activity is still in an initial stage it is difficult to estimate any economic contributions to the family budget.

3. Did the revenue contribute to meeting the cost of the health activities? What percentage of project costs did income generation cover?

See the answer for 2.

4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO CS projects or to AID's support strategy?

The activity is still too new to draw any conclusions.

SUPPLEMENTARY QUESTIONS/ISSUES

Although some of the questions relate to impact, there has been no attempt to measure impact of the interventions, nor would it be appropriate to do so. Where impacts have been measured, they estimate costs to be four times the cost of the most comprehensive package of services delivered per head of population. (Faruquee 1982). Furthermore, changes take place too slowly for impact evaluations to pick up, and process evaluation is more likely to depict which elements don't work.

There is a tendency for evaluations to focus more on process or intermediate or proximate variables or indicators, rather than on impact. Schrettenbrunner (1993) suggests that the main decision-makers accept this new approach.

1. Community Volunteers

What is the number of targeted communities and how many of these communities have established village health volunteers?

The number of targeted communities in the health post area is 40 VDC containing 360 wards while there are 11 wards in Banepa municipality.

In these communities basically there would have been 360 CHV's at VDC ward level but currently there are 281 functioning as 75 of them have dropped out and 4 have died. In Banepa town there are 12 CHV's in 11 wards, in one ward there are two CHV's because this ward is a comparatively large one. There are 14 urban TBA's trained by the Project staffs.

In the HP's there are 15 TBA's in each HP while in Nala HP there are 18 and in Khopasi PHC there are 72 trained by the Nepal Red Cross Society and the DHO.

Describe methods used by ADRA/Nepal and district health posts to motivate these volunteers?

ADRA/Nepal and district HP's provide six-monthly refresher training to CHV's. ADRA Nepal organizes quarterly meetings for HP level CHV's while urban CHV's have a monthly meeting at the PH Clinic to submit reports. Most of the urban CHV's are literate. The CHV's were given sign boards and badges and CHV kit bags by DHO. Similarly, ADRA Nepal provided a kit box, towel and soap to the CHV's. Last year the CHV's who motivated the greatest number of clients for VSC received incentives in kind, including a sari and a gagri (metal pitcher for carrying water)

The withdrawal of the Rs. 100 honorarium incentive that was given by HMG MOH, after the initial year of the CHV program was a setback. This discouraged the CHV's but, gradually they become more used to being without a monetary incentive. Their recognition by the Project, together with some form of status provided by the community, preferential access to literacy classes provided by ADRA, and the encouragement of the field representatives however, have been important factors in motivating to them. (New ERA 1993)

The FR could play a key role in motivating the CHV's. On a scheduled basis they make regular field visits to individual active CHV's, and encourage them in their work. The presence of the FR in the CHV's villages may increase the volunteer's motivation and enhance her status in the community. The FR also arranges a schedule to travel with the VHW's on their supervisory visits to CHV's. These VHW activities have varying effectiveness, depending on the individual VHW. The major

limitation of this approach is that of numbers, there are 281 active CHV's, and only 4 FR's. As travel times are long each CHV is only visited a few times a year by the FR.

Which method(s) appear to sustain volunteer involvement?

It is currently speculative as to which methods appear to sustain the CHV involvement. The role of the FR, if coverage were adequate, could be a major method. Involvement may be sustained by recognition of those who do exemplary work, together with timing of training and supervision when household and farm work activities are less onerous. The provision of a kit box, and additional materials as supplied by ADRA are probably also important factors. The other important potential factors include field supervision by the VHW, assistance with reporting of vital events in the ward, the development of a scheme for obtaining resupply of drugs and supplies, and training in health education.

2. Impact of Intervention Strategy

By comparing child survival indicators found in the baseline survey to current statistics, determine if this intervention strategy translated into the proposed improvement on mother/child health

Comparison of child survival indicators found in the baseline survey (first done in 1992) to current statistics (August 1993) does not reveal any significant differences. (See Appendix 7).

Discuss the role and impact of this unique implementation strategy in the results of this comparison?

Changes that may be noted are as follows. There is an increase in female literacy (primary) in Banepa from 10 to 21% . An increase in non-domestic employment of women in Banepa from 21 to 30% is noted as well as a decrease in the percentage of Banepa mothers continuing to breast-feed children < 24 months with diarrhea from 81 to 63%. There were decreases in DPT3 and OPV3 in Banepa children 12-23 months (93 to 79% for DPT3 and 92 to 57% for OPV3). Large increases in the percentage of surveyed women in health post areas in the acceptance in permanent methods of sterilization, Norplant® and condoms were noted. There was a more than 50% drop in the acceptance of DMPA but similar rates for pill usage over the same time interval.

There are two caveats: one year may be too short a period of time to detect any significant changes in the parameters studied; and one must be cautious in interpreting any observed changes as being solely attributable to the CS project intervention strategies. Many more indicators have been collected, but haven't been analyzed.

3. Technical Assistance provided by ADRA/I

Technical Assistance provided

Describe the TA provided and coordinated by ADRA/I?

TA was provided by Drs. William Dysinger and Ruth White (macromanagement/design); Lars Gustavsson (management); Lyndi Wolfe (data management/EPI INFO); Mr. Ed Baber (financial management and compliance); Ms Marwa O'Brien (assistance with DIP); Dr. Gary Hopkins (hospital survey and 3 health post surveys), Arlene Brown (October 1990, but no one currently with the Project is aware of what she did, all of the original staff have departed).

Was this TA sufficient in successfully implementing this CS intervention strategy?

The Project staff felt that assistance given by Dr. Ruth White and Dr. Dysinger was useful in that it was practical, field-based and utilized problem-solving approaches. In the absence of continuous, full-time Project leadership in Nepal, their guidance was essential. The continuous support from Mr. Baber was extremely valuable and practical for being in concordance with CS regulations; however, this was made

available to the Project only in the last year. Technical (computer) input from Ms Wolfe was given in a very short period of time and the information shared was useful in future survey work. The training should have occurred before the first survey was done. The support provided by the MPH interns (Ms Marwa and Dr. Hopkins) appears to be of very limited benefit.

Delivery of services

Describe delivery of TA provided by ADRA/I to ADRA/Nepal?

Because of frequent staff changes at ADRA /Hq, the ADRA Nepal staff reported never knowing who to identify for TA delivery.

Is this TA of sufficient capacity to meet the criteria demanded of the project design?

Overall, the TA was of limited scope and usefulness, was often not timely, and not sufficient in successfully implementing this program. In addition, there appears to have been a lack of regular, timely communication between ADRA/I and ADRA/Nepal. ADRA/Nepal staff stated they were not kept informed of the appropriate office/person at ADRA/I to which Project needs/problems could be addressed. There appeared to be poor linkages through ADRA/I between USAID CS and ADRA/Nepal.

Management of TA

Is there a system in place to continuously evaluate the appropriateness of TA provided by ADRA/I?

Apparently there is no system in place to continuously evaluate the appropriateness of TA provided by ADRA/I. Project staff stated they did not know who at ADRA/I was specifically responsible for coordinating and procuring TA for ADRA /Nepal.

Who at ADRA/I was responsible for coordinating and procuring TA for ADRA/Nepal?

This was not known to ADRA/Nepal. There exists a need for better coordination between ADRA/I and ADRA/Nepal in identifying the specific resources and personnel available, determining the type of expertise required, deciding the timing/duration of consultations, and establishing a mechanism for evaluating the quality and appropriateness of the TA provided.

Describe process for requesting TA from ADRA/I?

Requests for TA from ADRA/I are made through the ADRA office in Southern Asia (SUD), India and then forwarded to ADRA/I. The response time for these requests is felt to be not predictable and delays are fairly common.

4. Impact of training of MOH staff

What are specific training inputs by ADRA/Nepal to all levels and what is impact of training on the trainees?

The training inputs are found in Appendix 8.

Impact

ADRA CS training inputs focussed on practical applications together with problem based discussions. The perception by the trainees is that the training provided by ADRA is useful in their work and the impressions by DPHO are similarly favorable. However, ADRA CS has made no attempt to assess the impact of the training on the trainees. An effort here is needed.

The evaluation team made an effort to look at this using data from the HIS in the DHO. This was done by looking at indicators collected from various HP's in the district, and comparing some for ADRA and non-ADRA supported HP's. As indicators represent service output, it is difficult to draw conclusions, as the data are not adjusted for various socioeconomic variables in the respective areas. They do not represent rates. However, the table in Appendix 15, looking at VSC acceptors in 4 non ADRA supported HP's comparing them with the ADRA supported show marked differences in achievement of DHO set targets. The significance of this is questionable, but it demonstrates the kind of analysis that might be thought of by the Project.

How do training inputs compare with the projected training inputs outlined in the specific objectives of the DIP?

The training inputs outlined in the specific objectives for the most part met or exceeded the projected training inputs outlined in the objective revisions of the Second Annual Report. See Appendix 8 for the specific numbers trained.

Has this training assisted in developing confidence and acceptance of ADRA/Nepal by MOH and local DPHO as technical provider?

According to the DPHO it has.

Does ADRA have technical capacity to work at this level?

It would appear so, though the number of existing staff was not sufficient for all the training and other activities it attempted to do.

5. Banepa's PHC Clinic

Describe results of ADRA/Nepal's initiative to work with SMH and DPHO in assisting Banepa to develop own PHC program with emphasis on CS interventions

The Banepa PH Clinic is an unique intervention begun with ADRA Nepal's initiative. It is a mechanism of establishing coordination with the local municipality and SMH for promoting urban health via the provision of PH care, FP MCH services, immunization, ANC, and health education, to the urban people of Banepa. It has provided a referral system and a screening alternative to SMH.

From the perspective of the MOH, urban health services are not well organized in Nepal currently. Hence the PH Clinic is an important contribution of ADRA Nepal's to provide services to Banepa. The DHO is supplying necessary vaccines and drugs, medical equipment, instruments and one examination table as well as the services of a vaccinator, to support the clinic. It also provides the temporary FP contraceptives-condoms, pills, DMPA, and Norplant® sets. There is monthly reporting to the DHO.

6. Management assistance designed by ADRA/Nepal

Management Assistance provided.

Describe management assistance provided and coordinated by ADRA/Nepal?

Mrs. Dawn Dulhunty provides management support, and as well there is secretarial , accounting and vehicular support.

Was this assistance sufficient in successfully implementing this CS intervention strategy?

Yes.

Delivery of Services

Describe delivery of management assistance provided by ADRA/I to ADRA/Nepal?

Workshop and financial assistance was provided by Ed. Baber, and Lyndi Wolfe, as described in #3 above.

Is this assistance of sufficient capacity to meet the criteria demanded of project design?

See the answer to #3, note that improvement is needed.

Management of TA

Is there a system in place to continuously evaluate appropriateness of management assistance provided by ADRA/I?

No.

Describe process of requesting management for ADRA/Nepal?

See the answer to #3.

7. Health Information System (HIS), (Management Information System, MIS)
Briefly describe the development of the HIS (30-cluster sampling surveys)

The 30-cluster sampling surveys were initially carried out by the Project with technical assistance by consultants. They were then repeated with the questionnaire acceptable to the US AID CS program. Analysis awaited further technical assistance. On questioning, it was clear that the staff understood how to carry out such a survey. They did not fully understand the statistical validity of the results. Only preliminary analysis of the last survey, done in August 1993, was available at the time of the evaluation and complete analyses of the previous surveys were not available.

One person from the DHO and one from SMH was provided with a computer to organize information. Concurrently, 17 HP and DHO staff and 6 ADRA staff were trained to do surveys. A computer was placed at the DHO, and ADRA provided one HIS management staff person (Information Advisor) to that office.

A workshop on recording and reporting was held on Jan 14-15, 1992, at the PH Clinic in Banepa, for 2 days. It was organized by ADRA and the DHO to help ADRA staff do accurate reporting and recording. There were a total of 10 participants. On April 19-21 1993, all the HPIC of Kabhre District were invited to attend another workshop along with SMH staff who helped decide which cases should be referred to SMH. This was followed by a 2 day referral system seminar organized by ADRA and held at the municipality of Banepa.

To make the HIS more meaningful and accurate, the Information Advisor monitors the health post registration summaries and gives feed back to the HP. The outcome

of the survey is being shared with DPHO and through him to the HP and HPSC. The information collected is now organized in a cleaner form for transmittal to the MOH from the DHO. SMH is now reporting its activities to the DHO, as are other NGO's such as the Banepa PC Clinic.

What is status of DIP described monthly reports compiled and analyzed monthly and formal report to be compiled trimesterly?

See above, all facilities formally report all activities and analyses monthly.

8. Unexpected Results

From discussions with the Project staff, and from the evaluation process, there were some unexpected results due to presence of ADRA staff or implementation of this Project. For the Project itself, the change in initial program management team within the first year of the Project was obviously not expected, and has continued to exert a significant effect even now. However, the Project had done remarkably well, even without considering the lack of a full time Project director. Some of the Project staff had remarkable skills in communicating at the community level, whereas many were unaware of the importance of this. Financial support for the Banepa PH Clinic was felt to have dropped because of the change in the municipal administration. A political crisis and a natural disaster occurred during the program period, and the Project weathered this very well.

The CHV's were much more involved in their work than expected by the evaluation team. They were proud, enthusiastic, and motivated to serve by the concept of gaining dharma. Their knowledge base was quite appropriate for the work they should be doing and this was all the more remarkable in spite of being irregularly supervised. Some CHV's continued to say that breast feeding should be stopped during diarrheal episodes. TBA's who had worked previously before getting training, were sometimes paid in kind, but after the training, this no longer occurred, as they were perceived to be government employees and hence that they received a salary for this. An exception was a group of Newars, who perform delivery services as part of their caste status.

MOH curative facilities on or near the road continued to function generally in a perfunctory manner, without any concept of service. There is frequent transfer of MOH employees after completing training by the Project. Motivation seems to be lacking. Leadership in the DHO was felt to be good.

Near the road, there were many health services available from private practitioners, and private hospitals are being constructed in Dhulikhel, and Phalate. It is unlikely that such services will be available for those without significant economic means.

9. Recommendations For Future Funding

CLAIRIFICATION AND FACILITATION BETWEEN HEADQUARTERS AND NEPAL

That the respective roles and responsibilities of ADRA/Nepal and ADRA/I be clarified to facilitate

- greater local (in-country) input and participation in determining clearly-defined Project goals and objectives (as in DIP and proposal preparation) and in requesting the form, timing and duration of technical assistance provided;
- streamlining of procedures involving requests for information and assistance so that response times are minimized and timely communication assured.

MANAGEMENT IN NEPAL

That ADRA/Nepal

- prepare detailed written protocols, guidelines, procedures and work-plans to enable effective, regular supervision, coordination and assessment of all personnel together with comprehensive, systematic monitoring, documentation and evaluation of objective-oriented Project activities.
- enhance community participation and involvement in all aspects of the Project (planning, implementation and evaluation) and specifically as related to sustainability issues.
- explore and establish appropriate, proactive mechanisms to further strengthen networking relationships with the Scheer Memorial Hospital, local NGO's, USAID/Nepal, all levels of HMG MOH and related ministries, key stakeholders and relevant local organizations for information-sharing, problem-solving efforts, professional support and guidance.

SPECIFIC RECOMMENDATIONS

- **Community Involvement**

There is a pressing need to demonstrate community involvement in the Project. It could begin with definitions of different communities in the various settings of the Project, including Banepa and Dhulikhel municipalities, and the HP areas where the efforts are being directed. This could be followed by community consciousness awareness activities. Consider community distribution of the Health Education newsletter produced by Shanti Bhandari (P.O. Box 5382, Kathmandu) on a cost recovery basis.

- Perceptions of Illness and Healing

Formative research might be undertaken to help district providers better understand their clientele. ADRA /Nepal would be ideally suited to do this, for it would reinforce the concept of better understanding the population the system is to serve. ADRA could look at local perceptions of health, illness and healing among different ethnic groups represented in order to better target educational material and behavior change information. There is a need to learn when people go to a traditional healer, private practitioner, a sub-health post, HP, Banepa PH Clinic, SMH, or Kathmandu for care. It is also important to understand who in the family makes the decision to take a sick child to the HP or other care facility.

- Project Staffing

Consider hiring a social scientist to carry out formative research. When the current Banepa physician leaves, consider recruiting a physician who will live in Banepa or Dhulikhel. Stress community communication skills in all newly hired Project staff. Give training in appropriate skills for communication in the community to existing staff, emphasizing both verbal and non-verbal methods.

The FR's role is critical. Consider having at least two FR per HP, one male, the other female, to have greater influence in HP activities, and CHV support. Reports of the FR activities regarding visiting CHV's and VHW's should be compiled and compared with the results at the DHO to monitor activities of the VHW's and their reporting to the HPIC. Carry out supervision of the FR in the field, and not only on special functions such as drama shows, surveys, or external evaluation visits. Efforts can be made by the FR to provide health education sessions at HP's that are interactive and use time during which clients are waiting to be seen. In this activity explore innovative means of health education with HP patients, using PCS, MOH, MCH IEC materials.

- Training

Training activities should be related to learning objectives that are in some sense measurable, and some output or outcome needs to be assessed, both at the conclusion of the training and with follow-up at periodic intervals to assess some impact indicators to see if the training has any effect

- Technical Assistance

Consider making greater use of short term local consultants to advise on specific aspects and to evaluate particular activities of the Project.

Bamepa PH Clinic and Project Training Center

- Consider creating a Project Resource Center that would house international public health and development-related publications (books, periodicals, reports, monographs etc), health educational materials (videos, slides, flip charts) and audio-visual equipment.
- Operate the Clinic as a model urban health service delivery center and clarify its role with SMH, DHO and NGO's.

Consider community marketing of the Clinic, and providing outreach services to the wards in Banepa. Explore ways of getting the Banepa Municipality involved in the planning, operation, management and funding of the Banepa Primary Health Clinic by creating a steering committee with representatives from DHO, SMH, ADRA, and Banepa Municipality

There should be a community board created to oversee operations of the Clinic, to ensure quality of services offered, and look at cost recovery strategies. Let the community collect funds and be involved in the financial management of the clinic. Experiment with a revolving drug scheme for basic medicines used as a cost recovery measure, and consider having the rural population who use the Clinic pay a proportionately greater share. Explore why mother's groups are active in Banepa but not in rural HP's?

Explore ways of collaborating Clinic activities with SMH so that it acts as a triage for OPD at Scheer, exploring use of paramedicals for initial screening, then have selected patients seen by the PH Clinic doctor, then referral appropriate individuals to the hospital. The Banepa PH Clinic could be a true primary care provider, doing minor surgery, as well as post operative follow up care.

Make the Clinic more user friendly by scheduling maternal and child health services at the same time, so that clients wouldn't have to come back the next day, particularly for childhood immunizations, ANC, FP, growth monitoring, Vitamin A distribution, health and nutrition education. Consider having the Clinic open in the evening when it might be more accessible to the urban population and look into having diagnostic facilities in the clinic on a cost recovery basis. For this build up the skill of the existing staff nurse or others where possible, to do hemoglobin and urine albumin testing, for example. Study the flow of patients, and supplies, etc. to eliminate unneeded activities, and decrease waiting times for busy clients. Create a private space for counseling, at least a curtained desk area. The Clinic could become more user friendly to mothers and malnourished children, by having a nutrition and hydration area that has a mud floor and is more acceptable to mothers from the surrounding hills.

There is scope for innovation in health education. Begin by having a supply of MCH and FP IEC materials for both illiterate and literate clients. Coordinate with PCS, FPA/N and MOH who produce such materials rather than develop the Project's own. Feedback suggestions to PCS for improvement of the materials used. Have health education sessions that are interactive, and use time while clients are waiting. Couple this with exit interviews to see what clients remember about the instructions and messages given, compare this with information that was given, and improve the information giving process.

Data collected from Banepa PHC needs to be focussed on deviation from expected outputs, and related to inputs. For example, there is a secular trend in output of service provided. Can this be related to a per capita demand, or to some indicator of effect? Investigate the rural/urban difference and seasonality in service provision. Explore the perceived difference in immunization coverage between the rural and urban areas with a sample survey.

- Income Generating Activities and Literacy Programs

Expand opportunities for income generating activities in coordination with HMG agencies including Ministry of Local Development, Women's Development Division, Production Credit for Rural Women's Activity. Further efforts to give priority to CHV's and TBA's in literacy classes is warranted. Consider acting upon the recommendations of the external evaluation of the literacy program.

- HIS

The collection of quantitative information proceeds by rote without an attempt to link this to the meanings of the apparent patterns observed. Each piece of data collected and displayed in some fashion should refer to the objectives and lead to the question: what does this mean? The Project should attempt to answer that question, or not collect the data. Focus on collecting data to identify groups at high risk, and target interventions there. Explore qualitative methods of information collection, using Rapid Assessment Procedures, and Participatory Rural Development techniques. Develop an analysis framework for the HIS that would allow comparison of the ADRA supported HP's with the others in Kabhre.

- Health Post Strengthening

Make appropriate recommendations on a job description of HP personnel to the HMG/MOH, based on a work analysis conducted in the four HP's. The MOH sees this as essential, given the new reorganization and staffing cut backs. As a part of this process, ADRA could work with the staff of each HP to develop an efficient system designed to decrease time wastage of patients, who spend much time sitting

around waiting, which, considering that so many are women with very heavy work demands, is deplorable. The FR could incorporate health education into HP activities

much as should be done at the Banepa PH Clinic. Study the referral system ADRA has initiated to strengthen it, for it would give credibility to the HPIC and to the HP.

Specific recommendations relating to the health post activities are numerous. ADRA could explore ways of improving nutrition services at the HP by providing a nutrition area, modeled like a patient's home, where the mother would be able to care for the child, and do appropriate feedings to improve a severely malnourished child's nutritional state (SCF (UK) in Dhankuta is a good model here). Efforts should be made to standardize the patient retained record keeping system for FP, ANC and Growth Monitoring, throughout all the HP's. Consider producing a delivery kit locally, and having the HP personnel instruct pregnant mothers in its use, and also encourage TBA's to use it (SCF (USA) has a model kit). Similarly there is need for a mobile immunization program to increase coverage.

There should be a monthly focussed health education program (e.g. FP, CDD, ARI, etc.) for each vaccination day, involving the HP staff and the VHW's. Health post staff need to focus on information giving techniques, and to be able to monitor whether the information has been understood. Exit interviews can see what clients remember about the instructions and messages given, and when compared to information that was given, this can improve the communication process. Assist the community to develop quality assurance schema for health post activities.

Supervision of HP activities is problematic. Consider helping the DHO do spot checks of supervisor's reports to verify their accuracy. Supervision should be pro-active, more than an inspection or perfunctory visit, when it is actually carried out.

The HPSC might become more active with non-monetary incentives to improve their function and responsibility. They should be encouraged to display VHW field program and EPI activities in schools and at the VDC building. They should evaluate the active/inactive status of CHV's and replace those inactive. The Project should investigate ways for the committee to continue functioning after ADRA pulls out its support in 3 years. Consider amalgamating the HPSC at Khopasi with the Health Coordination Committee run by JMA, to oversee the operation of the PH Center there.

Further expansion to other HP areas should be delayed until activities in the four committed HP's are running smoothly, and the FR's have been expanded so they can be more effective in supporting CHV's.

- CHV Strengthening

Consider having a VDC (or even ward) based health committee to strengthen the activities of CHV's, to encourage supervision by VHW's, and to relate to the HP. In urban areas, consider increasing the number of CHV's so they are proportionate to population served. Consider as a trial program, setting up some CHV's in a business in their ward so they can be seen as offering services and charging for them. Consider ways of making the recipient of medicine from the CHV responsible to either replace it or pay for it. Explore indicators for CHV motivation and activity with a view to measuring the effectiveness of the FR in enhancing this aspect.

- Maternal Health

The Project should familiarize itself with the published report on maternal mortality in Kabhre District, and consider the recommendations for action stated there (Rijal, 1991).

10. Lessons learned

From conclusions and analysis, list lessons which ADRA/Nepal has learned from the design, implementation and evaluation of the project.

Many of the following are lessons the Project staff stated they learned.

- It is important to further involve local management personnel in the initial planning and implementation of the Project.
- Efforts at improving the socioeconomic disparities in the Project area will produce the most significant improvements in health.
- Surveys should be conducted not every six months, but three times during the Project period.
- The Project should upgrade the capabilities of local management personnel for program sustainability.
- The voice of the community must be listened to at planning and implementation.
- Internal evaluation of the program, as well as internal program monitoring is necessary.
- There should be sharing of documents among the staff and local MOH and funding agencies.
- Money or other incentives only are not the motivating factor for CHV's or TBA's but regular supervision and meetings is more appropriate and wanted.
- FR's efforts directed towards the CHV's may be the key activity of the Project. Time and personnel constraints and lack of field supervision limit their abilities to establish the Project's presence throughout their catchment area and to enhance the status and competence of the CHV's.

- Given the frequent staff turnover in both the Project and other agencies, Project activities and their evolution should be consistently documented, so that lessons learned may be shared with new personnel.

11. Evaluation Team Observations

These observations are those made by individual evaluators on the team.

1. LIMITATIONS

The activities actually observed were EPI, clinical services in HP's, Banepa PH Clinic, and a sewing class of IGA. Other information was obtained from review of documentation and interviews. Two evaluators also visited a HP area where there were no ADRA activities to compare the differences. Whereas all the ADRA HP sites can be reached by vehicle in fair weather, this one could only be approached on foot. A major finding was that there were no HP staff present at this non-ADRA HP perhaps because the visit was unannounced.

2. COMMUNITY DISCUSSIONS

Discussions with community members generally note a decline in measles and whooping cough deaths, as well as those from diarrhea. Deaths from fever continue. The perception among one VDC chairman is that before the ADRA program, only the most educated knew about and received health services, but the proportion of uneducated knowing about health services has now increased. With the advent of democracy, more people feel they have a right to demand services. Where people know about ADRA CS activities, they are uniform in stating a positive contribution has been made. There is a remarkable pluralism in seeking out health care, some people go directly to SMH, others to Kathmandu, in addition to seeking out traditional healers, SHP, and HP, as well as private practitioners. There is also a perception that more traditional healers are doing their rituals but also are referring people to other health care facilities.

3. PROJECT DESIGN

The goal of trying to strengthen government services, without undermining them, or trying to replace them appears worthwhile, though it is difficult to relate the Project activities to this goal in an evaluateable fashion. Project staff have difficulty relating to the concept of a project being that of having goals and objectives, with associated activities. The concept of how ADRA is

working to strengthen the health system in the district is not entirely clear, what can ADRA do much to keep the HP manned, to keep VHW's working?

4. LEADERSHIP

The original Project director and all Project staff resigned within a few months in first year of Project. There was a subsequent lack of continuing consistent leadership. There is role confusion regarding the senior consultants so Project personnel don't know who to look to, for direction.

5. STAFFING

Banepa Based Project Staff

They are bright, enthusiastic, energetic, hard working and motivated. They need leadership. Although they were to have an evaluation of job performance every 6 months, there has only been one evaluation in the Project so far, which has included two components, one being a self-evaluation. There is one staff member who has not had an evaluation. The staff tend not to ask questions such as why, or how come, in relation to the data they collect, or the observations they make. One observer remarked that this was a common Nepali characteristic, but it also is evidence of the lack of focus in the Project. There appears to be a tendency, common in many projects of not going to the field as often as they should. They appear to not have good skills (both verbal and non-verbal) in communicating with rural villagers, although one individual excels in this ability. Documenting Project activities and drawing conclusions and lessons learned is not done well.

- Anthropologist

Mention was made in the Project Proposal that an anthropologist would be used but this did not occur. Social science input to the Project would be very helpful.

- Field Representatives

These individuals are young, motivated, enthusiastic, and keen. In addition to taking training focussed for them, they have taken part in all other training activities that ADRA CS conducted, as well as those organized by the DHO, so their knowledge is broad based, and detailed. They are rarely supervised by CS Project staff while in the field, yet feel a great need for this and some have not had their work evaluated. They lack important communication skills with people in rural villages. Their journals do not reflect any attempts to describe the activities they engage in while in the field or to analyze them. Their

activities at the HP are secretarial in nature, and they do not utilize their abilities to do health education, or motivation, perhaps because their status is less than that of the HPIC. Their numbers make it impossible for them to work regularly and closely with CHV's to have much of an effect.

6. PROJECT ACTIVITIES

- ADRA training

There is no attempt made to learn about the effect of the training programs, how they may have changed behavior or activities of those who attended. The general perception is that the training is good because it is practical, rather than theoretical. Often people are asked to discuss their problems at the training sessions, which they like and find helpful. HMG training does not include refresher aspects, except to CHV's. Some training was district wide (management to HPIC). For CHV's and VHW's training was only offered to those in the 4 areas where ADRA CS is active. Many agencies are involved in refresher training activities and there is an impression, for example, that HP staff spend too much time in training, and not enough in giving service. There may be duplication of ADRA and MOH training. SMH staff has come to know the HPIC's because of ADRA's training efforts and HPIC's refer people to the SMH because they know the staff there. The concept of training urban TBA's, with refresher and supervisor training seems valuable.

- Banepa PH Clinic

The concept of an urban primary care clinic in Nepal is novel. The Clinic currently provides minilap service by transporting patients to Kathmandu to the FPA/N facility, while vasectomies are done in the Dhulikhel PH Center, pending completion of the new facility in Banepa. The clinic works on a weekly schedule, with Sunday being general patients, followed by ANC, then FP, then Norplant®, then Under Fives, followed by general patients on Friday. Scheduling makes it difficult to administer MCH concurrently, so clients have to return the next day for child immunizations. There is no mechanism for follow up of missed appointments for any services, except if patients have a phone, in which case they are called a week prior to due date for next DMPA injection. There are no lab services available, but referrals can be made to SMH for these. Most patients in the ANC are diagnosed with a urinary infection, and are given a prescription for medicine, as none is available in the clinic. There is no privacy for counseling. There is little or no health education carried out, especially for people waiting. There is no distribution of MCH and FP IEC materials for literate or illiterate clients. Data collected from

the operation is not analyzed discriminately. For example, more patients are seen from rural areas than from Banepa, without exploration of explanations.

The new clinical facility was built one story higher than its building permit allowed. The municipality is aware of this breach, but does not wish to raze the structure because it will provide health services.

- HIS

Data collection system began in the DHO in Jan. 93. Reports from the HP's come on time, but there is concern about their accuracy. EPI reports are felt to be more accurate now that people are not punished if they don't achieve quotas. The computer system at DHO is not sustainable (no budget for maintenance and consumables, estimated at Rs. 5000 per year). Some individuals did not want to go afield to do the initial 30-cluster sampling surveys preferring to sample places closest to the road.

- HPSC

HPSC's in the 4 HP areas have formed. They seem to lack direction in their meetings, except to ask for external assistance.

- PH Center in Khopasi

This new structure built by JICA and JMA is ultramodern, with state of the art facilities including a computer, copy machine, and a large video monitor, all of which seem inappropriate for the situation. The external funders will only support the efforts until next year. A preliminary estimate of budget and revenues predicted showing a significant shortfall (Rs 700,000 +) for the curative activities there alone!

- Referral system

This began June 93, and an initial qualitative survey evaluation is planned in Nov. 93. HP's have referral cards and have received training in this. So far there have been 86 referrals from the HP, of which 33 showed up at SMH, and feedback to HP occurred for 13. Many reasons are suggested for the low rate of referrals. There may be seasonal factors in referral patterns. Khopasi referrals to SMH have been doubling each month.

- Literacy classes

These are taught by school teachers with a health component taught by the HPIC. The results show that from Dec. 91 to July 92, 128 out of 150 completed the examinations for literacy, while from December 92 to August 93, 278 individuals out of 450 successfully completed the training. In a meeting with a literacy class after it was completed it was noted how eager these women were to learn to read, and they were very concerned about post literacy activities. An independent consultant evaluated the program and was concerned about proper management of literacy classes (Paudel 1993). Banepa municipality has as its objective to eradicate illiteracy in the town in 3 years!

- Kabhre Health Post Magazine

The current issue is 4th, it is written by CS staff, the DHPO, and other local resource people. It is distributed to HP's, schools, organizations, clubs, and political parties. The subject matter covers malnutrition, malaria, tuberculosis, sanitation, TBA activities, SMH, and ADRA/CS survey results. There is no monitoring of its usefulness.

- Other Activities

The Project has produced drama activities on diarrhea and FP, in different places that draw large crowds. It has recently completed producing a video on diarrheal diseases that has yet to be pretested. There is no attempt to assess any impact. As well the Project has had booths at 3 local festivals to distribute aspirin, do health promotion, and provide information about ADRA programs and services.

7. NETWORKING

The US AID Mission reports it can arrange for staff training, deal with supply problems, etc. and can help work with the MOH if they have regular communication with the Project. There was no reporting to US AID Mission office in Kathmandu according to current officer there, but this may be a problem with the Mission information system. It appears that NGO's tend to work in easily accessible districts close to Kathmandu.

8. MOH AND DHO OPERATIONS

MOH

The MOH wishes to see better coordination between central and district level operations, and those of NGO's. NGO's appear to be more flexible than MOH and can try a variety of activities and evaluate them. There is no mechanism to monitor health education at the HP or in the field.

CHV's

CHV's are a stronger force in health care than previously thought (New ERA 1993). Many CHV's are motivated and enthusiastic, undertake activities with a sense of mission, feel honored to serve others, and to acquire dharma. They appear proud to display the box and bag given them in training. They perceive their social status has increased and report that being supervised in the field would help this process even more. All of them know the monthly timing of vaccination days. Many seem to understand the need to motivate for FP, quite a few have had VSC. ADRA gives rewards in kind for those who motivate for VSC, and the MOH doesn't want to see monetary incentives. Some recognize high risk families. The local term for a condom is a Nepalization of balloon. Some CHV's counsel stopping breast feeding with diarrhea, but almost all know how to prepare ORS correctly and seem enthusiastic about promoting it.

Most have difficulties charging for the medicines they give out because the recipients are family members or others are friends in the community. Mothers groups are not functioning in HP areas because the CHV used to buy them tea, when she received an honorarium. When this ceased she stopped this practice, and the perception that although they received money from the government, they don't want to buy them tea has persisted. CHV's may state they are supervised by VHW's, but FR's tend to report this doesn't happen if they don't make arrangements with the VHW's to go on field visits with them.

CHV's appear to be not very capable of using IEC materials with which they have been provided. ADRA's attempt to initiate urban CHV's is excellent, as is the focus on identifying families at high risk. A mother's group is functioning in Banepa, and there is a perception that CHV's are more active in Banepa this year because of incentives. The high risk referral system hasn't worked, and needs further study. Efforts are needed to predict what kind of person will make a good CHV.

- TBA's

TBA's tend not to intervene in the delivery, or to stimulate the newborn after birth if no signs of life occur. But some have actively resuscitated newborns! Their concept of prolonged labor tends to be 3 days, in spite of what they have been taught (1 day). There should be 15 TBA's in each HP, the plan is to have 3 in each VDC. Some who were sudenis before training continue to receive some remuneration for their activities in kind, while others do not. Otherwise, almost no one receives any compensation from the family for their services, as they are seen to be provided by the government.

- VHW's

The VHW system generally appears to not be functioning well. It is difficult to carry out disciplinary actions against them for not performing satisfactorily, because of fear of political repercussions. Some VHW's report not receiving a register for reporting. VHW's themselves are rarely supervised in the field. They would like CHV's to be literate to make it easier for them to collect information.

- HP

HP activities are generally limited to prescribing medicines, and HP workers tend to avoid any attempts to do physical examinations of people, or to do procedures such as incision and drainage of abscesses. Examination of registers of patients seen, and activities performed by the team never showed any record of procedures such as suturing of wounds, or draining of abscesses. Peons are invariably present, and do most if not all of the physical contact with patients, wound care, etc (Justice 1983). The focus is on reporting rather than service delivery. Client's time is spent waiting for preparations that could have been planned in advance, such as sterilizing equipment for EPI activities. All HP's have a register supplied by ADRA for high risk families but none are not filled in. There are a number of different ANC, FP and Growth Monitoring cards seen in the various facilities, with no standardization.

There seems a greater range of FP services available without a proportionate increase in demand. There are no health education activities, and very poor or non-existent explanations to the patients about their problems. No attempt is made to ascertain whether or not anything about the encounter by the patient was understood. This is especially problematic for those who are not native Nepali speakers, there are many in this district. Outreach services by every HP to run 2 outreach clinics a month, are scheduled, with each district

to run 18 outreach clinics a month. This activity did not seem to be occurring in Kabhre.

- Urban health problems

The perception is that there is less immunization coverage, and increased maternal mortality in urban compared with rural centers. EPI campaigns in urban centers have not been scheduled to coincide with people's free time.

9. PRIVATE HEALTH SERVICES

With villages close to or on the road, there are plenty of private health facilities available on a fee for service basis. There are private hospitals being constructed in Dhulikhel, and Phalate, and there are numerous private practitioners with varying backgrounds. There is no mechanism to assess the quality of services provided privately.

APPENDIX: A

Scope of Work

ADRA CS Evaluation Scope of Work

The scope of work of this final evaluation include the purpose statement as made in the introduction, and to fulfill the agreement made between ADRA and US AID. It stated that the methods used would be: observation, interviews, surveys and review of written material. It required listing of data collection methods, sources of information and conclusions reached. Mention was made of surveys of: HP staff; VDC health committees; VDC VHW's; Ward Health Committees (which do not exist); Ward CHV's; and mothers and other care givers influencing decisions regarding health care. The scope of work also required answers to the CS Guidelines prepared by US AID, as well as to supplementary questions asked by ADRA/I. The report format was specified.

Stated in the scope of work, were the Project purposes, specifically: to establish a meaningful HIS and train its users and managers, to train and provide technical support to district health staff, health post staff, CHV's, VHW's in the delivery of health services so that DPHO can meet its goals in the improvement of maternal health and CS interventions: immunization coverage, ORT usage, malnutrition, contraceptive use, and the number of women receiving antenatal care.

APPENDIX: B

Goals and Objectives of Original Project Proposal

Goal and Objectives of Original Project Proposal (sic)

Goal: Improve maternal and child health in three rural Ilakas and one urban area in the Kabhre District through training, follow-up supervision and monitoring of the local health system

Objectives to be achieved by end of program in September 1993: ADRA proposes to utilize the following strategy as outlined in items 1-7 in order to achieve the eight objectives with quantifiable indicators listed under item eight:

1. There will be a well-established health information system reporting births, maternal and infant deaths, use of ORT, nutrition status, contraceptive use, and other important health information to the district Public Health Office not less than at quarterly intervals
2. Yearly training will have been provided to the health post staff and to the volunteer health workers to enable them to become better health promoters, nutrition educators, family planning counselors, data collectors and local program managers and supervisors.
3. Respected community members will function as the primary data collectors for the above HIS, maintaining a community roster of households. This may require selection and training of a new type of volunteer to work within the present health system with VHW's serving as their supervisors.
4. An integrated urban PHC system will function to serve all of Banepa's population.
5. The designated district hospital at Banepa (Scheer Memorial) will fully function as a community-oriented medical facility, serving the entire district as a training facility as well as a referral hospital
6. Panchayat (and ward) health committees will function in each Panchayat to continuously monitor basic health needs assuming their responsibility to remedy or improve community health as much as possible by their own efforts
7. Child survival and maternal health interventions will actively promote through local schools, other community organizations, as well as through the officially appointed health volunteers.

8. Although ADRA is not delivering the service itself, its training and supervision will aim for the following specific health targets by September 1993:
- A. Increased immunization coverage of one-year olds to 70%
 - B. Increased TT2 to WRA from the present level of less than 20% to 40% or more
 - C. Increased usage of ORS and continued feeding in cases of diarrhea in under-three-year olds to 20% or more
 - D. Reduced malnutrition in under-three-year-olds (as measured by the mid-upper arm circumference) from its present value of near 40% to 20%.
 - E. Increased contraceptive use prevalence in eligible couples from 1.5% to 10%
 - F. Increased numbers of pregnant mothers who receive at least two prenatal checkups per pregnancy from Health Post staff, ANM's or trained TBA's from the present less than 10% to 20% or more
 - G. Reduced infant mortality from its present rate of 148/1,000 live births to 120 (this is ambitious but the current objective of HMG is to decrease IMR by the year 2000 to a national average of 45. ADRA feels it is unrealistic to expect to achieve greater than a 50% reduction in this project). This is an ultimate project goal since ADRA is not expected to demonstrate Tier III indicators as a part of AID Child Survival Programs.
 - H. Two hundred female Community Health Volunteers (CHV's) will be trained and functioning in the target population. (One per ward, approximately 500 people or 80 households).

APPENDIX: C

Specific Objective from DIP

Specific Objectives from DIP (sic)

1. Assist the SMH to be recognized as a District training center
2. Establish an urban primary health care center in Banepa
3. Provide 6 management seminars/workshops in each of the three targeted Health Posts
4. Assist 32 VHW's in 3 rural Ilakha to revive CHV program
5. Provide training to the 32 VHW's in supervision of 150 CHV's
6. Help make present HIS more meaningful, efficient and effective
7. Train 10 individuals with skills in conducting and analyzing sampling surveys.

APPENDIX: D

Project DIP Details

Project DIP details presented in summary outline form

Design Intervention

- "helping post personnel analyze and recognize problems, seek solutions and thus design and accept training...assist in improving HIS helping make it an MIS"
- Targets for health behavior change in order of priority

ADRA largely dependent on MOH and local organizations to actually reach and influence these target groups. ADRA directly working only with VHW's, HP and DPHO staff

1. mothers and other care-givers who influence behavior at home
2. CHV's and mother's groups
3. VHW's
4. HPIC and other health post staff
5. DPHO and his staff

Monitoring/Evaluation

- 30-cluster sampling surveys repeated at not less than trimesterly intervals
- SMH to hold not less than 3 seminars or workshops annually for PHC workers in Kabhre District
- 6 management seminars/workshops in each of HP in Dapcha, Khopasee and Panchkhal

Major Interventions and Strategies

General Assistance

- in problem identification and problem solving
- training in management and supervision
- developing HIS directly useful to them
- helping town of Banepa develop PHC, emphasizing CS interventions
- assisting SMH to assume role of District Hospital and be responsible for aspects of community health (i.e. up-dating and continuing education of local PHC providers)

Immunizations

8th Five Year Health Plan (1990-1995) MOH objectives

1. immunization of 90% of children under one
2. vaccination of 90% of women 15-44 with TT
3. inservice to vaccinators and supervisors
4. new curricula
5. upgrade levels of supervision
6. strengthen management, record-keeping and reporting systems in EPI
7. standardize cold chain mechanism
8. reduce incidence of EPI diseases

ADRA assistance

- cluster sample surveys, training at HP and VHW level to facilitate parent health education
- Field coordinator will promote public awareness through seminars, health education, rallies, posters, film presentation and guest lecturers
- evaluation of effectiveness of training will be "teaching the teacher" method
- supplement EPI surveillance with formation of model of replicable HIS to monitor outcomes, trends, adjust EPI directives and formulate quarterly reports to DPHO

CDD

ADRA will explore following methods of identifying "high risk" families or households

- identify children at SMH with repeated diarrhea visits
- same at Banepa PHC clinic
- detection of "high risk families" through school and community visits by Health Post and clinic staffs

ADRA will promote MOH/CDD policies with training to HP staff and VHW's, and assess training level with evaluation of oral communication ability and knowledge

ADRA will promote more consumer cost-effective, home-based fluids

Nutrition Improvement

MOH not involved in routine growth monitoring, which ADRA will encourage (home kept road to health cards) and use Mid Upper Arm Circumference to screen and put children on "high risk" register for follow up

Indicators are

- numbers of infants/children weighed
- numbers who show increased weight gain
- numbers of malnourished (underweight) shown by MUAC Surveys
- increased knowledge of nutritious foods
- increased numbers of home gardens

ADRA will consider establishing community nutrition worker within district

community health education done in rallies, mobilization of women's groups, health committees, posters, pamphlets, film presentations

Component to Prevent High-Risk Births

MOH Definition of high risk birth

- pregnancy with mother over 35 or under 20
- if mother has had stillbirth or miscarriage in past
- if mother has delivered prematurely in past
- if mother is para >4
- possible twins

Ante-natal care includes

- height/weight
- blood pressure
- urine test
- fetus development test
- immunization health education
- Vitamin A/iron tablets

Post-natal exams include

- mother health check up
- child spacing education
- nutrition/personal hygiene

Other Project Interventions

Banepa Urban Health Care Program

- PHC clinic, to be phased over to Banepa Nagar Palika
- active PH Committee established and sustained by Banepa Nagar Palika
- volunteer health work force to do sampling surveys, disseminate information and inform health committee of local health conditions
- network of mothers groups

Added CS Interventions in the Second Annual Report

ARI, breast feeding, ANC and FP have been added to CS interventions listed in DIP

greater emphasis on 'At risk' mother and child, and use of referrals

5. Pipeline Analysis of Project Expenditures - includes Attached Schedule, and Details of Other Direct/Program Costs
6. Financial Audit, September 1, 1990 to September 30, 1992
7. Key Indicators of Child Survival Project Performance
8. ADRA CS Training Inputs
9. Literacy Program Evaluation
10. Itinerary for evaluation visit
 1. September 28, 1993
 - meeting and self-introduction of evaluators
 - presentation by Birendra Pradhan on an overview of the Project
 2. September 29
 - meeting with Molly M. Gingerich at USAID, Deputy Chief, Office of Health and FP
 - meeting with ADRA Nepal Staff who presented details of Project

3. September 30
 - meeting with Project staff
 - meetings of Project staff and evaluation team with
 - Dr. Hira Shrestha, Chief of FP Section of Family Health Division of MOH
 - Mrs. Sarada Pande directs Child Health Division
 - evaluation team meeting
4. October 1
 - visit to the PH Clinic in Banepa, then visit SMH and discussions with Dr. Vigna, and Gangar Saagar Shrestha (DPHO),
5. October 3
 - drive to Panauti, meet with CHV Dhani Maya Tamang
 - visit to Sanku Pati Chaur and a new sub-health post, met with VDC personnel, and saw FPA/N clinic, and met with all 9 CHV's and VHW in this VDC
 - walk to Dapcha, visit site of new health post, walk on with Field Representative, to her village (Khanaltok), and spend the night there
6. October 4
 - walk to Dapcha, visit HP, observe EPI activities, have meeting with HPSC, walk back to Panauti,
 - visit Banepa PH Clinic
7. October 5
 - discussions with Project staff
 - walk to Bhumlutar HP (a non-ADRA supported HP), visited peons who were carrying out clinical activities (Justice 1983), CHV's, and held a clinic in absence of health workers, who were either deputed elsewhere or in Kathmandu for training, spent night in HP
 - visit to Kabhre VDC, observe EPI, meeting with VDC Chairman and health workers in the area

8. October 6
 - visit to Nala HP
 - meeting of Project staff and DPHO with evaluators) for summary of ideas and comments, debriefing
 - visit to literacy class meeting, discussions with FR and with health workers and community
9. October 7
 - visit to Tusal, meeting with CHV's, TBA's and functioning mother's group
 - visit to Nala HP
 - meeting with Mayor of Banepa Municipality
10. October 8
 - meeting with DPHO of Kabhre, in District Health Office, Dhulikhel, and with Project staff
 - meeting at Banepa PH Clinic office with Project staff, regarding assembling the documentation of activities in relation to objectives
 - meeting at ADRA/Nepal with evaluators an staff
11. October 10
 - visit to Khopasi PHC Center, meeting with staff there an representatives of JMA and JICA
 - planning meeting for evaluation presentation and workshop
12. October 11
 - visit to Khopasi, to meet with community workers, HPSC, women's sewing class, and health educator
 - visit to Kusadevi VDC Sub Health Post, and meeting with community workers and VDC chairman
13. October 12
 - visit to Panchkhal HP, meeting with HPSC
14. October 13
 - all CS staff meet in Dhulikhel for discussion on draft of evaluation

15. October 14
 - all CS staff meet in Dhulikhel for session on planning for the next phase (CS IX), and presentation of executive summary
 - evaluation of evaluators by ADRA CS Staff
 16. October 15:
 - debriefing in Kathmandu with all staff, general discussion
11. List of individuals interviewed/surveyed during evaluation
- ADRA/Nepal Staff
- Paul Dulhunty
 - Ed Baber, ADRA/I financial officer
- ADRA/Nepal CS VI Staff
- Birendra Pradhan
 - Dr. Dan Bahadur Chhetri, Education/Field Coordinator
 - Jaya Mangal Baidya, Community Development Officer
 - Gyanendra Ghale Administrative/Fiscal Officer
 - Dr. Roshani Amatya, PH Clinic doctor
 - Krishna Khadka Banepa PH Clinic In Charge Nurse
 - Jean Baker, Senior Advisor
 - Bala Ram Bhui (Information Advisor)
- Field Representatives
- Indira Sharma, Dapcha
 - Madhu Sudan Satyal, Nala
 - Narayan Satyal, Panchkhal
 - Pradip Karmacharya, Khopasi
- USAID Kathmandu Mission
- Molly M. Gingerich, Deputy Chief, Office of Health and FP
- Ministry of Health, Kathmandu
- Dr. Hira Shrestha, Chief of FP Section of Family Health Division of MOH

- Pushpa Shrestha FP Section Demographer
- Mrs. Sarada Pande Director Child Health Division
- Ram Gobinda, Statistician, Child Health Division

Scheer Memorial Hospital Staff

- Dr. Vigna, Medical Director
- Estelle Ulrich, Nursing Director

VDC members

- VDC chairman, Mahendra Lama, Sanku Pati
- Kabhre VDC Chairman Mohan Bahadur Karki,
- VDC chairman Kusadevi, Bhim Neopani

Community Health Volunteers

- Urmila Humalgain, Kabhre
- Dhani Maya Tamang, Ward # 6, Panauti
- Mahnia Tamang, Sanku Pati
- Shanta Thapa, Sanku Pati
- Chandra Maya Tamang, Sanku Pati
- Nani Maya Tamang, Sanku Pati
- Kanchi Tamang, Sanku Pati
- Uma Devi, Sumara Ward # 9 in Ugrachandi
- Laxmi Thapa, Sanku Pati (also TBA)
- Shanta Maya Tamang, Sanku Pati
- Shanti Shrestha, Sanku Pati
- Bishnu Devi, Sanka Pati (also TBA)
- Ram Piyari Kharel, in Danpatok, Ward 1 of Bhumlutar VDC,
- Sarada Sigdel, Nala HP (also TBA)
- Buddhi Maya
- Pabitra Guragain, Ward #2 in Khopasi, (also TBA)
- woman in Ryali
- Iswari Dahal, Ward #9, Sumara, did Sudeni Training

Village Health Workers

- Urmila Thapa Ugrachandi VDC
- Narendra Karki, Kabhre
- Nara Bahadur Tamang, Chasinghkarkha VDC
- Nauraj Thapa, Ryali VDC
- Indura Puju, Kusadevi

- Krishna Lal, Mahendrajoti VDC,
- Krishna Kumar Shrestha, Panchkhal
- Ram Prasad Upreity, Bhumlutar
- Indra Bahadur Tamang, Sanku Pati

Sanku Pati Sub Health Post Staff

- AHW, Rajesh Bukaju
- MCH worker Saro Maichane

Kusadevi Sub Health Post

- Sharada Adhikari is CMA,
- Rama Thapa is MCH worker,

Krishna Kaji Shrestha, FPA/N outreach clinic Sanku Pati

HP Staff

Dapcha

AHW
ANM,
peons,

Bhumlutar

Gobinda Upreity, Krishna Prasad Kharel, night duty Khagendra Pan, peons

Nala

- HPIC Sam Babu Gautam
- ANM Shiva Ram Khatri
- ANM Sundari KC
- Mukiya Gopal Prasad Adhikari

Panchkhal

- HPIC Yagya Bahadur Shrestha
- Chet Nath Kaffle (AHW),
- Bhagwad Yadab (AHW)
- ANM Kuri Thapa
- ANM Maya Shrestha

HPSC

- Khopasi HPSC Chairman Bharat Raj Mahata,
- Panchkhal HPSC, Chairman Pitambar Nepal, Vice Chairman, Lul Prasad Adhikari, members: Rudra Bahadur Baniya, Ganesh Prasad Parajuli, Chet Nath Dhakal, Laxmi Adhikari

Khopasi Primary Health Center Staff

- Dr. Kishor Tamrakar, Medical Officer
- Mayor of Banepa Municipality, Rambhakta Kokh-Shrestha

DHO Kabhre Staff

- Ganga Saagar Shrestha, DPHO of Kabhre
- Baghwan Thapa, Statistical Supervisor for DHO, Kabhre

Individuals

- shopkeeper in Tar
- Bijuli Prasad Kharel, 85 year old grandfather
- Babu Ratna, Dapcha citizen
- 9th grade student, Tusal
- Shanti Bhandari, health educator
- Suman Shrestha, CMA, who runs Harishidddi medical hall near Dapcha

Japan International Cooperation Agency and Japan Medical Association Staff

- Japan Med. Assoc. (JMA) person . Midori Kitahara
- Y. Takamatsu, Coordinator: Nepal Primary Health Care Project

Income Generation Activities Staff at Khopasi IGA, sewing class

- Delaware Shrestha , teacher
- Chandani Miss teacher
- Indu Lama head teacher

12. Interviewer questionnaires

The following questions were used as a guideline in interviewing various categories of individuals during the evaluation.

USAID

What examples are there of NGO's working in Nepal to strengthen HMG's health service delivery?

- What have been the favorable outcomes achieved?
- What have been the difficulties they have encountered?
- What are the basic determinants of successful NGO projects from AID's viewpoint?
- What is the impression of ADRA's CS VI program in Kabhre Palanchok?
- How does AID use end of project evaluations for future program decision making?
- What are the features of evaluations that AID sees are most important?
- What role are Peace Corps playing in health in Nepal?
- What aspects are seen as irrelevant or problematic?
- CS-VI evaluation guidelines, are not very applicable to this project, how should the evaluation proceed regarding this, especially the sustainability issues?
- What should be the evaluation team look at to evaluate ADRA's project?
- What is a good evaluation in your opinion?

MOH (in Kathmandu)

- What are the significant improvements seen in health service delivery over the last three years?
- Could you outline the accomplishments of decentralization of health service delivery over the last 3-5 years?
- With the recent reorganization of the MOH, and the creation of the Dept of Health Services, how will decentralization proceed?
- Could you prioritize the difficulties in health service delivery at the district and health post level?
 - planning?
 - staffing?
 - supervision?
 - supplies?
 - motivation?
 - logistics
- What is the situation regarding registration/user fees in the health posts? District hospitals?
- Please describe the current status of the CHV program? Future plans?
- What kind of referral system has been set up for CHV's VHW's, Sub-Health Posts, Health Posts, etc.?

- What role does the private sector have in provision of health services in remote areas?
 - Is there any attempt to encourage or discourage private practice?
- What evaluation tools are there of government training programs?
- NGO Efforts
 - What is the role of NGO's in health service provision from HMG's perspective? Is there a formulated policy? Can we get a copy?
- What examples are there of NGO's working in Nepal to strengthen HMG's health service delivery?
 - What have been the favorable outcomes achieved?
 - What have been the difficulties they have encountered?
- What problems that you face are most applicable to assistance by NGO's
 - Nepali NGO's?
 - International NGO's?
- How is ADRA's efforts to strengthen government health care delivery services in Kabhre viewed? Do they fit in with the government plan?
- Does the HMG doctor posted to the PHC clinic in Banepa gets government credit for service there?

JICA

- Do you have copies of the surveys done in Kabre in 1987, and 1990?
- Could you outline the projects JICA has carried out in Kabhre?
- What is the relationship between JICA and ADRA?
- What future plans does JICA have in Kabhre?

Sheer Memorial Hospital (SMH)

- What has been the relationship between SMH and the ADRA CS project?
- What aspects can be improved?
- How many high risk pregnancies from the ADRA CS project health posts are delivered here?
- Describe the mechanism for referrals from ADRA supported health posts to be seen in the hospital? What type of feedback is given regarding the handling of the cases here? It had been suggested in the mid-term evaluation that there be a monthly meeting between SMH, DPHO, HPIC and the ADRA field coordinator to discuss these cases. Was this done? Successful?

- Have you been asked for technical advice or to provide training for the ADRA CS project?
- What role can SMH take in Primary Health Care in the district in the future?
- Have there been any community evaluations of SMH services in the district?

ADRA Kathmandu Staff

- Are there plans for a third annual report?
- Please give a current organogram for the project, and list the names of the staff in the various positions?
 - What evaluations of the performance of the field staff have been done? Copies of those?
- Describe any efforts made to provide CS and maternal health interventions promoted through local schools
- Describe the situation regarding attaining the outputs mentioned in the PP
- PP talks about need for community ownership to be emphasized from the very start. Describe how you went about trying to achieve this?
- PP talks about extra supervision of existing health services in the ilakha, what was done to strengthen supervision?
 - PP describes training strategy of VHW's doing supervisory skills and community organization. Describe efforts there?
 - Describe the philosophy of training in management and supervision that was undertaken for the various categories of workers that were trained?
- What efforts were made to judge the effect of the various training programs? Was there any attempt to do pre and post tests and follow up's 6 months later for the various trainings?
 - PP mentions use of problem-solving approach to training, using case studies. Please document this.
 - What are the curriculums for the various training programs?
 - DIP mentions that evaluation of effectiveness of training will be "teaching the teacher" method. Please describe this and document how effective it was.
 - Educational classes will be by participatory methods according to mid-term, and teachers who only read lectures will no longer be utilized. Describe these methods and how they were used?
 - How was the audio cassette tape recorder used?
 - What slide sets were used for educational purposes? How effective were they?

- Describe the role of the community and literacy facilitator that was added to the program, mentioned in the 1st annual report?
 - Women's literacy classes, please document the numbers held, the outcomes and the community response?
- Describe the disruptions in activity from the democracy demonstrations and political turmoil in the last three years.
- Nutrition
 - How were the nutrition messages mentioned in the DIP developed and promoted?
 - Were there any efforts to establish a community nutrition worker in the district as mentioned in the DIP?
- Describe efforts to explore cost recovery schemes, including revolving drug funds, charges for medication, revolving goat fund, health tax etc.
- Has there been any effort to organize and monitor the drug stores and traditional herbalists or ayurvedic practitioners in Banepa? Have they tried to develop a center in Banepa? (PP pg 13)
- Describe the district health targets and document progress in meeting them?
- Banepa clinic's purpose was to allow ADRA to gain experience in CS interventions to implement the rest of the program in rural HP. Describe how the experience in Banepa led to modifications of programs in the rural HP's?
- What subscriptions to professional journals were taken?
- Can we see copies of the "Kabhre Health Post", how often does it come out? What has been its impact in the health posts? Is it distributed widely throughout Nepal?
- Which foreign conferences did people attend? Who went? What was the result?
- Please list all the consultants used, and give copies of their reports?
 - Was there any anthropologist used as listed in the PP?
 - Nutritionist?
- Explain the decision to not have a full-time Project Director after the initial person terminated?
 - How much time did the ADRA country director spend as acting director? How available was he?
 - How have the consultants worked out in lieu of a Director?
 - What reports have the consultants generated?
- What do you feel have been the significant accomplishments of the project?
- What have been the major shortcomings?
- What are the lessons learned?
- Let us see the employee handbook.

- Please document the attempts to implement or not implement the recommendations of the mid-term review?
- Please describe the TA provided by ADRA/I?
 - Has it been helpful?
 - How could it be improved?
 - Who at ADRA/I was responsible for coordinating and procuring TA for ADRA/Nepal?
 - How was TA requested from Hq?
 - Is there monitoring and feedback to Hq on the effectiveness of the TA?
- Please describe the methods for carrying out the 30 cluster surveys?
 - When will the complete results be available?
 - What impact has doing these had on your program?
 - Who does the surveys? How long does it take?
- What was the result of the Banepa Urban Health and Literacy Survey?
- Accountant/Office Manager
 - Do you have a job description? What does it say?
 - Have you had your performance evaluated by the Kathmandu office? Is it in reference to the job description? How often is this done?
 - What was your experience in taking part in the mid-term evaluation?
 - Please go over the budget, accounting procedures, and audits?
- Please describe the workshops held for NGO's MOH representatives relevant to CS, as stated in the revised objectives in the 2nd annual report (I: E)
- Was a national workshop held to share information with other NGO's?
 - Is there a log of meetings with MOH, UNICEF, WHO, US AID, John Snow Incorporated, IOM, and NGO's operating in child survival programs? (SCF (US and UK), Freedom from Hunger, Swiss Association for Technical Assistance, JICA, United Mission to Nepal etc)
- Describe the answers for the ADRA (not USAID CS) evaluation guidelines listed in the scope of work

Banepa PH Clinic Staff

- Clinic in Charge Nurse
- What do you feel are the most important aspects of the job you do here?
- When do you give out immunizations here?
- Have monthly field and clinical training sessions been held monthly?
- How many mothers groups are functioning in Banepa? How often do they meet? What do they do at the meetings?

- What are the activities of the PH Clinic? Which ones are duplicated by SMH?
- What do you do for a malnourished child? A child with diarrhea? Fever?
- What system do you have for record keeping?
 - How do identify children who have had repeated episodes of diarrhea?
- What health learning materials do you use? Are there teaching sessions for the people visiting the clinic?
- What is a high risk family?
occ to DIP, is those with children with diarrhea in last 2 weeks, mothers who don't know about ORS, or live in households with unprotected water supply. WHO defines diarrhea as 3 or more loose stools in one day. MOH CDD defines high risk children as those suffering from parental neglect, malnutrition, default on immunization, and bad hygiene/sanitation
- What do you do when you identify a high risk family?
- Describe the disruptions in activity from the democracy demonstrations and turmoil in the last three years.
- Have you asked SMH for any technical advice, or have they taken part in any of your training activities?
- What role do the medical halls and traditional herbalists and ayurvedic practitioners play in providing health services in Banepa? Do you have any contact with them?
- What is the role of the Red Cross in Banepa? Do you work with it, or with any organizations?
 - Are there meetings held regularly with them?

ADRA CSVI Staff

Field Coordinator

- Do you have a job description? What does it say?
- Have you had your performance evaluated by the Kathmandu office? Is it in reference to the job description? How often is this done?
- What efforts are made not to duplicate training done by other agencies?
- Describe rallies held, posters produced, and films presented to assist in the EPI program? (DIP)
- How often do you have meetings with the DPHO? Is there a log of these?
- What do you do with the minutes of the weekly project staff meetings?
 - Have they been helpful?
- Describe the drama group production that was done in Ajad High School? Was it taken out to other areas of Kabhre?

- What is your supervision schedule of the field representatives? What happens in a supervision visit? How do you evaluate the performance of the field representatives?

Field Representatives

- Please describe your background and training you received to work in this project? (to be equivalent to HPIC)
- Do you have a job description? What does it say?
- Have you had your performance evaluated by the Banepa office? Is it in reference to the job description? How often is this done?
- Could you please describe the work you do in a typical day?
- Where do you live? How far is it from your health post? How many children do you have?
- Do you attend meetings in Banepa? How often? What is discussed there? How do you get there?
- What is your role in working with VHW's, CHV's?
- Do you prepare any written reports? Can we see them? What do you include in them?
- Have you made visits to other projects?

Banepa PH Clinic Physician

- Do you have a job description? What does it say?
- Have you had your performance evaluated by the Kathmandu office? Is it in reference to the job description? How often is this done?
- What do you do in a typical day?
- How do you feel about working for ADRA?
- What are the most enjoyable parts of your job? What do you find difficult or frustrating?
- Do you feel comfortable doing the mini-laps? Vasectomies?
- Where do you live? Is it difficult to get to get to Banepa from Kathmandu? How often are you unable to make it here?

Public Health Nurse

- Please describe your background and training you received to work in this project?
- Could you please describe the work you do in a typical day?
- Do you have a job description? (1st annual report pg 17) What does it say?
- Have you had your performance evaluated by the Kathmandu office? Is it in reference to the job description? How often is this done?

Community and Literacy Training Facilitator

- Please describe your background and training you received to work in this project?
- Could you please describe the work you do in a typical day?
- What is the literacy training curriculum?
- Do you have a job description? What does it say?
- Have you had your performance evaluated by the Kathmandu office? Is it in reference to the job description? How often is this done?

District Health Office (DPHO)

- What are the responsibilities of this office?
- Could you please describe the work you do in a typical day?
- How many VDC's have VHW's, how many wards have CHV's
 - What is the role of the VHW?
 - How do you sustain the interest and involvement of the CHV's?
 - What works best?
- Has ADRA carried out workshops in CS management, and in HIS?
 - When were they, and for how long?
 - What was the subject content of this training? How was the material presented?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
- Are growth cards and ANC-FP cards in use for mothers and under fives?
 - Where?
 - How effective are they? How often do the clients bring them to the facility when they come for care?
- What is the EPI schedule?
 - How is the cold chain monitored? Maintained?
 - Are immunization cards given out for EPI?
 - What is the surveillance system for EPI?
 - What is the situation regarding reporting measles cases? What are the figures?
- Drug Supplies
 - How do you allocate drug supplies to the health posts?
 - How long does the supply last?
- How many of the sanctioned posts are filled? Manned?
- What are the supervision guidelines for the health posts? How are they carried out?
- Some time back, the community surrounding the health post in Dapcha lobbied for the replacement of the HPIC there. Why was this, and

- what happened to him? Have there been other occasions like this?
- Are there any user fees, or other attempts at cost recovery?
 - How much of the operating costs are recovered this way?
- Is there any attempt to monitor the quality of service provided at the health posts? How could this be done?
- Describe the disruptions in service activity from the democracy demonstrations and turmoil in the last three years.
- Health Information System (HIS)
 - Can you go over the VDC HIS collection procedures on births and deaths?
 - How has this HIS changed over the time period of the ADRA CS project?
 - Has there been Epi Info Data Management and HIS workshops conducted for your office staff?
 - When were they, and for how long?
 - What was the subject content of this training?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
 - How do you use the HIS to influence policy or to change the way health care services in the district are carried out?
 - Where is the data analyzed?
 - What reporting requirements do you have with the data in the HIS?
 - How can you see improving the HIS?
- Who are all the NGO's and other organizations involved in health in the district?
 - Is there any involvement by Peace Corps, VSO, other volunteers?
 - What changes would you like to see in how the NGO's function here?
 - Are there regular meetings of NGO's and DPHO?

Health Post

Health Post in Charge

- Could you please describe the work you do in a typical day?
- How many patients are seen daily? (Why are there so few seen?)
- What are the most enjoyable aspects of working here?
- What are the most difficult aspects?
- What records do you keep? How do you use them?
- Is there a library of health education materials here? Who has access to it?

- Have you seen a copy of the newsletter “Kabhre Health Post”? How often does it come? Is it useful?
 - Are there other publications distributed by ADRA? Are they used? Useful? (Kurakani, AIDS and Bhalakusari in mid-term)
- Pregnancy
 - What do you say to a mother who is pregnant?
 - If she is very young?
 - What if her previous child was born 6 months ago?
 - What if she has had 1 or 2 children die in the past?
 - What if she has 5 children already?
 - Do you refer mothers for antenatal care? Where? How many of them go? Do you follow up?
 - What do you do for an ante-natal check up and a post-natal check up? (DIP pg. 25)
 - How many do you do?
- Do you refer patients to the PH Clinic in Banepa or the SMH from the health post? Do you send a form with them? Do you get any feedback?
- What has been the effect of the ADRA project in your health post?
- Can you tell us about the ADRA field representative who has been working with this health post?
 - What has he/she been doing?
 - What do you like best about the presence of the field representative?
- Can you tell us the training programs you have attended in the last three years?
- Have you attended refresher training programs/workshops run by ADRA?
 - When were they, and for how long?
 - What was the subject content of this training? How was the material presented?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
 - Do you feel the need for further training? In what subject areas?
- Describe the disruptions in service activity from the democracy demonstrations and turmoil in the last three years.
- What is the single main improvement that you see would improve health service delivery?
- What is the single main improvement that you see would improve health knowledge and awareness in the community?

- What is the single main improvement that you see would improve the functioning of your health post.
- Do you have a private practice? What are its hours? What do you charge? Do you refer any patients to other facilities from there?

AHW

- Could you please describe the work you do in a typical day?
- Have you attended refresher training programs/workshops run by ADRA?
 - When were they, and for how long?
 - What was the subject content of this training? How was the material presented?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
 - Do you feel the need for further training? In what subject areas?
- Have you seen a copy of the newsletter "Kabhre Health Post"? How often does it come? Is it useful?
 - Are there other publications distributed by ADRA? Are they used? Useful?

ANM

- Could you please describe the work you do in a typical day?
- Have you attended refresher training programs/workshops run by ADRA?
 - When were they, and for how long?
 - What was the subject content of this training? How was the material presented?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
 - Do you feel the need for further training? In what subject areas?
- Have you seen a copy of the newsletter "Kabhre Health Post"? How often does it come? Is it useful?
 - Are there other publications distributed by ADRA? Are they used? Useful?

HPSC

- How often do you meet?
- What do you discuss in your meetings?
- How do you feel health care can be improved in this area?
- Have you seen any changes in deaths from measles, whooping cough, diarrhea, fever?
- What do you see as being your responsibilities?

Sub Health Post

AHW

- Could you please describe the work you do in a typical day? What records do you keep? How do you use them?

MCH worker

- Could you please describe the work you do in a typical day?

Village Development Committee (VDC)

- VDC Chairman

VHW

- Could you please describe the work you do in a typical day?
- Do you refer sick people to the health post? Do you use any form for this? Do you get any feedback from the health post?
- How many of the CHV's in your VDC are active? What do they do?
- What is your role in supervision of CHV's and TBA's?
- Have you received any training in supervising the CHV's?
- Have you attended refresher training programs/workshops run by ADRA?
 - When were they, and for how long?
 - What was the subject content of this training? How was the material presented?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
 - Do you feel the need for further training? In what subject areas?

TBA

- Could you please describe the work you do in a typical day?
- How many deliveries do you assist at a month? What do you do for a delivery?
- What do you say to a mother who is pregnant?

- If she is very young?
- What if her previous child was born 6 months ago?
- What if she has had 1 or 2 children die in the past?
- What if she has 5 children already?
- Do you refer mothers for antenatal care? Where?
 - How many of them go?
 - Do you follow up?
- What training have you received?
- Have you attended refresher training programs/workshops run by ADRA?
 - When were they, and for how long?
 - What was the subject content of this training? How was the material presented?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
 - Do you feel the need for further training? In what subject areas?
- Are you aware of HIV/AIDS?
 - How is this disease spread?
 - Do you know anyone who has this problem?
 - How can it be prevented?

CHV

- How long have you been working? How were you recruited?
- Please describe how you learned the work that you do?
- Have you attended refresher training programs/workshops run by ADRA?
 - When were they, and for how long?
 - What was the subject content of this training? How was the material presented?
 - Was there any evaluation component of the training, either your evaluating the training (feedback), or the trainers evaluating your performance?
 - How did this program change the way you worked?
 - Do you feel the need for further training? In what subject areas?
- Could you please describe the work you do in a typical day?
- Do you hand out any medicines? How do you get them? What are they for?
- What do you tell a mother who says her child has diarrhea? (role play here?)
 - What is Jeevan Jal? Nun-chini-pani? How do you make it?
- How do you identify a malnourished child, and what do you do then?

- What advice do you give for breast feeding?
- How do you evaluate a child who has a fever? What do you do?
 - Can you count or estimate how fast the child is breathing?
- What do you say to a mother who is pregnant?
 - If she is very young?
 - What if her previous child was born 6 months ago?
 - What if she has had 1 or 2 children die in the past?
 - What if she has 5 children already?
 - Do you refer mothers for antenatal care? Where?
 - How many of them go?
 - Do you follow up?
- What do you do if someone has a wound? Skin infection?
- What do you do to motivate people for family planning?
- Do you refer sick children for care? Where?
 - How many of them go?
 - Do you follow up?
- Do you have monthly visits for continuing education by ANM's, VHW's and HPIC's?
 - What happens at these?
- What records do you keep?
- What materials for health education do you have? Use? Do you have "Matri-Shishu swayam sebike pustak"?
- How do you take care of your family responsibilities when you work?
- Are you aware of HIV/AIDS?
 - How is this disease spread?
 - Do you know anyone who has this problem?
 - How can it be prevented?
- Community members
 - Where do you go when you are sick? What happens?
 - How far away from the health post do you live?
 - Are any fees charged at the health posts?
 - What do you tell a mother who says her child has diarrhea? (role play here?)
 - What is Jeevan Jal? Nun-chini-pani? How do you make it?
 - Has your child been immunized? Did you receive a card?
 - Do you get a card when you take your child to the health post?
 - If you are pregnant and go to the health post, what happens there? Do you get a card?
 - How do you wean your child? How long do you exclusively breast feed?
 - Describe the disruptions in service activity from the democracy demonstrations and turmoil in the last three years.

- School teachers?
 - What aspects of health are taught in the curriculum?
 - What do you do if a child is malnourished? Sick?
 - Have there been any programs about health in your area?
 - Who ran them? What effect did they have?
- Literacy classes
 - Are there places to learn to read? What happens there?
 - What do you read after you have learned to?

Banepa residents

- Mayor of Banepa
 - What has been the result of the PHC clinic present in Banepa?
 - How has the community felt about it?
 - What would they like to see improved?
 - The town council was to be involved in a fee schedule for services. Has this happened?
- What do you do if you are sick? Injured?
- How far do you live from the hospital? The PHC?
- Do you go to the drug store, or herbalist or ayurvedic practitioner?
- Describe the disruptions in service activity from the democracy demonstrations and turmoil in the last three years.
- Women's groups
 - How many mothers groups are functioning in this town? How often do they meet? What do they do at the meetings?

13. References cited

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APPENDIX: E

Pipeline Analysis

11/24/1993
05:10:14

ADRA NEPAL CHILD SURVIVAL VI
P O BOX 4481 KATHMANDU

PAGE 1

USD = 37.8748
CURRENCY :

INCOME AND EXPENSE DETAIL
FOR 12 MONTHS/12 ENDED SEPTEMBER 30, 1993

INCOME	YEAR TO DATE	TOTAL BUDGET	(YTD) USD

ADRA INCOME			

ADRA CASH INCOME	1,106,386.94	0.00	29,211.71
ADRA NON-CASH INCOME	3,482,987.62	0.00	91,960.63
TOTAL ADRA INCOME	4,589,374.56	0.00	121,172.34

USAID INCOME			

USAID CASH INCOME	15,045,540.15	0.00	397,244.39
USAID NON-CASH INCOME	1,143,770.68	0.00	30,198.75
TOTAL USAID INCOME	16,189,310.83	0.00	427,443.14
TOTAL INCOME	20,778,685.39	0.00	548,615.47

EXPENSES			

PROCUREMENT			

OFFICE EQUIPMENT	1,074,591.55	26,200.00	28,372.23
TEACHING EQUIPMENT	0.00	0.00	0.00
TRANSPORTATION (ADRA)	1,011,807.18	26,250.00	26,714.54
TRANSPORTATION (USAID)	223,468.59	9,100.00	5,900.20
TOTAL PROCUREMENT	2,309,867.32	61,550.00	60,986.96

SUPPLIES			

OFFICE SUPPLIES	508,211.73	11,400.00	13,418.21
SUBSCRIPTION	13,504.90	343.00	356.57
MEDICAL	342,218.81	2,074.00	9,035.53
TOTAL SUPPLIES	863,935.44	13,817.00	22,810.31

SERVICES			

WORKSHOP/TRAINING	336,626.02	11,151.00	8,887.87
AUDIT	129,611.60	3,656.00	3,422.11
TOTAL SERVICES	466,237.62	14,807.00	12,309.98

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ADRA NEPAL CHILD SURVIVAL VI
P O BOX 4481 KATHMANDU

PAGE 2

USD = 37.8748
CURRENCY :

INCOME AND EXPENSE DETAIL
FOR 12 MONTHS/12 ENDED SEPTEMBER 30, 1993

EXPENSES	YEAR TO DATE	TOTAL BUDGET	(YTD) USD
CONSULTANTS			
LOCAL CONSULTANTS	12,934.00	4,349.00	341.49
EXTERNAL CONSULTANT	1,196,890.78	38,800.00	31,601.27
TOTAL CONSULTANTS	1,209,824.78	43,149.00	31,942.76
EVALUATION			
EVALUATION	437,594.63	11,400.00	11,553.72
PERSONNEL - ADMIN			
ADMIN ASSIST.	383,466.33	7,800.00	10,124.58
ACCOUNTANT	120,099.08	3,204.27	3,170.95
COUNTRY DIRECTOR	1,043,659.50	9,551.00	27,555.53
PROJECT DIRECTOR	2,402,357.33	106,621.00	63,428.96
PROJECT DIRECTOR	0.00	11,500.00	0.00
ADMIN SECRETARY	258,745.83	4,886.66	6,831.61
SECRETARY	89,457.66	1,747.21	2,361.93
TOTAL PERSONNEL - ADMIN	4,297,785.73	145,310.14	113,473.58
PERSONNEL - TECHNICAL			
PROGRAM COORDINATOR	39,554.00	1,145.66	1,044.34
FIELD COORDINATOR	283,124.55	8,500.00	7,475.28
PUBLIC HEALTH NURSE	236,871.74	4,651.70	6,254.08
COMMUNITY DEV OFFICER	197,002.66	4,500.00	5,201.42
COMMUNITY DEV NURSE	70,747.50	1,600.00	1,867.93
FIELD MOTIVATOR	332,684.11	9,600.00	8,783.79
DATA INFO ASSIST	141,880.11	2,591.17	3,746.03
DRIVER	104,395.00	2,600.00	2,756.32
TOTAL PERSONNEL - TECHNIC	1,406,259.67	35,188.53	37,129.19
PERSONNEL - CLINIC			
PHYSICIAN	398,322.46	9,400.00	10,516.83
SR. NURSE	216,007.58	4,500.00	5,703.20
CLINIC NURSE	71,525.93	1,600.00	1,888.48
SR. VACCINATOR	26,353.93	1,200.00	695.82
CUSTODIAN	84,117.50	2,000.00	2,220.94
TOTAL PERSONNEL - CLINIC	796,327.40	18,700.00	21,025.27

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ADRA NEPAL CHILD SURVIVAL VI
P O BOX 4481 KATHMANDU

PAGE 3

USD = 37.8748
CURRENCY :

INCOME AND EXPENSE DETAIL
FOR 12 MONTHS/12 ENDED SEPTEMBER 30, 1993

EXPENSES	YEAR TO DATE	TOTAL BUDGET	(YTD) USD
PERSONNEL - OTHERS			
CONTRACT	610,945.42	5,000.00	16,130.67
CASUAL	78,237.69	1,270.47	2,065.69
TOTAL PERSONNEL - OTHERS	689,183.11	6,270.47	18,196.36
TRAVEL			
SHORT TERM - ADRA	8,562.77	3,300.00	226.08
SHORT TERM - USAID	600,460.88	20,100.00	15,853.85
VEHICLE MILEAGE	647,122.40	13,499.74	17,085.84
PARTICIPANTS EXPENSES	147,391.17	8,600.00	3,891.54
LONG TERM EXPT ALL-ADRA	168,157.60	68,725.00	4,439.83
LONG TERM EXPT ALL-USAID	102.00	1,000.00	2.69
TOTAL TRAVEL	1,571,796.82	115,224.74	41,499.84
DIRECT PROGRAM COST			
HELATH INFO SYSTEM	1,291,946.18	29,000.00	34,111.00
PILOT PROJECT	134,827.22	8,955.00	3,559.82
PHC CLINIC	347,262.76	8,800.00	9,168.71
FAMILY PLANNING	478,777.75	9,000.00	12,641.07
COMMUNITY INVOLVEMENT	33,346.00	4,000.00	880.43
UTILIZATION	335,581.30	4,700.00	8,860.29
COMMUNITY DEVELOPMENT	156,924.50	8,000.00	4,143.25
REFERRAL SYSTEM	9,099.00	4,300.00	240.24
TRAINING CENTRE	909,716.08	14,000.00	24,019.05
LITERACY	457,139.93	9,500.00	12,069.77
HEALTH EDUCATION	288,944.37	6,000.00	7,628.94
TOTAL DIRECT PROGRAM COST	4,443,565.09	106,255.00	117,322.56
OTHER DIRECT COSTS			
CS ORIENTATION	8,000.00	2,115.00	211.22
COMMUNICATION	627,826.55	12,211.80	16,576.38
EQUIPMENT LEASE	166,825.00	5,791.32	4,404.65
LANGUAGE	4,212.50	500.00	111.22
EQUIPMENT MAINTENANCE	339,840.48	8,200.00	8,972.74
RENT	310,330.00	6,000.00	8,193.58
PVO WORKSHOP	0.00	4,600.00	0.00
VOLUNTEER INCENTIVES	0.00	1,500.00	0.00
FIELD EXPENSES	188,155.04	4,530.00	4,967.82

11/24/1993
05:10:27

ADRA NEPAL CHILD SURVIVAL VI
P O BOX 4481 KATHMANDU

PAGE 4

USD = 37.8748
CURRENCY :

INCOME AND EXPENSE DETAIL
FOR 12 MONTHS/12 ENDED SEPTEMBER 30, 1993

EXPENSES	YEAR TO DATE	TOTAL BUDGET	(YTD) USD
----- OTHER DIRECT COSTS -----			
STAFF SUPPORT	360,202.71	10,600.00	9,510.36
PUBLICATION	184,549.75	5,000.00	4,872.63
MEETING EXPENSES	21,725.80	1,000.00	573.62
VOLUNTEER ACCOMODATION	16,726.00	1,000.00	441.61
INSURANCE	57,913.95	3,000.00	1,529.09
TOTAL OTHER DIRECT COSTS	2,286,307.78	66,048.12	60,364.93
-----	-----	-----	-----
INDERECT COST -----			
INDIRECT COST (ADRA)	0.00	35,739.00	0.00
-----	-----	-----	-----
INDIRECT COST -----			
INDIRECT COST (USAID)	0.00	70,472.00	0.00
-----	-----	-----	-----
TOTAL EXPENSES	20,778,685.39	743,931.00	548,615.47
-----	-----	-----	-----
NET INCREASE/-DECREASE	0.00	-743,931.00	0.00
=====	=====	=====	=====

APPENDIX: F
Financial Audit

ATTACHMENT 3

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Cooperative Agreement No. OTR 0500-A-00-0098-00

Financial Audit
for the period September 1, 1990, to September 30, 1992.

performed
by

KB CHITRACAR & CO.

Cooperative Agreement No. OTR 0500-A-00-0098-00

Financial Audit
for the period September 1, 1990, to September 30, 1992

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(international)

October 6, 1993

Mr. Paul Dulhunty
Country Director
ADRA Nepal
Child Survival Project VI
Nepal

Dear Mr. Dulhunty,

This report presents the results of our financial audit of the ADRA Nepal Child Survival Project pertaining to its Cooperative Agreement No. OTR 0500-A-00-0098-00 with the USAID, Washington D.C., as it relates to the Nepal Program for the period September 1, 1990, to September 30, 1992.

Background of the Project

ADRA has located this child survival project in the northwest portion of the Kavre district in the hill country east of Kathmandu, where the Adventist Church has operated a mission hospital for more than 30 years. The target population of 120,000 in the town of Banepa and three rural health posts of Dapcha, Khopasi and Panchkhal includes 19,200 children under age 5 and 24,000 women of reproductive age.

The goal of this project is to improve the health of mothers and children by helping the District Public Health Office strengthen its delivery of services in increasing immunization coverage, ORT usage and contraceptive use, increasing percentage of women receiving ante natal care, and reducing malnutrition. ADRA is not directly responsible for the delivery of health services, but acts in a training and support role.

As per the Cooperative Agreement, USAID has obligated funds amounting to US\$ 485,015 with a matching contribution from ADRA amounting to US\$ 258,916 during the three years' period 9/1/90 to 8/31/93. The implementation of activities was however delayed and field work was not started until August 1991.

Audit Objectives and Scope of Work

We have conducted a financial audit of the ADRA Nepal Child Survival Project pertaining to its Cooperative Agreement No. OTR 0500-A-00-0098-00 with the USAID, Washington D.C., as it relates to the Nepal Program for the period September 1, 1990, to September 30, 1992.

For the period, ADRA Nepal received transfer of US\$ 187,138 from USAID Fund and US\$ 36,253 from ADRA Fund for the purposes of the Cooperative Agreement.

The Fund Accountability Statement comprises the Statement of Sources and Utilization of Fund and Schedule of Expenses together with the closing balances for cash, receivables and payables for the period September 1, 1990, to September 30, 1992, and the notes thereon. The results of our work are reflected in the accompanying Independent Auditor's Reports on the

- (a) Fund Accountability Statement;
- (b) System of Internal Control; and
- (c) Compliance with Agreement Terms, Applicable Laws and Regulations.

The objectives of our work were to determine whether:

- (a) The Fund Accountability Statement for ADRA Nepal presents fairly the income, expenditures and closing balances of ADRA Nepal for the period noted above and in accordance with the terms of the Cooperative agreement;
- (b) ADRA Nepal's internal accounting controls were adequate to provide reasonable assurance that the assets of ADRA Nepal were safeguarded against loss from unauthorized use or disposition and that transactions were properly recorded; and
- (c) ADRA Nepal has complied with applicable laws, regulations and agreement terms.

Our audit was conducted in accordance with generally accepted auditing standards and US Government Auditing Standards and, accordingly, included such tests as we considered appropriate in order to satisfy our objectives.

The scope of our work included the following general procedures:

- (a) Holding meetings with ADRA officials;
- (b) Reviewing the Cooperative agreement and appropriate amendments, OMB circulars, USAID handbook regulations, periodical reports prepared by ADRA, audit reports of previous auditors;
- (c) Obtaining an understanding of the accounting, administrative and internal control systems of ADRA;
- (d) Reviewing and performing appropriate tests on the transactions recorded in the Fund Accountability Statement;

- (e) Designing appropriate audit steps and procedures to provide reasonable assurance of detecting errors, irregularities, and illegal acts that could have a direct and material effect on the results of our audit. We were also aware of the possibility of illegal acts that could have an indirect and material effect on the results of our audit, and
- (f) Testing the effectiveness of administrative controls applied by ADRA's management to ensure compliance with applicable laws, regulations and agreement terms.

Audit Results

(a) **Opinion on the Fund Accountability Statement**

As explained more fully in our report on pages 5 to 6, we were unable to audit the expenditure incurred by ADRA International US\$ 33,140.57 due to lack of documentation and we have identified questioned costs amounting to US\$ 9698.40 that may be disallowable. Except for these matters, in our opinion, the Fund Accountability Statement presents fairly, in all material respects, the income, expenditure and closing balances of ADRA Nepal for the September 1, 1990, to September 30, 1992, as they pertain to the fund transferred from ADRA International for the Child Survival Project VI.

(b) **Opinion on Internal Control Structure**

In accordance with Paragraph 19 of Chapter 5 of Government Auditing Standards, we limited our reliance on ADRA's internal control structure as our preliminary review and documentation of the accounting and control systems indicated that an adequate structure did not exist for our reliance due to the small size of the entity. In order to maintain the efficiency of our audit, we therefore expanded our substantive testing.

During the course of our audit, we noted certain matters involving the internal control structure and its operation that we considered to be reportable conditions. These matters have been detailed within the body of our report on pages 11 to 18.

(c) **Opinion on Compliance**

Our tests for compliance with agreement terms, applicable laws and regulations of selected transactions and records of ADRA indicated that, for the items tested, except for the items noted in the following paragraph, ADRA principally complied with those provisions of its agreement terms, as well as applicable laws and regulations, for the period under our review.

Certain instances of non-compliance were noted and these are discussed further in our detailed report on pages 19 to 25. Total USAID funded costs that were questioned amounted to US\$ 9698.40. However, the overall result of these non-compliance issues is not considered to have a material effect on the Fund Accountability Statement of ADRA for the period under our review.

With respect to transactions and records not tested by us, nothing came to our attention that caused us to believe that ADRA Nepal had not complied, in all material respects, with agreement terms, applicable laws or regulations.

In the course of our work, no significant or material findings and recommendations from previous audits, that affect the current audit objectives, were noted.

Comments on Findings and Recommendations

The management of ADRA Nepal has generally agreed to our findings and recommendations on the internal control and non-compliance issues set out in our report. Management comments can be found on the relevant pages of our findings.

Acknowledgements

We would like to express our gratitude for the assistance given to us by the management and staff of ADRA Nepal during the course of our audit.

Yours sincerely

K.B. Chitrakar
K.B. CHITRACAR & CO
Chartered Accountants



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October 6, 1993

Mr. Paul Dulhanty
Country Director
ADRA Nepal
Child Survival Project VI
Nepal

Dear Mr. Dulhanty

**ADRA NEPAL CHILD SURVIVAL PROJECT VI
Independent Auditor's Report on the Fund Accountability Statement**

1. We have audited the accompanying Fund Accountability Statement of the ADRA Nepal Child Survival Project pertaining to its Cooperative Agreement No. OTR 0500-A-00-0098-00 with the USAID, Washington D.C., as it relates to the Nepal Program for the period September 1, 1990, to September 30, 1992.
2. This Statement, comprising the Statement of Sources and Utilization of Fund and Schedule of Expenses together with the closing balances for cash, receivables and payables for the period September 1, 1990, to September 30, 1992 and the notes thereon, is the responsibility of ADRA Nepal's management. Our responsibility is to express an opinion on these financial statements based on our audit.
3. Except as discussed in paragraph 5 below, we conducted our audit in accordance with generally accepted auditing standards and Government Auditing Standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

4. As stated in Note 2 on page 10, the Fund Accountability Statement presents only the transactions of ADRA Nepal as it pertains to funds received from and expenditure incurred by ADRA International out of USAID Contribution and ADRA contribution under the Cooperative Agreement.

5. We have not audited the expenditure incurred by ADRA International USS 33,140.57 which were booked only as per the advices received by ADRA Nepal. Necessary documentation for the purpose of audit of the expenditure was available with ADRA Nepal.

6. As part of our examination, we identified questioned costs amounting to USS 9,698.40 which may be disallowable. Details of these costs can be found in Appendix A.

7. In our opinion, subject to paragraph 5 and 6 above, the financial statements referred to above present fairly, in all material respects, the receipts, expenditure and closing balances of cash, receivables and payables of the Project for the period September 1, 1990, to September 30, 1992 in conformity with generally accepted accounting principles.

8. This report is intended solely for the use of ADRA and USAID.

K.B. Chitrakar

K.B. CHITRACAR & CO.
Chartered Accountants





ADRA



CHILD SURVIVAL PROGRAM

Adventist
Development and
Relief Agency

P.O. Box 4481
Kathmandu, Nepal
Phone: 411874
Telex: 2640 ADRA NP
Fax: 977-1-410599

ADRA International
12501 Old Columbia Pike
Silver Spring, MD
USA 20904

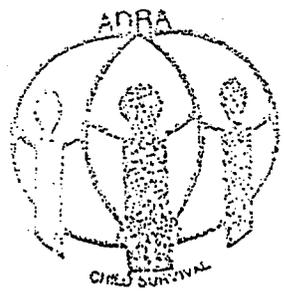
ADRA NEPAL CHILD SURVIVAL PROJECT VI USAID COOPERATIVE AGREEMENT NO. OTR 0500-A-00-0098-00

Statement of Cash, Receivables and Payables as at September 30, 1992

	<u>Nep. Rupees</u>	<u>US Dollars</u>
Bank balances in US Dollars		
USAID Fund	1,655,681	35,606.04
ADRA Fund	57,852	1,244.13
Balances in Nepalese Rupees		
Bank and Cash balances	23,623	
Advances and Deposits	408,955	
Accounts Payable	-83,078	
Total	<u>349,500</u>	<u>7,516.14</u>
Net Current Assets	<u>2,063,033</u>	<u>44,366.31</u>

The notes on page 10 form part of this statement

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ADRA



CHILD SURVIVAL PROGRAM

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ADRA NEPAL CHILD SURVIVAL PROJECT VI

USAID COOPERATIVE AGREEMENT NO. OTR 0500-A-00-0098-00

ADRA International
12501 Old Columbia Pike
Silver Spring, MD
USA 20904

Schedule of Expenditures

for the period September 1, 1990 through September 30, 1992

	Nep. Rupees	US Dollars
1. Expenditure charged to USAID Fund		
Procurement	586,440	14,248.51
Evaluation	59,966	1,581.97
Other Program Costs		
Supplies	229,447	6,053.04
Services	130,327	3,438.17
Consultants	1,420,104	32,270.13
Personnel Administration	390,853	10,311.11
Personnel Technical	630,596	16,635.79
Personnel Clinic	352,910	9,310.15
Personnel Other	198,106	5,226.23
Travel	370,855	9,760.55
Program Cost	933,867	24,141.23
Other Direct Cost	846,101	22,321.03
Total	6,149,573	155,297.91
2. Expenditure charged to ADRA Fund		
Procurement	794,448	20,958.37
Other Program Costs		
Supplies	572	14.54
Services	39,762	1,048.95
Total	834,782	22,021.87
Total Expenditure for the period	6,984,355	177,319.78

The notes on page 10 form part of this statement

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ADRA NEPAL CHILD SURVIVAL PROJECT VI

Note on the Fund Accountability Statement

for the period September 1, 1990, to September 30, 1992

1. Significant Accounting Policies

a. The Fund Accountability Statement expressed in Nepalese Rupees and their US dollar equivalent, is prepared in accordance with the historical cost convention.

b. Expenditure is accounted for on an accrual basis.

c. Incomes relate to fund transfers from ADRA International out of USAID Contribution and ADRA Contribution as per the Cooperative Agreement for the project, in cash as well as account transfer for expenditure incurred by ADRA International for the Nepal program.

d. Expenditures from fund transfer in cash are translated to US Dollar using an average rate for the statement period of US\$1 = Rs. 37.906. Assets and liabilities are translated at the closing rate of US\$ 1=Rs. 46.50. During the period, the exchange rate ranged from Rs. 29.90 to Rs. 46.50.

e. Account transfer of expenditure incurred by ADRA International for the Nepal Program are given in US Dollars and translated in Nepalese Rupees using an average rate for the statement period of US\$ 1 = Rs. 45.838. During the period, the exchange rate ranged from Rs. 42.60 to Rs. 46.50.

2. Component Unit of ADRA Nepal

The Fund Accountability Statement which includes the Statement of Sources and Utilization of Fund and the Statement of Cash, Receivables and Payables presents only the transactions and balances of ADRA Nepal as they pertain to the Cooperative Agreement for the Child Survival Project VI Nepal Program and are not intended to present fairly the income, expenditure, assets and liabilities of ADRA Nepal as a whole.

3. Non-expendable property

The expenditure includes US\$ 45,047.14 worth of non-expendable property having unit cost exceeding US\$ 500.

4. Expenditure incurred by ADRA International

Account transfer by ADRA International for expenditure incurred on behalf of the Nepal Project is subject to final confirmation of ADRA International.

5. Indirect Costs

Indirect costs as per the Cooperative Agreement have not been charged to the accounts of the Project to date.

6. Outstanding Liabilities

The amount of liabilities outstanding for utilities and severance compensation payable to staff as at September 30, 1992 which has not been booked in the accounts is estimated to be Rs 163,117 equivalent to US \$ 3,508.

B. K. Kharel



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October 6, 1993

**Mr. Paul Dulhunty
Country Director
ADRA Nepal
Child Survival Project VI
Nepal**

Dear Mr. Dulhunty

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Independent Auditor's Report on the Systems of Internal Control

1. We have audited the accompanying Fund Accountability Statement of the ADRA Nepal Child Survival Project pertaining to its Cooperative Agreement No. OTR 0500-A-00-0098-00 with the USAID, Washington D.C., as it relates to the Nepal Program for the period September 1, 1990, to September 30, 1992.
2. This Statement, comprising the Statement of Sources and Utilization of Fund and Schedule of Expenses together with the closing balances for cash, receivables and payables for the period September 1, 1990, to September 30, 1992 and the notes thereon, is the responsibility of ADRA Nepal's management. We have issued our report thereon dated October 6, 1993.
3. Except for the matter noted in paragraph 5 of our report on the Fund Accountability Statement, we conducted our audit in accordance with generally accepted auditing standards and Government Auditing Standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.
4. In planning and performing our audit of the financial statements of ADRA Nepal, we considered its internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control structure.

5. The management of ADRA Nepal is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control structure policies and procedures. The objectives of an internal control structure are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with generally accepted accounting principles. Because of inherent limitations in any internal control structure, errors or irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of the structure to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

6. For the purpose of this report, we have classified the significant internal control structure policies and procedures in the following categories:

- Cash disbursements
- Payroll
- Procurement Policy
- Property and equipment
- Program cost

7. For all of the internal control structure categories listed above, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation, and we assessed control risk.

8. As a result of these procedures, and in accordance with Government Auditing Standards, we limited our reliance on the internal control structure as, given the small size of the entity, an adequate structure for the purpose of audit reliance was considered not to be in existence. As a consequence, we adopted a substantive testing approach in our audit of the Fund Accountability Statement.

9. We noted certain matters involving the internal control structure and its operation that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect the organization's ability to record, process, summarize, and report financial data in a manner that is consistent with the assertions of management in the financial statements.
10. Our audit revealed the reportable conditions set out in summary on page 14, and in detail on pages 15 to 16.
11. A material weakness is a reportable condition in which the design or operation of one or more of the internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.
12. Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses as defined above. However, we believe none of the reportable conditions described above as a material weakness.
13. This report is intended solely for the use of ADRA and USAID.

K.B. Chitrakar

K.B. CHITRACAR & CO.
Chartered Accountants

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Summary of Findings on Internal Control System

1. Cancellation of Supporting Documents
2. Safeguarding of Property
3. Maintenance of Property Register
4. Documentation for Payroll

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of findings on Internal Control System

1. Cancellation of Supporting Documents

Condition

Supporting documents for payments were not canceled and stamped "PAID".

Criteria

One of the effective internal control measures requires that supporting documents for cash disbursements must be canceled to prevent possible re-use.

Cause

The project's accounting staff were not aware of the practice of canceling supporting documents.

Effect

The bills already paid if not duly stamped "PAID" might be re-used to support invalid disbursements.

Recommendation

The projects should establish and implement procedures to cancel all supporting documents upon payments.

Management's comment

The recommendation is accepted.

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of findings on Internal Control System

2. Safeguarding of Property

Condition

Although insurance was obtained for vehicles, insurance coverage against risks of loss was not taken out for office equipment.

Criteria

One of the internal control measures requires that proper measures should be taken for the safeguard of assets against risks of loss and damage.

Cause

The management had inquired about insurance coverage for equipment through proper channels, but did not receive a reply and did not follow up. The management felt the risk of loss was minimal given the location of the office and the twenty-four hours a day watchman.

Effect

With no insurance coverage undertaken, there is risk of loss due to accidental fire or theft.

Recommendation

Equipment should be adequately insured against the risk of fire and burglary.

Management's comment

There is around the clock security watchman at the office site as well as anti-burglary iron work on the windows. The office is located in a very low crime neighborhood. However, appropriate insurance coverage will be investigated.

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of findings on Internal Control System

3. Maintenance of Property Register

Condition

A property register was maintained, however, it did not contain all of the information required under USAID or ADRA guidelines.

Criteria

ADRA/I Financial Procedure Manual, Guideline No. 10 as well as USAID guidelines requires proper recording and physical verification of non-expendable property.

Cause

The project's staff were not effectively following the ADRA/I Financial Procedure Manual Guidelines No 10.

Effect

Numerous items of property located at scattered places might be lost or misused.

Recommendation

The Project should maintain a Property Register with complete details as required under guidelines and verify the physical existence and condition of all non-expendable property periodically.

Management's comment

The property register has been updated to include all information as required by USAID and ADRA guidelines. All equipment is accounted for, and equipment condition will be noted at the time of annual physical inventory.

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of findings on Internal Control System

4. Documentation for Payroll

Condition

Daily Time Record (DTR) was not attached with Individual Pay sheets.

Criteria

Effective internal control measure on payroll requires employees DTR or its equivalent as minimum documentation.

Cause

Employees are required to keep and submit DTRs, which are signed by the supervisor, however they are filed separate from the Payroll sheets.

Effect

The payroll disbursement might be questioned.

Recommendation

A copy of DTR should be attached to the monthly payroll.

Management's comment

The recommendation is accepted.

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October 6, 1993

Mr. Paul Dulhunty
Country Director
ADRA Nepal
Child Survival Project VI
Nepal

Dear Mr. Dulhunty

**ADRA NEPAL CHILD SURVIVAL PROJECT VI
Independent Auditor's Report on Compliance with
Agreement Terms, Applicable laws and regulations**

1. We have audited the accompanying Fund Accountability Statement of the ADRA Nepal Child Survival Project pertaining to its Cooperative Agreement No. OTR 0500-A-00-0098-00 with the USAID, Washington D.C., as it relates to the Nepal Program for the period September 1, 1990, to September 30, 1992.
2. This Statement, comprising the Statement of Sources and Utilization of Fund and Schedule of Expenses together with the closing balances for cash, receivables and payables for the period September 1, 1990, to September 30, 1992 and the notes thereon, is the responsibility of ADRA Nepal's management. We have issued our report thereon dated October 6, 1993.
3. Except for the matter noted in paragraph 5 of our report on the Fund Accountability Statement, we conducted our audit in accordance with generally accepted auditing standards and Government Auditing Standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

4. Compliance with laws, regulations, contracts, and grants applicable to ADRA Nepal is the responsibility of ADRA Nepal's management. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of ADRA Nepal's compliance with certain provisions of laws, regulations, contracts, and grants. However, the objective of our audit of the financial statements was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.
5. Material instances of noncompliance are failures to follow requirements, or violations of prohibitions, contained in laws, regulations, contracts, or grants that cause us to conclude that the aggregation of the misstatements resulting from those failures or violations is material to the financial statements.
6. The results of our tests of compliance disclosed some material instances of noncompliance, the effects of which have not been adjusted for in the Fund Accountability Statement. They are set out in summary on page 21, and in detail on page 22 to 24.
7. We considered these instances of noncompliance in forming our opinion on whether the financial statements are presented fairly, in all material respects, in conformity with generally accepted accounting principles and have made appropriate qualifications in our report on the Fund Accountability Statement.
8. Except as described above, the results of our tests of compliance indicate that, with respect to the items tested, ADRA Nepal complied, in all material respects, with the provisions referred to in the third paragraph of this report; and, with respect to items not tested, nothing came to our attention that caused us to believe that ADRA Nepal had not complied, in all material respects, with those provisions.
9. This report is intended solely for the use of ADRA and USAID.

K.B. Chitrakar

K.B. CHITRACAR & CO.
Chartered Accountants

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Summary of Findings on Compliance

1. **Income Tax not deduction at source**
2. **External consultants' local expenses not supported by agreements.**
3. **Repairs on old vehicle purchased not allowable.**

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of findings on Compliance

1. Income Tax Deduction at Source

Condition

Income tax on salary and house rent are not deducted at source and deposited with the tax office.

Criteria

As per the provision of Income Tax Act 1974, tax deduction at source is required and the amount should be deposited with the tax office within 15 days of deduction.

Cause

The management had been under the impression that it was exempt from withholding tax due to its status as an INGO.

Effect

The Project is exposed to the liability as per tax legislation.

Recommendation

The management should make it sure that the employees file income tax returns immediately. Henceforth, tax should be deducted on all payments as per tax law.

Management's comment

The recommendation has already been implemented in F. Y. 1992/93.

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of findings on Compliance

2. External consultants' local expenses

Condition

Expenses are incurred locally as well for lodging, food, excess baggage, medical check up, visit fees, etc., of external consultants. Agreements with them are not available for audit verification.

Criteria

If the expenses are required to be incurred as per agreements, they should be available for audit verification.

Cause

Expenses are incurred as per ADRA/I advice.

Effect

The expenses may be disallowed if they are not as per agreement and guidelines.

Recommendation

The payments should be supported by full documentary evidence.

Management's comment

The contracts and documentation are located at the recipient's office where the primary dispersal is made. The recipient's external auditors Ernst and Young can verify this.

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of findings on Compliance

3. Vehicle Purchases & Repairs

Conditions

A second hand vehicle was purchased at Rs 98,000 out of ADRA Fund. Heavy expenses incurred on repairs amounting to Rs 116,530 was charged to USAID Fund. However, the charge to USAID fund was reduced by Rs 22,000 being capital gain on resale of the vehicle.

Criteria

Repairs incurred are not allowable cost and charged to USAID cost.

Cause

ADRA was unaware of the repair cost not being allowed to be charged to USAID fund.

Effect

The repair cost on used vehicle is not allowable under USAID guidelines.

Recommendation

All repair cost should be transferred to ADRA fund.

Management's comment

The repairs charged to USAID related to this vehicle will be transferred to ADRA fund.

Appendix A

ADRA NEPAL CHILD SURVIVAL PROJECT VI

Schedule of Questioned Costs

	<u>Nepales Rupees</u>	<u>US Dollars</u>
1. Repair of old vehicle not allowable from USAID fund	94,530	2,493.80
2. Consultants' local expenses not supported by agreements	<u>273,097</u>	<u>7,204.40</u>
Total	<u>367,627</u>	<u>9698.40</u>

APPENDIX: G

Key Indicators

Appendix 7: KEY INDICATORS OF CHILD SURVIVAL PERFORMANCE

ADRA Child Survival VI Project - Kabhre District
Results of 30 Cluster Surveys

UPDATED DATA
FEB. 1994

INDICATOR	May 1992	October 1992		August 1993	
	HP*	HP	Banepa	HP	Banepa
1. Education: Level of female education					
-none	80.53	84.03	53.19	75.00	49.17
-primary, reads	10.31	9.24	10.21	12.92	21.25
-secondary & higher	4.20			4.17	22.08
2. Employment: Woman works away from home	21.37	34.87	20.85	50.00	30.42
3. Breast Feeding: Infant fed within 8 hours after birth	72.36	72.27	73.19	75.83	70.84
4. Infant Feeding:					
Exclusive breast feeding-Infant < 4 months fed breast milk only	90.00	85.00	84.20	83.90	80.40
Introduction of foods-Infant 5-9 months fed solid or semi-solid food	37.20	74.60	66.10	77.60	68.30
Persistence of breast feeding-Infant 20-24 months still breast feeding	77.10	85.70	75.00	65.50	58.30
5. Diarrhea:					
Continued breast feeding- Child < 24 months with diarrhea in last 2 weeks, given same or more breast milk	74.00	81.08	80.88	87.70	66.10
Continued fluids- Infant with diarrhea in last 2 weeks, given same or more fluids	29.92	40.54	42.64	76.60	64.70
Continued food- Infant with diarrhea in last 2 weeks, given same or more food	20.47	31.09	36.76	50.00	42.90
Use of ORS- Children with diarrhea in last 2 weeks, given ORT (ORS sachet, SSS, cereal ORT)	33.07	32.49	57.35	34.14	56.46
6. ARI: Mother sought medical treatment for child with cough, rapid or difficult breathing in past 2 weeks		55.06	59.76	40.00	83.00
7. EPI:**					
-Children 12-23 months who had DPT1	100.00	92.90	100.00	20.60	13.30
-Children 12-23 months who had OPV3	91.70	71.40	92.30	17.60	9.60
-Children 12-23 months who had measles	75.00	53.60	61.50	17.60	9.60
-Drop out rate [(DPT1-DPT3)/DPT1] x 100	8.33	23.58	7.70	15.00	27.30
8. Maternal Care:**					
-Mothers with 2 or more doses of TT	61.08	52.09	31.71	18.80	12.50
-Mothers who had at least 1 ante-natal visit	25.95	31.09	48.94	27.92	55.00
-Mothers who had help at delivery by a TBA	1.91	2.10	2.10	4.60	7.10
-Mothers who had help at delivery by a Health professional	8.40	10.50	36.17	9.60	45.42
9. Family Planning:					
-Yes, currently using	20.69	17.24	46.55	16.00	40.31
-Do not want another child in next 2 years	81.70	78.67	73.36	75.34	80.80
Method - Tubal/vasectomy	21.43	13.33	14.81	29.60	13.50
Method - Norplant	2.38	3.33	7.41	7.40	14.90
Method - DMPA	54.76	70.00	32.10	33.30	48.60
Method - Pill	7.14	10.00	27.16	11.10	12.20
Method - Condom	0.00	3.00	6.17	11.10	6.80
10. AIDS:					
Have you heard about AIDS? (Yes responses)		13.87	47.23	19.17	55.00
Do you know how AIDS is transmitted?					
-Sexual intercourse		24.24	60.36	50.00	57.58
-Blood or blood products		18.18	43.24	32.61	57.58
-Infected needles		9.09	30.63	15.22	38.64

* In the May 1992 survey, only the Health Posts of Panchkhal, Dapcha, and Khopasi were included.

** Data collected only from mothers with EPI cards.

Appendix 7: KEY INDICATORS OF CHILD SURVIVAL PERFORMANCE

ADRA Child Survival VI Project - Kabhre District

Results of 30 Cluster Surveys

**INCORRECT DATA
USED FOR EVALUATION**

Indicator	May 1992	October 1992		August 1993	
	HP*	HP	Banepa	HP	Banepa
1. Education: Level of female education					
-none	80.53	84.03	53.19	75	49.17
-primary, reads	10.31	9.24	10.21	12.92	21.25
-secondary & higher	4.20				22.08
2. Employment: Woman works away from home	21.37	34.87	20.85	50.00	30.42
3. Breast feeding: Infant fed within 8 hours after birth	72.36	72.27	73.19	75.83	70.84
4. Infant feeding:					
Exclusive breast feeding- Infant < 4 mo. fed breast milk only	90.00	85.00	84.2	83.9	80.4
Introduction of foods- Infant 5-9 months, given solid or semisolid food	37.20	74.60	66.10	78.3	60.3
Persistence of breast feeding Infant 20-24 months, still breast feeding	77.10	85.70	75.00	65.5	58.3
5. Diarrhea:					
Continued breast feeding- Child <24 mo. with diarrhea in last 2 weeks, given same or more breast milk	74.00	81.08	80.88	86.58	62.90
Continued fluids-Infant with diarrhea in last 2 weeks given same or more fluids	29.92	40.54	42.64	43.91	35.49
Continued food-Infant with diarrhea in last 2 weeks, given some or more food	20.47	31.09	36.76	29.27	24.19
Use of ORS- Children with diarrhea last 2 weeks, given ORT (ORS sachet, SSS, cereal ORT)	33.07	32.49	57.35	34.14	56.46
6. ARI:-mother sought medical treatment for child with cough, rapid or difficult breathing in past 2 weeks	-----	55.06	59.76	51.52	71.25
7. EPI:**					
-children 12-23 mo. who had DPT1	100.00	92.90	100.00	90.9	78.6
-children 12-23 mo. who had OPV3	91.70	71.40	92.3	77.3	57.1
-children 12/23 mo. who had measles	75.00	53.60	61.5	72.7	57.1
-drop out rate [(DPT1-DPT3)/DPT1] x 100	8.33	23.58	7.7	14.96	27.35
8. Maternal care:**					
-mothers with 2 or more doses TT	61.08	52.09	31.71	49.45	39.47
-mothers who had at least 1 ante natal visit	25.95	31.09	48.94	27.92	55.00
-mothers who had help at delivery by					
-TBA	1.91	2.10	2.10	4.58	7.08
-health professional	8.40	10.50	36.17	7.50	45.42
9. Family planning					
-yes, currently using	20.69	17.24	46.55	16.00	40.31
-do not want another child in next 2 years	81.70	78.67	73.36	75.34	80.80
Method					
-tubal/vasectomy	21.43	13.33	14.81	28.57	12.99
-Norplant	2.38	3.33	7.41	7.14	14.29
-DMPA	54.76	70.00	32.10	32.14	46.75
-pill	7.14	10.00	27.16	10.71	11.69
-condom	0.00	3.00	6.17	10.71	6.49
10. AIDS:					
-Have you heard about AIDS-yes	-----	13.87	47.23	19.17	55.00
-Do you know how AIDS is transmitted					
-sexual intercourse	-----	24.24	60.36	50.00	57.58
-blood or blood products	-----	18.18	43.24	32.61	57.58
-infected needles	-----	9.09	30.63	15.22	38.64

* In the May 1992 survey, only the Health Posts of Panchkhal, Dapcha and Khopasi were included

** Data collected only from mothers with EPI cards.

APPENDIX: H
ADRA Training Inputs

APPENDIX 8 ADRA Child Survival Training Programs							
Participants	From	To	No.	Area of Focus	HP Involved	Resource Persons used	Remarks
District Supervisors	Sept 22, 1991	Sept 27	8	-national health policy, PHC -supervision/coordination -community participation -HIS -health messages		Public Health officers (3) from MOH Associate Prof. from IOM ADRA/CS staff	DHO staffs 6 days training
Field Representatives	Aug. 12, 1991	Aug 19	4	-Public Health System in Nepal -Health Messages		ADRA/CS staff	6 days training
Field Supervisors	Nov 26, 1991	Dec 2	9	-national health policy and PHC -supervision -coordination/ community participation -HIS -health messages	Dapcha Khopasi Panchkhal		6 days training
AHW's	Feb 16, 1992	Feb 24	7	-national health policy and PHC -management in HP -supervision/coordination/ community participation -HIS -public health problems -MCH services in HP	Dapcha Khopasi Panchkhal Nala	public health officers (MOH) ADRA/CS staff Local NGO (FPA/N, Jaycees)	7 days training
HPIC	Nov 17, 1991 Nov 24 Dec 1	Nov 22 Nov 29 Dec 6	4 4 4	-relation between SMH & HP's -referral system -technical skill development -sharing of ideas	13 HP's	SMH doctors and nursing staff	-SMH organized -ADRA/CS coordinated & arranged financial management
TBA's	Jan 20, 1992	Jan 30	14	-prenatal care -preparation for aseptic delivery procedure of delivery -postnatal care		DHO staff ADRA/CS staff	TBA from Banepa 10 days training
HPIC	Mar 22, 1992	Apr. 5	11	-management -coordination -supervision -community diagnosis -community participation -training -health education -public health problems	9 Kabhre HP 1 Surkhet HP 1 ayurvedic center in Kabhre	-public health officers (2) -Associate Professor (IOM) -Chief, Regional Training Center, Surkhet -Assistant Lecturer (IOM) -ADRA/CS (Doctor, T.M.)	-13 days training -certificate distributed
HPIC	July 15, 1992	July 15	11	-supervision -HIS	all HP's in Kabhre	DHO ADRA/CS	
CHV's	July 8, 1992	July 21	12	-formation of mother's groups -immunization -diarrheal diseases -nutrition		DHO	12 day training
CHV's	Aug. 2, 1992	Aug 4	90	-high risk maternal and child referral system	Panchkhal	HP staff	orientation of ADRA/CS
CHV's	Aug 11, 1992	Aug 17	90	-high risk management referral system	Khopasi	HP staff	orientation of ADRA/CS

APPENDIX 8 ADRA Child Survival Training Programs							
Participants	From	To	No.	Area of Focus	HP Involved	Resource Persons used	Remarks
TBA's	Dec 21, 1992	Jan 7, 93	70	-high risk maternal and child referral system	all 4 HP's		orientation of ADRA/CS
TBA's	Feb 15, 1993	Feb 25	13	-hand washing, -ANC -post natal care	Panchkhal	HP staff	TBA initial training
CHV's	Mar 1, 1993	Mar 28	250	-recording & reporting problem based discussion	all HP's	DHO & HP staff	work with DHO staff
VDC leaders, HP staff	Apr 7, 1993	Apr 8	20	-HPSC formation/HP activities -job description of HP staff -public participation	Nala	DHO & HPIC	
TBA's	Apr 5, 1993	Apr 16	13	-hand washing, -ANC -post natal care	Dapcha	HP staff	TBA initial training
Traditional Healers	Apr 12, 1993	Apr 13	29	-health education/MCH -service/EPI/referral	Nala	HP, DPHO, ADRA/CS staff	
HPIC ADRA/CS DHO SMH Red Cross	Apr 19, 1993	Apr 21	33	-HIS -recording and reporting	all HP & SHP of Kabhre	UNICEF, DPHO Central Region Health Director ADRA Director ADRA/CS staff	workshop on HIS
HPIC ADRA/CS DHO SMH Red Cross	Apr 23, 1993	Apr 23	33	-referral system	all HP & SHP of Kabhre	UNICEF, DPHO Central Region Health Director ADRA Director ADRA/CS staff	workshop on referral system
VDC leaders social workers	Apr 29, 1993	Apr 30	27	-HPSC formation/HP activities -job description of HP staff -community participation	Panchkhal	DPHO, SMH ADRA Director ADRA/CS staff	
VDC leaders social workers	May 3, 1993	May 4	33	-HPSC formation/HP activities -job description of HP staff -community participation	Dapcha	DPHO HPIC ADRA/CS staff	
Traditional healers	May 18, 1993	May 19	30	-health education/MCH -service/EPI/referral	Dapcha	HP, DPHO, ADRA/CS staff	
VDC leaders social workers	May 23, 1993	May 24	26	-HPSC formation/HP activities -job description of HP staff -community participation	Khopasi	DPHO HPIC ADRA/CS staff	
Traditional healers	May 26, 1993	May 27	26	-health education/MCH -service/EPI/referral	Khopasi	HP, DPHO, ADRA/CS staff	
TBA's	Aug 4, 1993	Aug 15	9	-hand washing, -ANC -post natal care	Nala	HP staff	TBA initial training
Traditional healers	Aug 8, 1993	Aug 9	27	-health education/MCH -service/EPI/referral	Panchkhal	HP, DPHO, ADRA/CS staff	
TBA's	Aug 22, 1993	Aug 27	12	-problem based discussion	Banepa PH Clinic		6 days training

APPENDIX: I

Literacy Program Evaluation

AN EVALUATION STUDY OF LITERACY
PROGRAM IN KAVRE DISTRICT

Submitted to:

ADRA/CS, KATHMANDU, NEPAL

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AUGUST, 1993

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ADRA/CS has selected women literacy program as its strategy to pursue its goal of improving the health of mother and child. This study is an attempt to evaluate the different aspects of this literacy program.

- The basic objective of this study was to evaluate the organizational structure of literacy unit, operational status, efficiency and effectiveness of the program.
- For the purpose of evaluation, two types of study tools - questionnaire and literacy test paper were developed. Literacy test was attended by 229 participants. Questionnaires were administered to 120 participants and 29 facilitators. The study covered all 15 centres. Field as well as office staff provided necessary secondary information.
- The overall impression from the evaluation of WL Program is that the program has been quite successful to create a great zeal towards learning. All most all the participants expressed their zeal for learning by repeatedly requesting for the extension of WL Program during the course of interview and informal discussion. In view of the socio-economic status of the participants and their compulsion to be heavily involved in household chores from early morning to the late evening, the creation of such zeal for learning can be considered as one of the significant achievement of ADRA/WL Program. Below are some other important findings:
 - These was absence of long-range planning concordant with project period.
 - The absence of formalized organizational structure has created role confusion among the key personnel.
 - The inclusion of "Facts for Life" as additional health course and occasional visit by health personnel in WL centres are compatible to program objective of providing health message to illiterate women.
 - The average achievement score on health was not as expected. Failure to cover the course, lack of appropriate instructional material, predominance of lecture method and comparatively low frequency of visits of health personnel specially in remote centres were identified as major factors affecting the achievement level.
 - The overall operational status of ADRA/WL Program as measured in terms of location of WL centres, class-room space, lighting system, instructional materials, teaching method, supply of books and stationery and regularity of participants was moderate.
 - Forty-one percent participants have achieved literacy skill at the literate and fully literate levels. The score of about 30 percent of the participants was too low to consider them literate. The average achievement test score on language was comparatively better than on numeracy.

- In addition to reading, writing and numerical skills, the participants acquired some knowledge of developmental activities like health, sanitation, agriculture, livestock and poultry farming.
- All facilitators were given 10 days orientation training and 2 days refresher training which they considered useful.
 - The planned operational cost in terms of enrollment was Rs 617. But in actual terms, the operational cost on the basis of enrollment and number of participants as per the register of Asar came out to be Rs 416 and Rs 549 respectively. Likewise, the operational cost on the basis of number of participants present in literacy test day and number of participants by literacy status turned out to be Rs 784 and Rs 2,126 respectively.
 - The following recommendations are made to enhance the effectiveness of the program:
 - The quality of literacy program can be improved by identifying critical planning variables and completing the planning process in time.
 - Formal organizational structure needs to be designed to remove role confusion among key personnel.
 - Past performance of WL centres should be taken as guideline for selecting appropriate program at that place.
 - Training to facilitators should enable them to make proper use of instructional materials and methods; use of local materials as instructional materials; and manage class properly.
 - The effectiveness of literacy program can be improved by qualitative supervision. This can be attained through training to supervisors, arrangement of scheduled/surprise visit of supervisors, introducing written reporting system and initiating local level supervision through literacy committee.
 - The relevance and utility of literacy program can be enhanced by designing simplified mini health course suitable to literacy program and prescribing "Facts for Life" as text book for post-literacy program.
 - Field representatives, community health workers and other field staff may be used to kindle interest and create demand for literacy program.

1.1. Background

Nearly one billion people of the world - 35% percent of the adult population - are still illiterate. Of which two-thirds are women. (Human Development Report 1993, P. 12). In Nepal, the majority of the population is illiterate. According to the census report of 1991, only 39.6 percent of the total population is literate: the male and female literacy rate being 54.5 percent and 25 percent respectively (Gorkhapatra, June 1, 1993). The adult literacy rate is considerably lower than the literacy rate. It was only 25.6 percent for 1990 (Human Development Report, 1993, p.137).

The adult literacy rate is one of the important components of Human Development Index (HDI). In an index of 173 countries of the world, Nepal's position is 7th from bottom. In such a situation, literacy program in Nepal requires no exaggeration. HMG/N, INGOs and NGOs have, therefore, adopted literacy program as an integral part of their social development strategy.

ADRA Nepal, an INGO, has conducted a Child Survival Project. The project intends to strengthen the health delivery system of HMG/N in the one hand and educate the mothers (with due emphases on health message) on the other so that an equilibrium of demand for and supply of health service is achieved.

To educate women ADRA/CS has been conducting women literacy program in 15 centres in Kabre - a district having highest infant mortality rate in the central and eastern region of Nepal (Children and Women of Nepal, UNICEF 1987). This study is to make an evaluation of this program.

1.2. Objective of the Study

The basic objective of this study was to evaluate the operational status, efficiency and effectiveness of the program in order to provide meaningful feedback to the program sponsor. The specific objectives were:

- to examine the organizational structure and process of literacy unit;
- to assess the relevance of literacy course contents and method in relation to the need of ADRA/CS;
- to determine the status of operation of literacy classes at all sites;
- to evaluate the efficiency and effectiveness of the literacy program;
- to examine the adequacy of facilitators' training program and compensation; and
- to recommend for the improvement of the literacy program in line with the demands of ADRA/CS program requirement.

1.3.1. Preliminary Work:

As the major intention of this study was to evaluate the ADRA/WL Program launched in Kavre District and to provide meaningful feed-back to the program sponsor, the matters relating to study objectives, coverage, samples and tools were finalized on the basis of mutual consultation and consent of program sponsor.

In the first phase of the study, various journals, published literatures on adult literacy and study reports on evaluation of adult literacy program were thoroughly reviewed. Then, the major objectives, existing structure and process of ADRA/WL Program were identified by way of discussions held with concerned ADRA/CS staff and the review of written documents made available to the study team. On the basis of information generated during this phase of investigation study tools were developed.

1.3.2. Study Tools:

The following two types of study tools were developed in order to evaluate the WL Program.

Literacy Test Paper: Three sets of 7-item literacy test paper were constructed to assess the literacy achievement levels of adult participants. The types and weightage of items in different components of language and numeracy are shown below:

Language Sub-category		Numeracy Sub-category	
Items	Weight	Items	Weight
1.Sentence recognition	8	1.Addition	15
2.Sentence Completion	20	2.Subtraction	15
3.Comprehension	20	3.Multiplication	10
4.Free expression	12		
	<u>60</u>		<u>40</u>

Interview Questionnaire: Two sets of questionnaires, one each for adult participants and facilitators were constructed in order to assess their reactions as to the operational status of WL Program, relevancy of course contents, teaching materials and method, local participation, effectiveness of WL Program etc.

Observation Form: Observation form was also developed to observe and evaluate teaching method and management of WL classes.

Pre-test: Literacy test papers and questionnaires were pre-tested on July 7-8, 1993 in ADRA clinic I, II and Nala WL centres. After necessary modification, the test papers and questionnaires were printed and prepared for administration.

1.3.3 Population and Sample :

Sampling Procedure : ADRA/WL Program was in operation in 15 WL centres covering 1 municipality and 9 VDCs of Kavre district. About thirty women participants, as stated by concerned ADRA/CS official, were enrolled in each WL centre. Hence, it was planned to cover all the WL centres and to administer literacy

of questionnaires was present on the day of administration of test and questionnaires. It was planned to select randomly not less than 17 percent of the participants present on that day. In case of facilitators, it was planned to include all facilitators in the sample.

Field Visit and Administration of Test : Field work was started from July 12, 1993 and completed on July 15, 1993. The WL centres were visited by strictly following the schedule prepared in consultation with the program sponsor. Administration of questionnaires and literacy test were conducted in the presence of ADRA/CS staff deputed for this purpose.

Study Sample : The total number of participants as recorded in the attendance register of the month of Asar 2050 B.S. was 364 (population) of which 255 participants were present on the day of administration of test and questionnaires. Of them 15 belong to post-literacy group and 11 participants were found unable to take test due to poor vision and other domestic reasons. Therefore, literacy test was administered to 229 participants which was about 63 percent of the population. Out of 255 participants present on the day of the test 119 (47 percent) were randomly selected and interviewed. Similarly, questionnaire was administered to 29 facilitators who were present on the day of scheduled visit. The population and sample of participants in WL centres are presented in Table 1:

Table - 1
Population and Sample of the Study

WL Centre	Population	Sample		Presence on the day of administration
		Literacy Test	Questionnaire	
ADRA Clinic I	22	17	13	17
ADRA Clinic II	26	-	3	15
Anekot	31	21	6	21
Balthali	23	8	5	8
Budol up	15	13	6	13
Budol down	28	19	10	19
Khopasi	22	11	6	14
Kusadevi	20	19	10	19
Magargaon	25	19	9	20
Mahadevsthan	31	30	9	30
Nala	28	24	13	24
Nayabasti	24	14	10	18
Phulbari	32	10	7	12
Sankhupati	24	16	6	16
Sunthan	13	8	7	9
Total	364	229	120	255

Note:

1. There was heavy rain fall on the day of test administration in Balthali and Sunthan WL centres.
2. Post literacy class was run in ADRA clinic II. Hence, literacy test was not administered.

1.3.4. Data Processing

The quantitative data obtained through literacy test and structured questionnaire administration were entered in the master-sheet. After proper classification, these data were systematically arranged in the separate tables and necessary computations, generally the percentage and mean, were done. Then, they were analyzed, interpreted and inferences were drawn. The qualitative information obtained by way of informal discussion with concerned authorities of ADRA/CS and local people; and review of relevant documents were analyzed and synthesized to shed light on the proper issues.

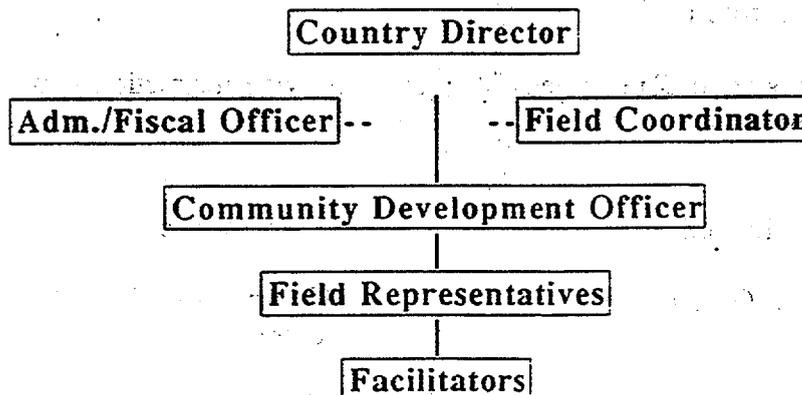
This chapter is intended to evaluate the ADRA/WL Program in terms of existing structure and process of WL Program, relevancy of literacy course, operational status of WL Program, efficiency and effectiveness of the program and issues relating to facilitators' training and compensation, on the basis of the data and information collected during the course of this study.

2.1 ADRA/WL Program Organization and Process :

This section evaluates the organizational structure, planning process, the system of supervision and monitoring, provision of instructional materials and budgetary aspects of ADRA/WL program.

2.1.1 Organizational Structure of WL Program:

Formally designated organizational structure of ADRA/WL program was not found. As stated by the Community Development Officer, the present structure turns out to be as follow:



As shown in the above chart, the Field Coordinator works on staff capacity. The Community Development Officer is responsible for the execution of WL Program. He works directly under the direction and control of the Country Director in close co-operation with the Administrative/Fiscal Officer and Field Coordinator. He is assisted by four Field Representatives who supervise WL classes in their respective field area. Thirty facilitators, two in each WL centre, are appointed to conduct WL classes. They are put under the control of Community Development Officer.

During the course of our discussion with some key personnel of ADRA/CS a remarkable difference was found in their perception as regards to the organizational structure of ADRA/WL Program. It indicates that these authorities were facing a situation of role confusion. The prevalence of such situation may be detrimental in the long-run. Therefore, it is necessary to design the organization structure of WL Program by clearly specifying the authority, responsibility and roles of key authorities like Community Development Officer, Administrative/Fiscal Officer and Field Coordinator.

Planning in ADRA/CT is a team work. The administrative committee represented by Administrative/Fiscal Officer, Field Coordinator, Community Development Officer and other concerned staffs looks after matters relating to formulation of plans and program of various ADRA/CS activities including Women Literacy Program. It takes decisions within the broad policy frame-work of the project. Decisions in matters like fixation of number of WL centres, their location, training of literacy personnel are taken by this committee.

Number of centres and Participants: At present, 15 centres are running at different sites within the project command area. The number of centres were determined on the basis of the demand from local community, availability of funds, availability of man-power and recommendation of field representatives, social workers, VDC Chairman and ward Chairman.

It was planned to enroll 30 participants in each centre. The actual enrollment was also around 30 in most of the centres except a few exceptions - Anekot 42 and Phulbari 52.

Manpower: Except 30 facilitators, no additional man-power was employed to look after literacy program. All managerial as well as supervisory works were carried by the exiting staff of the project. The effectiveness of the provision of two facilitators in each centre is an issue to reconsider while planning the manpower for literacy program in future.

Instructional materials: The project planned to provide instructional materials in the following manner:

Items to be distributed	Party to receive
Four primers (Naya Goreto I-IV)	30 participants in each centre
Stationery (Exercise-books and pencil: as per requirement)	All participants
Blackboard, charts and posters etc. Post-literacy books	Each centre Participants who complete literacy class
Reference books (Facts for Life)	Facilitators

The following are some of the issues identified with respect to instructional materials planning of the current session:

Only the items to be distributed was listed. But another important aspect of planning - the timing of distribution - was ignored. This generated problems in execution. For example, Naya Goreto-iv was distributed only a few days before the scheduled closing date(Asar last).

Next, about 85 percent facilitators suggested that there must be timely supply of primers to make the literacy program more effective. Our query with Community Development Officer revealed that the main reason of late supply of the primers was because of failure to order the books in time. This highlights the need for systematic material planning.

The session schedule was extended for one month with a view to achieve the additional objective, that is providing health message to illiterate mother. But it was not accompanied by necessary logistic support.

Session Schedule : Current session was scheduled to operate from 5th of Poush to the end of Asar with 161 working days. The classes were run 5 days a week, two hours a day and mostly in the evening.

One important planning input from the survey relates to the beginning and ending of the session. Out of 61 respondents 38 percent suggested that the session should begin by the end of Kartik; next 38 percent stated that it should begin in the month of Marg and rest 24 percent preferred the month of Poush. Only 32 respondents clearly expressed their opinion as to when the session should end. Out of them, about 91 percent reported that the session should be completed by Jestha

Budget: The budget and actual expense (upto the end of Asar) was as under:

	Planned	Actual
Books and stationeries for participants	Rs 80,025	Rs 26,663.75
Allowance for facilitators	1,69,050	1,54,590.00
Others (Black-board Class-room light-management Graduation exp, miscellaneous exp)	<u>47,670</u>	<u>18,631.50</u>
	Rs <u>296,745</u>	Rs <u>1,99,885.25</u>

NOTE:

The program has been extended to the month of Srawan. Therefore, Rs 16,800 for remuneration (for 16 working days); Rs. 15,000 for graduation program and Rs.22,500 for post- literacy books remains to be expended.

The approximate unit cost per participant is calculated as follows:

	Planned	Actual (up to end of Asar)
i. On the basis of enrollment (N=481)	617	416
ii. On the basis of number of participants as per attendance register of the month of Asar (N=364)	815	549

- iv) On the basis of the number of participants by literacy status (N=94)
- | | | |
|--|------|------|
| | 3157 | 2126 |
|--|------|------|

2.1.3 Supervision and Monitoring:

Officially, out of 15 centre, 7 centres are under the direct supervision of Community Development Officer and rest 8 centres are supervised by field representatives. Some note-worthy issues regarding supervision are:

- None of the field representatives have participated in supervisory training.
- Since field representatives are pre-occupied in other project activities they used to consider WL class supervision as of secondary importance. This is evident from the fact that they had no schedule of WL class supervision. Rather they used to visit WL classes whenever they had other assignment in that locality.
- In the absence of training, one can not expect qualitative technical supervision.
- In one case, the field representative was in leave for last 2 months. The replacing field representative visited the centre for the first time with our team.
- In another case, a facilitator reported that about 2 months were disturbed because of late supply of primers and lighting problems which is a clear manifestation of weak supervision and monitoring.
- Written reporting system about literacy supervision does not exist in the office.
- There is no scheduled/surprise visit system from the office bearers.
- There is no local level supervisory committee.
- The poor quality of supervision is also evident from the fact that the office bearers were found unable to state whether the classes in a few centres are currently running in the morning or evening.

On our query about the need of supervision all facilitators viewed that they felt the need of supervision. About 60 percent suggested that the supervision should be carried on by the project staff; about 11 percent suggested it to be carried on by local supervisory body and rest 29 percent suggested it to be done by project staff as well as local supervisory body.

Further, in the opinion of more than 80 percent of the facilitators, proper supervision can improve the effectiveness of the literacy program.

Proper selection of facilitators, their training and compensation are key to the success of literacy program. Altogether 30 facilitators were selected and trained for conducting 15 WL centres. Out of them one left the job and next was replaced by an untrained one. Thus 29 facilitators are working at present.

Basic criteria laid down for the selection of facilitators were academic qualification and experience. In addition, preference was given to female candidate who was recommended by field representatives, social workers, VDC Chairman and Ward Chairman.

These facilitators were given 10 days' (Dec. 6-16, 1992) orientation training followed by 2 days' (April 25-26, 1993) refresher training. The training program focussed on the role of non-formal education, principles of adult learning, methods of non-formal education, teaching lessons of Naya Goreto, methods of numeracy teaching, evaluation techniques and class-room management.

The response of facilitators (N=28) on training was positive. Almost all facilitators found the training useful. They stated that clear explanation of the subject matter, the use of posters and charts, role-playing, group division and discussions were the positive aspect of training.

On duration factor there was no consensus as in usefulness of the training. About 70 percent facilitators (N=27) considered the duration of training adequate and the rest considered it inadequate. Similarly, about 62 percent facilitators (N=21) responded that they got sufficient opportunity to learn functional skills. But our observation as to the use of skill in teaching by the facilitators was mixed.

At the current session facilitators were paid at the rate of Rs 35 per day. About 52 percent of facilitators suggested that the rate should be increased to improve the effectiveness of literacy program.

2.2. Relevancy of Literacy Course :

- Since the primary objective of ADRA/WL Program was to make the mother conscious of her children's health and sanitation, an attempt was made to find out to what extent the program had been effective to achieve this objective. A written test was given in order to evaluate the level to which the participants had acquired primary knowledge about health and sanitation. The test paper consisted of items relating to family planning, maternal child health care, immunization, nutrition, diarrhoeal diseases and sanitation. Test questions were based on the contents covered in primers prescribed for study and "Swasthya Jeevan ko Saral Tarika" which was found to be distributed to facilitators in each WL centre to be used as basic instructional materials for health and sanitation.

Test Scores : The average score on this test as shown in Table 2 was found to be 35.54. It means the level of participants in terms of acquisition of knowledge about primary health care was not so much encouraging. However, it reveals the fact that the program had been successful to put some input which could be of a great significance in creating consciousness towards health and sanitation.

WL Centres had the following scores on health and sanitation tests: Sankhupati, Nayabasti, Phulbari and Khopasi WL Centres were found to be satisfactory in health and sanitation tests, the scores being 57.50 percent, 53.20 percent, 53 percent and 52.75 percent respectively. The average achievement of ADRA clinic I, Budol down and Kusadevi WL Centres on health and sanitation tests was found to be moderate; the scores being 42 percent, 38.50 percent and 45 percent respectively. The average scores of Balthali, Budol up and Sunthan WL Centres was 37.50 percent, 38.50 percent and 30 percent respectively; which was not so much encouraging. The score of Magargaon and Nala WL centres was poor; being 20.25 percent and 22.70 percent respectively. The achievement of Mahadevsthan and Anekot WL Centres was very poor. The former scored only 1.35 percent and the latter 3.30 percent.

Table-2
WL Centrewise Scores on
Health and Sanitation Tests

WL Centre	Average Scores (%)
ADRA Clinic I	42.00
Anekot	3.30
Balthali	37.50
Budol up	38.50
Budol down	40.50
Khopasi	52.75
Kusadevi	45.00
Magargaon	20.25
Mahadevsthan	1.35
Nala	22.70
Nayabasti	53.20
Phulbari	53.00
Sankhupati	57.00
Sunthan	30.00
ADRA/WL Program Total	35.54

Perception of Participants : Out of the 109 respondents selected for interview, only 95 respondent answered the question relating to health and sanitation. Of them about 60 percent respondents reported that the health personnel used to visit their centre and take health classes. The remaining 40 percent participants who did not know about the visit of health personnel, most probably, might have been absent at the time of their visit. Out of the respondents who knew about such visit, about 43 percent had participated in more than 5 classes, about 27 percent in 2 to 3 classes, and about 16 percent in 4 to 5 classes. The large majority of the respondents felt that the lectures delivered by health personnel in the health classes were very useful in their day to day life. About 94 percent of the total respondents were found to be highly impressed by the health classes and quite interested to participate in such classes. Of them the majority (54%) stated that health classes should be conducted at least 4 times each month. About 24 percent respondents viewed that such classes should be taken 2 to 3 times each month and about 11 percent more than 5 times each month. It suggests that the WL Program has been quite successful to make the participants more conscious about health and sanitation.

...that they had to cover all the contents of "Swasthya Jeevan ko Saral Tarika". The major reasons, as stated by them, were slow progress of participants (48.28%), inadequacy of time (37.93%) and failure to make the book available in time (17.24). This outcome reveals that the major factor responsible for poor achievement on health and sanitation tests was the failure to cover all the course content in class.

All the facilitators interviewed stated that the participants were interested (highly 48.28% and moderately 48.28%) to read "Swasthya Jeevan ko Saral Tarika". In view of the facilitators "Swasthya Jeevan ko Saral Tarika" was easy (41.38), interesting (65.52%) and useful (86.21%). Only a negligible number (6.90%) stated it difficult. It suggests that "Swasthya Jeevan ko Saral Tarika" is most relevant book to meet the basic objective of ADRA/WL Program. However, in view of literacy standard of the participants and time factor, it seems better to prescribe this book as a text book for post-literacy group.

For WL classes a supplementary mini health course needs to be developed. Emphasis on scheduled visit of health personnel and demonstration classes may help to fulfil ADRA/CS objective of enhancing health consciousness among illiterate women.

2.3. Operational Status of ADRA/WL Program :

A convenient location, suitable class-room condition, suitable instruction materials, dedicated facilitators and interested adults are the pre-requisites for the successful operation of the literacy program. Hence, the existing operational status of ADRA/WL Program is assessed in terms of location of WL centres, class-room space, light, instructional materials and methods, regularity of the participants, and supply of books and stationeries.

2.3.1. Perception of Participants and Facilitators :

Location: The location of the most of the WL centres was found to be convenient and easily accessible to the participants. Out of the total sample of 118 respondents, about 88 percent stated that they could reach to the WL centre within ten minutes. However, in certain centres, a few participants had to walk for more than 30 minutes to attend the literacy class.

Class-room space: Out of the total sample of 115 respondents about 62 percent viewed that the class-room in terms of space, was good, about 23 percent viewed it moderate and about 16 percent reported it poor. Through observation, too, it was found that the class room space was not sufficient in six WL centres in proportion to the number of the participants.

Lighting: Out of the fifteen WL centres, four centres used petromaxes for lighting. There was electricity supply in nine centres. The literacy class was run in the morning in the remaining two centres. In view of the majority (61%) of the participants, the lighting system in their class was good. About 16 percent participants viewed it moderate and about 23 percent - poor.

Instructional materials: Four literacy primers - Naya Goreto Step-I, II, III and IV were distributed to each participant as reading materials, of which only three

...found that the V.L. centres. About 75 percent of the participants selected for interview said that they found all the primers interesting to read. The percentage of the respondents who preferred only three primers, two primers and one primer was found to be 14, 12 and 29 respectively. The major reasons for these primers being interesting, as stated by participants, were such factors as easy to follow and learn, most helpful for developing reading and writing skills, and lessons related with health and sanitation. The percentage of the respondents who reported these primers as easy to follow and learn, and useful to develop reading and writing skills was 84 and 63 respectively. Similarly, the percentage of the respondents who stated that these primers contained lessons with health and sanitation, agriculture, numeracy and poultry turned out to be 46, 39, 39 and 16 respectively. Only about 26 percent respondents viewed that the reading materials should be improved for the effectiveness of the literacy program.

Training to Facilitators : More than 90 percent of the facilitators interviewed reported that the explanation with actual objects, demonstration with posters and charts, game method, method of teaching in small group, and discussion method as good aspects of their training. About 69 percent of them viewed that the duration of their training was adequate for practical training and about 45 percent stated the time allocated for training adequate even to learn functional skills. However, the need of facilitators' further training was felt in most of the WL centres during the course of observation.

Instructional methods: Almost all the facilitators reported that the training guidelines were quite helpful in conducting WL classes and they widely used these guidelines in conducting their classes. Most of them viewed that the methods like small group division, discussion, game and question-answer were most appropriate in conducting WL classes. In view of about 24 percent respondents, the role-playing technique was also very important. However, the lecture method was found to be predominantly used in most of the WL centres during the course of observation.

Majority (65 %) of the participants viewed that the teaching methods used in their class was of average standard; about 30 percent stated good and about 7 percent-poor. About 21 percent emphasized the need of improvement in the method of teaching for the effectiveness of WL classes.

Regularity: The total number of participants enrolled in the month of Poush was 481 which dropped down to 364 in the month of Asar, the proportion of drop-outs being about 24 percent (Two points should be noted with this rate. One, the classes are still running. Two, the basis of striking off the name of participants from the register in each succeeding month is not uniform across centres). As stated by the participants themselves, the proportion of the participants missing less than 10 percent of the total classes, 10 to 20 percent classes, and more than 20 percent classes turned out to be 56 percent, 25 percent and 19 percent respectively. The major reasons for absence, as reported by the participants, were factors such as household chores (57%), sickness (46%), laziness (5%), social and religious activities (3%) interference from family (2%) and others (10%).

Stationery: A considerable gap was found between the number of exercise books and pencils needed and actually received by the participants. The majority reported that they needed in average, 2 exercise books per month, but they had received only

... facilities during the session. The quality of materials as rated by about 10 percent facilitators and irregular supply of materials, as rated by about 14 percent facilitators, were some of the major problems they had faced in conducting WL classes.

2.3.2 Operational Status Position :

In this section, attempt has been made to determine the operational status position of ADRA/WL Program on the basis of the data presented above. For this purpose an index consisting of seven items discussed above, was constructed to measure the operational status position (OS Position). The index was constructed as follows:

Items	OS Position	Weightage
1. Location -		
- Maximum time to reach WL Centre		
10 minutes	G	3
11 to 30 minutes	M	2
More than 30 minutes	P	1
2. Class-room space		
- Participant perceives		
Quite sufficient	G	3
Sufficient	M	2
Insufficient	P	1
Provided observation results do not contradict with participants' view		
3. Lighting		
- Participant perceives		
Quite sufficient	G	3
Sufficient	M	2
Insufficient	P	1
Provided observation results do not contradict with participants' view.		
4. Instructional materials		
- Participant finds all the primers interesting and serve her main purpose to join the WL class	G	3
- Participant finds only 3 or less primers interesting and serve her main purpose to join the WL class.	M	2
- Participant finds the primers interesting but they do not serve her purpose of joining WL class or feels the need of improved reading materials	P	1

Good	G	3
Average	M	2
Poor	P	1

provided observation results and facilitators' opinion relating to instructional methods do not contradict with participants' view.

6. Regularity
- Participant missing less than 10 percent of the total classes G 3
 - Participant missing 10 to 20 percent classes M 2
 - Participant missing more than 20 percent classes P 1
- provided facilitators' ratings do not contradict

7. Stationery
- Participant receives as much as she needs G 3
 - Hardly meets her need M 2
 - Receives less than she needs P 1
- Provided facilitators' view relating to adequacy and regularity of supply of materials do not contradict.

Since most of the participants failed to respond to the questions relating to the seventh item specified in the index, the OS position was calculated on the basis of six items viz: location, class-room space, lighting, instructional materials, instructional method and regularity. Of the total sample of 119 participants, only 109 responded all the questions included in OS Index. Therefore, the view of only 109 respondents was taken into consideration for the purpose of this analysis.

ADRA/WL Program: The OS scores are exhibited in Table 3. As shown in the table, the OS mean score was found to be 2.32. It indicated that the overall operational status of ADRA/WL program was moderate. The itemwise scores reveal that the operational status of the program in terms of location of WL centres and class room space was good: the score being 2.83 and 2.48 respectively. But the mean scores on lighting system, instructional materials, instructional method and regularity indicated moderate status: the scores being 2.36, 1.92, 1.94 and 2.37 respectively. It suggests that more emphasis should be given for the improvement of instructional materials and instructional method in order to make the program more effective.

ADRA Clinic I, WL Centre: Data presented in Table 3 indicate that the operational status of ADRA Clinic I WL Centre was moderate: the mean score being 2.39. The itemwise scores indicate need for improvement in class-room conditions like sitting arrangement and lighting system, instructional materials, and instructional method in order to uplift the operational status of the centre.

The overall operational status of this centre was moderate; the OS mean score being 2.20. Itemwise, the operational status of this centre turned out to be good in terms of location, class-room space, lighting, instructional method and regularity; moderate in terms of instructional materials. The location was good.

Anekot WL Centre: The operational status of this centre was moderate; the OS mean score being 2.37. Itemwise, the operational status of this centre turned out to be good in terms of location, class-room space, lighting system and regularity; moderate in terms of instructional method; poor in term of instructional materials.

Budol up WL Centre: The operational status of this centre was moderate; the OS mean score being 2.36. Location and class-room space of this centre were good. The other aspects were moderate.

Budol down WL Centre: The OS mean Score of this centre was found to be 2.05 which indicated moderate operational status. In this centre location was good. Lighting system was poor. Rests were moderate.

Khopasi WL Centre: The OS mean score of this centre was 2.08. It indicated moderate operational status. However, itemwise scores in instructional materials, instructional method and regularity were comparatively very low; the scores being 1.75, 1.50 and 1.25 respectively. Emphasis should be given to boost up these aspects.

Kusadevi WL Centre: The operational status of this centre was moderate; the OS mean score being 2.22. Itemwise, the operational status in terms of regularity was good and other aspects were moderate. However, the mean score on instructional method was comparatively low.

Magargaon WL Centre: The operational status of this centre turned out to be good; the OS mean score being 2.63. In this centre all aspects except instructional materials were good. The score on instructional materials indicated moderate status.

Mahadevsthan WL Centre: The overall operational status of this centre was moderate; the score being 2.27. However, location of the centre, lighting system and regularity were good. Score on instructional materials was moderate and on instructional method - poor.

Nala WL Centre: The operational status of this centre was moderate; the OS mean score being 2.32. In this centre, location, class-room space, regularity and instructional materials were good. However, scores on lighting system and instructional method were comparatively low.

Nayabasti WL Centre: The OS mean score, in this centre, was found to be 2.27, which indicated moderate status. In this centre, location and lighting system were good. The class-room space, although, participants perceived good; was found to be too congested in proportion to the number of participants attending class during the course of observation. Besides, the scores on instructional materials and method were also very low.

...with an overall OS score of 2.55. In this centre class-room space and lighting system were good and other aspects -moderate.

Sankupati WL Centre: The operational status of this centre turned out to be good; the OS score being 2.58. In this centre all aspects except instructional materials and method were good. These two aspects were moderate.

Sunthan WL Centre: The OS score of this centre was found to be 2.24 which indicates moderate status. The location, class-room space, and lighting system were good in this centre. However, the score on instructional materials and method were moderate and regularity -poor.

Table-3
Scores on Operational Status
By WL Centre

Centre	N	Location	Space	Light	Instructional Materials	Instructional Method	Regularity	Total
ADRA Clinic ₁	12	2.75	2.17	2.08	2.08	2.42	2.83	2.39
ADRA Clinic ₂	3	2.67	2.00	2.33		2.00	2.00	2.20
Anekoj	5	3.00	2.50	3.00	1.40	2.00	2.60	2.37
Balthali	5	3.00	1.80	3.00	2.00	2.57	3.00	2.56
Budol up	6	3.00	3.00	2.00	2.17	2.00	2.00	2.36
Budol down	10	3.00	2.20	1.00	1.80	2.20	2.10	2.05
Khopasi	4	3.00	2.25	2.75	1.75	1.50	1.25	2.08
Kusadevi	9	2.22	2.44	2.33	2.00	1.67	2.67	2.22
Magargaon	9	2.89	2.89	3.00	1.89	2.56	2.56	2.63
Mahadevsthan	8	3.00	2.13	2.63	1.88	1.38	2.63	2.27
Nala	11	2.91	2.64	1.45	2.45	1.91	2.55	2.32
Nayabasti	10	3.00	2.60	2.70	1.40	1.50	2.40	2.27
Phulbari	6	2.17	3.00	3.00	2.17	1.83	1.83	2.33
Sankhupati	4	3.00	3.00	3.00	2.00	2.00	2.50	2.58
Sunthan	7	2.86	2.71	2.86	1.57	2.00	1.43	2.24
Total	109	2.83	2.48	2.36	1.92	1.94	2.37	2.32

2.4. Efficiency and Effectiveness of ADRA/WL Program:

This section focuses on the distribution of participants by literacy category and the average achievement levels of participants in language and numeracy sub-categories by WL centre.

2.4.1. Distribution of Participants by Literacy Category:

For the purpose of this analysis the participants were classified into the following literacy categories on the basis of their scores on literacy achievement test (LAT).

Literacy Category	Scores on LA Tests
- Fully Literate	75 - 99.99
- Literate	50 - 74.99
- Semi-literate	25 - 49.99
- Non-literate	00 - 24.99

ADRA/WL Program: As shown in Table 4, out of the total sample of 229 participants about 9 percent were found to be fully literate, about 32 percent literate.

found to be about 18 percent, 29 percent, 29 percent and 24 percent respectively. However, it is worthwhile to mention that almost all the participants revealed their great zeal towards learning during the course of interview and informal discussion by repeatedly requesting for the extension of the program. In view of the socio-economic status of the participants and their heavy involvement in the household chores from early morning to late evening, creation of such zeal for learning can be considered as the greatest achievement of the ADRA/WL Program. Likewise, it is important to note that considerable follow-up assistance in the form of post-literacy program will be required for participants in the semi-literate category so as to refine and ensure retention of literacy skills.

Table-4
WL Centrewise Distribution of
Participants by Literacy Status

WL Centre	Literacy Categories				Total
	Fully Literate	Literate	Semi-Literate	Non-Literate	
ADRA Clinic-I	3(17.65)	5(29.41)	5(29.41)	4(23.53)	17(100)
Anekot	0(0.00)	3(14.29)	5(23.81)	13(61.90)	21(100)
Balthali	3(37.50)	1(12.50)	4(50.00)	0(0.00)	8(100)
Budol up	1(7.69)	6(46.15)	5(38.46)	1(7.69)	13(100)
Budol down	2(10.53)	8(42.11)	5(26.32)	4(21.05)	19(100)
Khopasi	0(0.00)	6(54.55)	5(45.45)	0(0.00)	11(100)
Kusadevi	0(0.00)	9(47.37)	7(36.84)	3(15.79)	19(100)
Magargaon	0(0.00)	3(15.79)	10(52.63)	6(31.58)	19(100)
Mahadevsthan	1(3.33)	2(6.67)	4(13.33)	23(76.67)	30(100)
Nala	1(4.17)	5(20.83)	8(33.33)	10(41.67)	24(100)
Nayabasti	2(14.29)	11(78.75)	1(7.14)	0(0.00)	14(100)
Phulbari	3(30.00)	3(30.00)	2(20.00)	2(20.00)	10(100)
Sankhupati	2(12.50)	11(68.75)	2(12.50)	1(6.25)	16(100)
Sunthan	2(25.00)	1(12.50)	1(12.50)	4(50.00)	8(100)
ADRA/WL Program					
Total	20(8.73)	74(32.31)	64(27.95)	71(31.00)	229(100)

Figures within parentheses indicate percentage.

ADRA Clinic I WL Centre: In this centre the proportion of the participants belonging to fully literate, literate, semi-literate and non-literate categories was found to be about 18 percent, 29 percent, 29 percent and 24 percent respectively. As majority of the participants are either semi-literate or non-literate, a follow-up assistance in the form of post-literacy program is necessary in order to refine and ensure retention of literacy skills acquired by them.

Anekot WL Centre: In this centre the majority (61.90%) of the participants were found to be non-literate. About 24 percent participants were semi-literate and about 14 percent literate. It indicates need for the continuity of literacy program.

Balthali WL Centre: One half of the participants in this centre were found to be semi-literate, about 13 percent literate and about 38 percent fully literate. As majority are semi-literate a follow-up assistance in the form of post-literacy program is required to refine and to retain their literacy skills.

... of the participants. Fully literate, literate, semi-literate and non-literate participants were found to be about 28 percent, 38 percent and 7 percent respectively. As majority of the participants are either literate or semi-literate, the post-literacy class is required for refinement and retention of their literacy skills.

Budol down WL Centre: About 11 percent participants were found to be fully literate, about 42 percent literate, about 26 percent semi-literate and about 21 percent non-literate. It indicates need for post literacy class.

Khopasi WL Centre: About 45 percent participants were semi-literate and about 55 percent literate. Hence, post literacy program is necessary for the refinement and retention of their literacy skills.

Kusadevi WL Centre: The proportion of literate, semi-literate and non-literate was found to be about 47 percent, 37 percent and 16 percent respectively. This proportion of literacy category indicates need for post-literacy program.

Magargaon WL Centre: Majority of the participants in this centre were either non-literate (31.58%) or semi-literate (52.63%). Only about 16 percent were found to be literate. It indicates the need for continuity of the WL program.

Mahadevsthan WL Centre: The majority (76.67%) of the participants, in this centre, were found to be non-literate. The proportion of fully literate, literate and semi-literate was only about 3 percent, 7 percent and 13 percent respectively. Hence, the continuity of WL program is highly needed in this centre.

Nala WL Centre: The proportion of fully literate, literate, semi-literate and non-literate participants was found to be about 4 percent, 21 percent 33 percent and 42 percent respectively. Since more than two-third of the participants are semi-literate or non-literate, the continuity of WL program is necessary.

Nayabasti WL Centre: Majority (78.57%) of the participants, in this centre, were found to be literate. About 14 percent were fully literate and only 7 percent semi-literate. It indicates the need for program intended to develop vocational skills.

Phulbari WL Centre: In this centre, the proportion of fully literate, literate, literate, semi-literate and non-literate participants was about 30 percent, 30 percent, 20 percent and 20 percent respectively. Since the majority of the participants are fully literate and literate, they need program intended to develop vocational skills.

Sankhupati WL Centre: Majority (81.25%) of the participants in this centre, were found to be fully literate and literate. Only about 19 percent participants fall into semi-literate and non-literate categories. The program intended for developing vocational skills will be more appropriate in this centre.

Sunthan WL Centre: One half of the participants, in this centre were found to be non-literate. About 13 percent were semi-literate, next 13 percent literate and 25 percent fully literate. Hence the continuity of WL program is desirable.

Table-5 Average Achievement Levels in Literacy Tests

The average literacy test scores are exhibited in Table 5. As shown in the table, the average literacy test score was found to be 44.37 which is below the expected level. This situation has obvious implications for periodic supervision and monitoring of progress in literacy classes.

Table-5
Average Literacy Test Scores
by Language and Numeracy Sub-categories

Literacy Category	Weightage	Average Score	Percentage
1. Language	<u>60</u>	<u>28.57</u>	<u>47.62</u>
- Sentence Recognition	8	3.32	41.50
- Sentence Completion	20	7.08	35.40
- Comprehension	20	14.55	72.75
- Free Expression	12	3.62	30.17
2. Numeracy	<u>40</u>	<u>15.80</u>	<u>39.50</u>
- Addition	15	7.13	47.53
- Subtraction	15	6.12	40.80
- Multiplication	10	2.56	25.60
3. Literacy Total	<u>100</u>	<u>44.37</u>	<u>44.37</u>

The average achievement test score on language was comparatively better than that on numeracy. The score on comprehension was satisfactory (72.75%). However, the scores in other subcategories like sentence recognition(41.50%) and sentence completion, (35.40%) were not satisfactory. In free expression the score was very low (30.17%). The average score on numeracy turned out to be 39.50 percent; the scores on addition, subtraction and multiplication being 47.53 percent, 40.80 percent and 25.60 percent respectively. These results reveal considerable differentials on inter-sub-category achievement scores. Such differentials may be expected in the situation where all the contents are not completely covered, most probably either due to lack of appropriate instructional materials or due to facilitator's failure to follow appropriate instructional method. Timely and regular supply of appropriate instructional materials, refresher training to facilitators and periodic supervision and monitoring of classes are highly desirable to overcome this situation.

WL Centre	Language		Numeracy		Total
	x	%	x	%	
ADRA Clinic	25.20	42.00	19.09	47.73	44.59
Anekot	12.82	21.37	12.90	32.25	25.75
Balthali	36.20	60.33	19.40	48.50	55.60
Budol up	27.40	45.67	21.50	53.75	48.90
Budol Down	32.04	53.40	13.25	33.13	45.29
Khopasi	35.36	58.93	13.18	32.95	48.54
Kusadevi	32.87	54.78	13.02	33.00	46.07
Magargaon	36.4	60.67	05.78	14.45	42.18
Mahadevsthan	06.73	11.22	15.17	37.93	21.90
Nala	20.00	33.33	13.47	33.68	33.47
Nayabasti	37.08	61.80	17.92	44.80	55.00
Phulbari	36.20	60.33	19.50	48.75	55.70
Sankhupati	36.40	60.67	24.00	60.00	60.40
Sunthan	25.25	42.08	13.13	32.83	38.38

ADRA Clinic I WL Centre : WL centrewise average achievement test scores are presented in Table 6. As exhibited in the Table, the average literacy test score of this centre turned out to be 44.59 percent -which is below expectation. Score on numeracy (47.73%) was comparatively better than that on language (42.00%). However, both scores were below the satisfactory level.

Anekot WL Centre : The average literacy score of this centre was found to be very low (25.75%). The score on numeracy (32.25%) was slightly better as compared to that on language (21.37%). However, both scores were far below the expected level. It indicates the need for effective supervision and monitoring on the one hand and improvement in instructional materials and method on the other.

Balthali WL Centre: The average literacy score of this centre was found to be satisfactory (55.60). The difference between the scores on language (60.33%) and numeracy (48.50%) was considerable. It indicates need for appropriate numeracy instructional materials and method.

Budol up WL Centre: The average literacy scores of this centre turned out to be 48.90 which is below the expected level. The score on numeracy (53.75%) was satisfactory. However, the score on language (45.67%) was below the expected level.

Budol down WL Centre: The average literacy achievement of this centre was not satisfactory: the score being 45.29. The score on language (53.40%) was found to be satisfactory. But the score on numeracy was below the expected level.

Khopasi WL Centre: In this centre the average literacy score was found to be satisfactory: the score being 48.54. The average achievement score on language was good (58.93%). However the score on numeracy was not satisfactory (32.95). It indicates the need for appropriate numeracy instructional materials and method.

Magargaon WL Centre: The average literacy score of this centre was found to be 42.18 which is below the expected level. The score on language was satisfactory (54.78%) but that on numeracy (33.00%) is below expected level.

Magargaon WL Centre: The literacy achievement of this centre was found to be below the expected level; the score being 42.18. The score on language (60.67%) was good. But the score on numeracy (14.45%) was very low. Emphasis should be given for the improvement of numeracy instructional materials and method.

Mahadevsthan WL Centre: The literacy achievement of this centre was found to be very poor; the score being only 21.90. The score on numeracy was 37.93 percent which is below expected level. The score on language (11.22%) was very poor. It indicates need for effective supervision, monitoring and improvement in instructional materials and method.

Nala WL Centre: The average literacy score of this centre was found to be 33.47 which is not satisfactory. The scores on both the language (33.33%) and numeracy (33.68%) were below expected level.

Nayabasti WL Centre: The literacy achievement of this centre was found to be satisfactory; the score being 55.00. The score on language was good (61.80%); but that on numeracy was comparatively low (44.80%).

Phulbari WL Centre: The literacy achievement of this centre was found to be satisfactory; the score being 55.70. The score on language was good (60.33%) and that on numeracy - comparatively low (48.75%).

Sankhupati WL Centre: The average literacy score of this centre was found to be 60.40 which is satisfactory. The scores on both the language (60.67%) and numeracy (60.00%) were consistent and good.

Sunthan WL Centre: The literacy achievement of this centre was not satisfactory; the score being 38.38. The score on language (42.08%) was comparatively better than that on numeracy (31.83).

2.4.3. Major Skills Learnt :

Participants' Perception : Out of the sample of 115 participants about 90 percent stated that they could read and write. About 65 percent responded that they had learnt some numeral skills as well. They could count and solve simple addition, subtraction and multiplication problems. In addition, they had acquired some knowledge about developmental activities like health and sanitation (79.13%), agriculture and livestock (41.74%) and poultry farming (14.78%). Besides this WL Program had made important contribution in developing reading habit. About 10 percent participants, as stated by them, used to read at home daily. About 29 percent used to read most often as soon as they got any spare time and about 61 percent used to read sometime.

Facilitators' Perception : The majority of the facilitators viewed that their participants were interested in reading (89.66%), writing (79.31%) and numeracy (65.52%). They were also interested in learning developmental activities such as health and sanitation (65.52%) and agriculture and livestock (55.17%).

They reported that their participants had been able to read and write (86.21%). Besides this, they have been more conscious about health (82.76%) and sanitation (79.31%). The majority of the facilitators (79.31%) had experienced some changes in the attitude and manner of participants. They viewed that most of the participants could actively participate in social activities.

3 Major Findings and Recommendations

3.1 Major Findings

The major findings of this study are presented below:

Planning and Organization

- Planning decisions on number and location of WL centres, number of participants in each centre, selection of facilitators, budget etc. were taken by an administrative committee which comprises key personnel of ADRA/CS.
- Determination of number of centres was based, basically, on demand from the local community, availability of funds and manpower.
- In many cases, the benefit of planning was lost by late planning.
- There was absence of formalized organizational structure relating to WL Program which had created role confusion among key personnel of the program.
- No supervisory training was organized. Therefore, technical aspect of supervision could not take place.
- There was no scheduled visit by the field representative. They used to visit literacy centre whenever they had other assignments in that locality.
- The present system of supervision was confined to check regular supply of logistics and to identify whether the classes were taking place or not.
- There was no system of surprise visit by project staff.
- The monitoring system had not been effective in the absence of written reporting system.
- In the absence of local literacy committee, no local level supervision could take place.

Relevancy of Literacy Course

- One of the objectives of ADRA/WL Programme was to make the mother conscious of her children's health and sanitation. In order to achieve this objective "Swasthya Jeevan ko Saral Tarika", a book on primary health care was distributed to the facilitators to be used as basic instructional material for teaching health and sanitation. In addition, few health classes were conducted by health personnel in each WL centre.

Health classes conducted by health personnel were found to be very useful in the day to day life of the participants. Almost all participants were found quite interested to participate in such classes and felt that such classes should be conducted at least four times each month.

The average achievement test score on health and sanitation was not found as expected. However the score indicated that the program had been successful to put some input which could be of a great significance in creating consciousness towards health and sanitation.

The inter-WL centre differentials on achievement test scores on health and sanitation were found to be remarkably wide. The following were some of the important factors responsible for such differentials and low level of achievement.

- i The course content concerning health and sanitation was not completely covered.
- ii Appropriate instructional materials for teaching health courses were not developed.
- iii Basically lecture method was followed for teaching health courses as well.
- iv Reference material for teaching health and sanitation courses was not made available in time.
- v Facilitators had been unsuccessful to manage time properly. Consequently, adequate time was not devoted to health classes.
- vi Frequency of visit of health personnel in Women Literacy Centres located in remote village was comparatively low.

"Swasthya Jeevan ko Saral Tarika" was found to be most relevant book to meet the basic objective of ADRA/WL Program. However, in view of the literacy standard of the participants and time factors, it seemed better to prescribe this book as text book for post literacy program.

Operational Status

The overall operational status of ADRA/WL Programme as measured in terms of location of WL centre, class-room space, lighting system, instructional materials, teaching method, supply of books and stationeries, and regularity of the participants was found to be moderate.

The location of the most of the WL centres was convenient and easily accessible to the participants.

The class-room space was adequate in nine WL centres. But it was found to be too congested in six WL centres even though the majority of the participants perceived it adequate.

The status of instructional materials in WL centres was not as expected. There was irregular supply of instructional materials and classes were run in the morning shift in two WL centres.

In most of the WL centres the status of instructional materials was not found as expected. The following problems were identified in this respect:

- i There was irregularity in the supply of instructional materials, text books and stationeries in some WL centres, particularly in remote villages.
- ii Most of the facilitators depended on ADRA/CS for instructional materials; only a negligible number used to develop necessary instructional materials themselves.

The instructional method used in WL classes was found to be moderate. The following deficiencies were identified:

- i Lack of appropriate instructional materials
- ii Inadequacy of training input to facilitators
- iii Predominance of lecture method
- iv Lack of proper management of time in class-room:

The operational status in terms of regularity of the participants was not so bad. The proportion of the irregular participants (those missing more than 20% classes) was found to be about 19 percent. Factors such as household chores and sickness were the major reasons of absence.

Efficiency and Effectiveness

The literacy level of the participants, as revealed by the literacy test scores, was not so much encouraging. The score of about 30 percent of the participants was found to be too low to consider them literate. Based upon the score, about 28 percent participants could be categorized as semi-literate, about 32 percent as literate and about 9 percent fully literate. However, it is important to note that it will be blunder to evaluate the effectiveness of the program solely on the basis of literacy test score. The impact of socio-economic and cultural factors on WL program cannot be completely neglected particularly in case of the society having predominantly adverse attitude towards women literacy.

The analysis of questionnaires revealed that the WL Program had been quite successful to create a great zeal towards learning. Almost all the participants expressed their zeal for learning by repeatedly requesting for the extension of WL program during the course of interview and informal discussion. In view of the socio-economic status of the participants and their compulsion to be heavily involved in household chores from early morning to the late evening, the creation of such zeal for learning could be considered as the greatest achievement of ADRA/WL Program.

The average achievement test score on language was comparatively better than that on numeracy. Subcategory wise, the scores on all sub-categories was satisfactory. The scores on sentence recognition, sentence completion, addition and subtraction was not as expected, and that on free expression and multiplication very low.

There were quite remarkable differentials on inter-subcategory and inter-WL Centre achievement scores. The following factors were considered to be responsible for such differentials and low level of literacy achievement:

- i. Failure to cover all the course content
- ii. Lack of appropriate instructional materials
- iii. Irregular supply of instructional materials, text books and stationeries
- iv. Facilitators' failure to follow appropriate instructional method
- v. Lack of periodic supervision and monitoring

All facilitators were given 10 days' orientation training and 2 days' refresher training. The training was found useful by all facilitators.

The training focussed mainly on role of non-formal education, principles of adult learning, methods of non-formal education, teaching lessons of primers, evaluation technique, and class-room management.

Clear explanation of the subject-matter, the use of poster and charts, role playing, group division and discussion were the positive aspects of training. But, it failed to impart skill on preparing and using instructional materials.

About 70 percent of the facilitators considered the duration of the training adequate and the rest considered it inadequate.

About 62 percent facilitators responded that they also got sufficient opportunity to learn functional skill. But our observation as to the use of skill in teaching was mixed.

In the current session facilitators were paid at the rate of Rs 35 per day. About 52 percent facilitators suggested that this rate should be increased to improve the effectiveness of literacy program.

Basically facilitators were selected on the basis of academic qualification and experience. Preference was given to female candidates who were recommended by field representatives, social workers, VDC Chairman and Ward Chairman. These criteria were almost followed while selecting the facilitators.

The planned operational cost in terms of enrollment, number of participants as per attendance register of the month of Asar, number of participants present on literacy test day and number of participants by literacy status turned out to be Rs 617, Rs 815, Rs 1164 and Rs 3157 respectively.

In actual terms, the operational cost on the basis of enrollment and number of participants as per an income register of Asar came out to be Rs. 119 and Rs 529 respectively. Likewise, the operational cost on the basis of number of participants present in literacy test day and number of participants by literacy status turned out to be Rs 784 and Rs 2,126 respectively.

3.2 Recommendations:

On the basis of major finding the following recommendations are made:

Planning and organization:

- Use survey data to identify and select areas with heavy concentration of illiterates.
- Complete micro-level planning - selection of centres and facilitators and provision of instructional materials in time.
- Establish coordination with other agencies - particularly those conducting literacy classes - in deciding location.
- Design formal organizational structure and make all the concerned staff clear about their authority, responsibility and roles.
- Improve coordination by bringing WL Program under direct command of the Field Coordinator.

Selection of Appropriate Program:

- Continue WL Classes in centres where more than 50 percent of the participants are non-literate.
- In WL centres, where majority of the participants are semi-literate provide a follow-up assistance in the form of post literacy program in order to refine and ensure retention of their literacy skill.
- In WL centres where majority of the participants are literate, give emphasis for program intended to develop vocational skills rather than literacy program.

Supervision and Monitoring :

- Organize training program for supervisors.
- Prepare a schedule of supervision in advance.
- Introduce a system of surprise visit by office staff.
- Initiate written reporting system of supervision in order to facilitate evaluation and monitoring.
- Design suitable forms for supervision and monitoring. Basically, two types of forms - one for record-keeping and another for reporting - need to be designed.

Facilitators' Training :

Provide necessary training to facilitators in order to enable them to :

- i. follow appropriate method of teaching;
 - ii. make proper use of the instructional materials developed by the project;
 - iii. Prepare necessary instructional materials themselves;
 - iv. Use local materials as instructional materials; and
 - v. manage class properly
- Give more emphasis on demonstration method particularly in health and sanitation classes.
 - Make necessary arrangements for health personnels' scheduled classes in each WL centres.

Text Book for Health and Sanitation:

- Prescribe "Facts for Life" as a text book for post-literacy program.
- Develop a mini health course for WL Program.

Instructional Material :

- Develop appropriate instructional material for language, numeracy, health and sanitation courses.
- Introduce the system of periodic evaluation of the instructional material developed by the facilitators and reward those who stand first and second.

Others :

- Use field representatives, community health workers, and other field staff to kindle interest and create demand for literacy program.
- Form a local level literacy committee which can help in the management and supervision of the classes.
- Prepare a list of potential facilitators so that the best facilitator can be selected within a short span of time.
- Begin session by the end of Kartik or early Marg so that the course could be completed by the end of Jestha.

Questionnaire for the Facilitators

1. Name.....
2. Age.....
3. Academic qualification.....
4. Occupation.....
5. Had you ever conducted Adult Literacy Classes ?
(a) Yes (b) No ()
6. In the training you had undergone;
(a) The duration was: (a) adequate () (b) inadequate ()
(b) Opportunity to learn functional skill was: (a) adequate () (b) inadequate ()
(c) Opportunity of practical demonstration was: (a) adequate () (b) inadequate ()
7. What were the positive aspects of training ?
(a) Clear explanation of the subject-matter ()
(b) Extensive use of posters and charts ()
(c) Use of game method ()
(d) Division in small group ()
(e) Discussion method ()
8. Do you use teaching materials in WL class ?
Yes () No ()
9. If Yes, which materials do you use ?
(a) Black-board () (b) Chart and Posters
(c) Flash Cards () (d) Others (specify)
10. From where do you get the materials ?
(a) ADRA Nepal () (b) Prepare myself ()
11. Are the participants regular ?
(a) Yes () (b) No ()
12. In your opinion which are the appropriate teaching methods ?
(a) Work in small group () (b) Role-playing ()
(c) Lecture method () (d) Question-answer ()
(e) Game methods () (f) Others (Specify)

13. Are you satisfied with the participants' activities ?
- (a) Yes () (b) No ()
14. If not, what may be the reasons ?
- (a) Lack of interest among the participants ()
 (b) Slow progress of the participants ()
 (c) Irregularities of the participants ()
 (d) Others (specify)
15. Are training-guidelines useful in conducting classes ?
- (a) Yes () (b) No ()
16. Did you complete the book "Facts for Life" ?
- (a) Yes () (b) No ()
17. If not, what were the reasons ?
- (a) Slow progress of the participants ()
 (b) Insufficient time ()
 (c) Late receipt of the books ()
 (d) Others (specify)
18. How much do the participants like the books 'Facts for Life' ?
- (a) Very much () (b) Moderate () (c) Do not like
19. In your opinion, how is the book "Facts for Life" ?
- (a) Simple () (b) Moderate () (c) Difficult ()
 (b) Interesting () (b) Moderate () (c) Boring ()
 (c) Useful () (b) Moderate () (c) Useless ()
20. In which area are the participants more interested ?
- (a) Reading () (b) Writing ()
 (c) Airthmetic () (d) Health Education ()
 (e) Agriculture () (f) Poultry ()
 (g) Others (specify)
21. In your opinion, what are the reasons of dropout ?
- (a) Sickness () (b) Marriage ()
 (c) Agricultural Works () (d) Other domestic works ()
 (e) Migration () (f) Others (specify)
22. Do you feel the need of supervision of your class ?
- (a) Yes () (b) No ()

23. Who should do it?

(a) Local literacy committee ()

(b) ADRA office ()

24. What were the difficulties that you encountered while conducting the classes?

(a) Problem of lighting ()

(b) Problem of teaching materials ()

(c) Interference from the outsiders ()

(d) Irregularity of the participants ()

(e) Lack of willingness and seriousness of participants ()

(f) Difficult to teach Primers ()

(g) Others (specify).....

25. What assistance did you obtain from the local people?

(a) Economic assistance ()

(b) Teaching materials ()

(c) Arrangement of space ()

(d) Motivation to participants to take classes ()

(e) Supervision ()

(f) Did not receive any help ()

26. In your opinion, what should be done to make the literacy program more effective?

(a) Timely and adequate supply of educational materials ()

(b) Extend the duration of the course ()

(c) Provision of supervision ()

(d) Physical facilities should be increased ()

(e) Remuneration of the facilitators should be increased ()

(g) others (specify)

27. What changes have you felt in the participants because of joining literacy classes?

(a) They have learnt reading and writing skills

(b) They pay more attention on cleanliness

(c) Health consciousness has increased

(d) Have been able to actively participate in social activities

(e) Others (specify)

Annex 2

Questionnaire for the Participants

Name Caste Age

Marital status: Unmarried Married No of Children

Occupation Mother tongue

1. Had you joined any of the following educational program before this AL class ?

- (a) School ()
- (b) AL Class ()
- (c) Learned elementary reading writing in the home ()
- (d) No where ()

2. Who inspired you to join this program ?

- (a) Friends ()
- (b) Social Workers ()
- (c) Family members
- (d) Self ()
- (e) Others (Specify)

3. What is the main objective of joining this literacy program ? (Specify)

4. How did you feel this program ?

- (a) Easy () Difficult ()
- (b) Interesting () Boring ()
- (c) Useful () Useless ()

5. Which book did you find interesting ?

- (a) Naya Goreto step I
- (b) Naya Goreto step II
- (c) Naya Goreto step III
- (d) Naya Goreto step IV

What are the reasons of your preference ?

- (a) Easy to read ()
- (b) Teaches arithmetic well ()
- (c) Teaches reading and writing ()
- (d) Provides new skill on agriculture and kitchen-garden ()
- (e) Provides new skill on poultry ()
- (f) Provides new knowledge on cleanliness and health education ()
- (g) Others (Specify)

6. How do you rate the teaching method followed in the class ?

- (a) Very good () (b) Good ()
- (c) Satisfactory () (d) Poor ()

7. How long does it take you to arrive at WL centre ?
Approximately hours (.....) minutes (.....)
8. Do some outsiders (like Health Assistant, Village Health workers etc) come to take classes ?
(a) Yes () (b) No ()
9. Do you feel that such arrangement should be made permanent ?
(a) Yes () (b) No ()
10. If yes, how often ? (Specify)
11. How is the lighting arrangement in the class ?
(a) Good () (b) Moderate () (c) Poor ()
12. How is the sitting arrangement in the class ?
(a) Good () (b) Moderate () (c) Poor ()
13. What time is the most appropriate to run the class ?
(a) Morning () (b) Day () (c) Evening ()
14. How many classes did you miss in this session ?
(Specify)
15. What were the major reasons for not attending the class ?
(a) Household chores () (b) Sickness ()
(c) Laziness () (d) Others (specify)
16. How often do you study in your home ?
(a) Regularly () (b) Often () (c) Rarely ()
17. Please specify the important things that you learned in this class.
(a) Reading/writing ()
(b) Arithmetic ()
(c) Useful information on cleanliness and health ()
(d) Modern skill on agriculture and kitchen-garden ()
(e) New skill on poultry ()
(f) Others (specify).....

18. Besides the Primers, indicate your requirement and receipt of other essential materials.

Requirement	No.	Receipt from the Project	No.
Exercise-books	...	Exercise-books	...
Pencils	...	Pencils	...
Others (specify)	...	Others (specify)	...

19. Are you interested to join post-literacy program ?

(a) Yes () (b) No ()

If yes, in which aspect the program should focus ?

- (a) Health and cleanliness (b) Language-Reading/Writing
(c) Agriculture (d) Arithmetic
(e) Farming (f) Others (specify).....

20. Among the things that you learned in WL class which has been the most useful in your day to day life ?
(specify)

21. In your opinion, in which month should such program begin and end ?

(a) Month to begin (b) Month to end

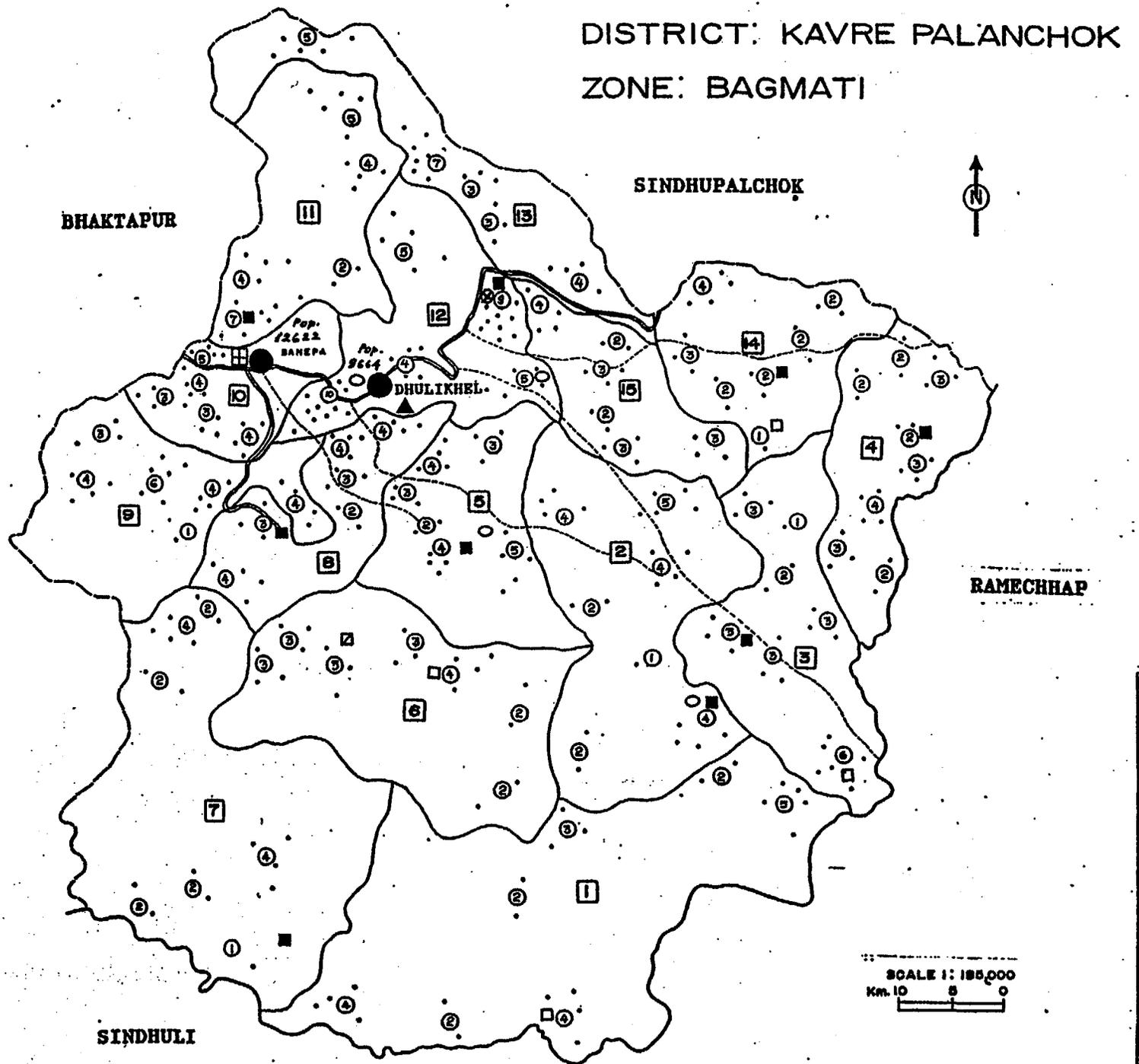
22. What measures do you suggest to make such program more effective ?

- (a) Improve teaching method ()
(b) Improve text-books ()
(c) Extend the period of the program ()
(d) Others (Specify)

APPENDIX: J

Map

DISTRICT: KAVRE PALANCHOK
 ZONE: BAGMATI



LEGEND	
1	INTERNATIONAL BOUNDARY
2	ZONAL BOUNDARY
3	DISTRICT BOUNDARY
4	ALL WEATHER ROAD
5	SEASONAL ROAD
6	TRACK
7	MUNICIPALITY
8	ILAKA No. (Figure inside Ilaka number)
9	VILLAGE DEVELOPMENT COMMITTEE (VDC) (Figure inside indicates population)
10	1991, POPULATION (1 dot = 1000 persons)

HEALTH INSTITUTIONS	
1	HOSPITAL (P.M.G.)
2	HOSPITAL (Private)
3	HEALTH CENTER
4	PRIMARY HEALTH CARE CENTER
5	NGO CLINICS
6	HEALTH POST (Ilaka)
7	HEALTH POST (STATIC)
8	SUB-HEALTH POST
9	AYURVED AUSHADHALAYA
10	Food Asst. Health Inst. (WFP)

Ilaka	Health Post	VDC/M	Population
1.	Banakhu (sub)	7	21,278
2.	Mangotar	7	22,160
3.	Narayansthan Mechhe (sub)	7	20,773
4.	Siwalaya	8	21,816
5.	Dapcha	6	20,215
6.	Bhugdeo (static)	7	19,155
7.	Shikhar Ambote (sub)	7	17,533
8.	Takhunga	6	20,058
9.	Khopast	6	22,359
10.	---	5+1	30,605
11.	Nala	5	21,845
12.	Panchkhal	4+1	33,022
13.	---	5	22,443
14.	Bhumkar Simie (sub)	7	15,529
15.	---	6	16,258
TOTAL		93+2	324,646

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APPENDIX: K
VSC Accepters Table

Appendix 15. VSC Acceptors, FY 2049-50 (Approx. 1992)

ADRA Support HP	Target	Achievement Vasectomy (VA)	Achievement Laparoscopy(LA)	Achievement VA + LA	Pentage of Target Achieved
Nala	112	44	119	163	45.531
Panchkhal	136	51	54	105	77.2
Dapcha	110	18	42	60	54.54
Khopasi	156	17	126	143	91.66
Non ADRA Supported HP					
Bhumlutar	132	13	15	28	21.21
Shivalaya	99	6	7	13	13.13
Pokharinarayan	95	13	15	28	29.47
Mangaltar	85	8	4	12	14.11

APPENDIX: L

USAID Health & Child Survival Project Questionnaire

1993 USAID Health and Child Survival Project Questionnaire

with AIDS/HIV Activities Reporting Schedule



	Pages
Main Schedule	1
Schedule 1 - Demographic	7
Schedule 2 - Diarrheal Disease Control	8
Schedule 3 - Immunization	9
Schedule 4 - Nutrition	10
Schedule 5 - High Risk Births	12
Schedule 6 - AIDS/HIV Activities	13
Schedule 7 - Other Health and Child Survival	14

Country NEPAL

Project Title EY 90 CHILD SURVIVAL GRANT TO ADRA

Project Number 938 ADRA.03

Name(s) of person(s) responding to questionnaire: _____

Title(s): _____ Date: _____

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

9. Percentage Attributions to Program Functions

This question should be answered in two steps. First complete Column A, and then complete Column B.

Step 1 - In Column A, write the percent of the Life-of-Project budget (USAID funding) that is attributable to each of the program functions listed. For further explanation, and definitions for each category, please refer to the instruction guide. The percentages in Column A should sum to 100%.

Step 2 - In Column B, write the percent of the entry in Column A devoted to Child Survival. In general, diarrheal disease/ORT, immunization, breastfeeding, growth monitoring and weaning foods, and Vitamin A are considered to be 100% Child Survival. In special cases, this may not be true and a percentage other than 100% may be entered in Column B.

PLEASE REVIEW THE EXAMPLE BELOW BEFORE COMPLETING THE TABLE

EXAMPLE

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration... (HEDD)	40%	100%	► Schedule 2
-	-	-	-
-	-	-	-
j. Water and Sanitation for Health (HEWH)	60%	20%	► Schedule 7
-	-	-	-
-	-	-	-
TOTAL, All Functions	100%		

This means that 20% of the water and sanitation component of the project is attributed to child survival.

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

9. Percentage Attributions of Fiscal Year 1993 Funds to Program Functions - Continued (See instruction guide for definitions)

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration (HEDD)			► Schedule 2
b. Immunization/Vaccination (HEIM)			► Schedule 3
c. Breastfeeding (NUBF)			► Schedule 4
d. Growth Monitoring/Weaning Foods (NUGM)			► Schedule 4
e. Vitamin A (NUVA)			► Schedule 4
f. Women's Health (HEMH)			► Schedule 7
g. Women's Nutrition (including iron) (NUWO)			► Schedule 4
h. Child Spacing/High Risk Births (HECS)			► Schedule 5
i. HIV/AIDS (HEHA)			► Schedule 6
j. Water and Sanitation for Health (HEWH)			► Schedule 7
k. Acute Respiratory Infections (HERI)			► Schedule 7
l. Malaria (HEMA)			► Schedule 7
m. Health Care Finance (HEFT)			► Schedule 7
n. Prosthetics/Medical Rehabilitation (HEPR)			► Schedule 7
o. Orphans/Displaced Children (ORDC)			► Schedule 7
TOTAL, All Functions	100%		

Project funding/budget is not broken down in this way.

FUNDING INFORMATION

10. What is the total USAID authorized LIFE-OF-PROJECT funding for this project (authorized dollar funds from ALL USAID funding accounts)? \$ _____

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

11. Commodities

During FY93, were project funds committed to the purchase of any of the following? (PLEASE CIRCLE ALL THAT APPLY.)

- a. ORS packets
- b. vaccines
- c. iron supplements
- d. vitamin A
- e. essential drugs
- f. food supplements
- g. weighing scales/growth charts
- h. contraceptives
- i. cold chain equipment
- j. laboratory equipment
- k. medical equipment
- l. educational materials
- m. audio-visual equipment
- n. construction materials for water/sanitation and other activities
- o. prosthetics
- p. other (please specify) _____

None

12. What type(s) of initiatives to stimulate or support the local private sector are a part of this project? (CIRCLE ALL THAT APPLY.)

- 1 - Assistance to privatize public health programs or services
- 2 - Training of private sector health care providers
- 3 - Involvement of for-profit businesses in project activities
- 4 - Other (please specify) _____

None

13. Training Activities

a. Please indicate which of the following groups participated in a course, workshop or training program under the project during FY93: (CIRCLE ALL THAT APPLY.) If available, also provide the number of persons trained.

	Numbers Trained	
① - Physicians.....	8	
② - Nurses.....	14	
③ - Community Health Workers.....	497	CRVs and TBAs
④ - Traditional Healers.....	112	
5 - School Teachers.....		
⑥ - Community Leaders.....	106	
7 - Mothers.....		
8 - Others (please specify).....		

b. If training was a significant component of project activities during FY93, please include a brief description of training activities and accomplishments in the space below.

Please see the attached tables on Training.

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**ADRA CHILD SURVIVAL PROJECT
TRAINING PROGRAM
Jan, 1992 - March 1993**

Date From	To	Participants	Focused Area	No.	H.P. Involved	Resource P.	Remarks
Jan 20	Jan 30,92	Traditional Birth Attendants	Prenatal Care Preparation for delivery adoesptic delivery at home	14		From Neg. divi	TBA Initial at B. Mu.
July 15	July 15	Health Post Incharges	Supervision & Health information system	11	All Health Posts	DPHO & ADRA/CS	
July 8	July 21	Community Health Volunteer	Formation of Mothers group Immunization Diarrhoeal disease Nutrition	12		From DPHO	12 day Training for CHV
Aug 2	Aug 4	Community Health Volunteer	High risk Mother and child referral system	90	Panchkhal Health Post	H.P. staff	Orientation of ADRA/CS
Aug. 11	Aug 17	Community Health Volunteer	High risk management referral system	90	Khopasi Health Post	H.P. staff	Orientation of ADRA/CS
Dec 21	Jan 7. 93	Traditional Birth Attendants	High risk management referral system	70	All four Health Post		Orientation of ADRA/CS
Feb 15	Feb 25	TBA	Hand washing Antenatal care Delivery Post natal care	13	Panchkhal H.P.	H.P. staff	TBA Initial training
Apr 5	Apr 16	TBA	Hand washing Antinatal care Delivery Post natal care	13	Dapcha H.P.	H.P. staff	TBA Initial training
Aug. 4	Aug 15	TBA	Same as above	9	Nala H.P.	H.P. staff	TBA Initial training
Aug 22	Aug 27	TBA	Problem Based Discussion	12	P.H.C.		6 days training for DHV at Banepa
March 1	March 28	CHV	Recording & Reporting Problem based discussion	250	All Health Post	DHO & H.P. staff	Work with DHO staff

**ADRA CHILD SURVIVAL PROJECT
TRAINING PROGRAM
Jan, 1992 - March 1993**

Date From To		Participants	Focused Area	No.	H.P. Involved	Resource P.	Remarks
Jan 20	Jan 30,92	Traditional Birth Attendants	Prenatal Care Preparation for delivery adceptic delivery at home	14		From Nag. divi	TBA Initial at B. Mu.
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March 1	March 28	CHV	Recording & Reporting Problem based discussion	250	All Health Post	DHO & H.P. staff	Work with DHO staff

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

14. Research Activity

Estimate the percent of Life-of-Project funds available to this project for research activities related to health and child survival _____ → 0 % IF 0% SKIP TO ITEM 15

For projects with research percentages > 0%, please provide the following information:

a. Which program functions does this research address? (PLEASE CIRCLE ALL THAT APPLY)

- | | |
|--|---|
| 1 - ORT/Diarrheal Disease | 10 - HIV/AIDS |
| 2 - Immunization/Vaccination | 11 - Water and Sanitation |
| 3 - Breastfeeding | 12 - Acute Respiratory Infection |
| 4 - Growth Monitoring | 13 - Malaria |
| 5 - Targeted Feeding and Weaning Foods | 14 - Other Vector Borne Disease Control |
| 6 - Vitamin A | 15 - Health Care Financing |
| 7 - Women's Health/Nutrition | 16 - Health Systems Development |
| 8 - Other Nutrition | 17 - Other (please specify) _____ |
| 9 - Child Spacing/High Risk Births | |

b. What types of research are being funded? (CIRCLE ALL THAT APPLY)

- | | |
|-----------------------------|---------------------------------|
| 1 - Biomedical | 5 - Policy/Economic/Development |
| 2 - Vaccine Development | 6 - Demographic Data Collection |
| 3 - Epidemiologic | 7 - Operational Research |
| 4 - Behavior/Communications | |

c. If this project has previously reported research titles, a summary list will be attached on the next page. Please review and update this list with current information.

d. If this is a new project or if there is additional research to report, please provide descriptive titles, years of the research, and the name, affiliation and address of the primary researcher. Also, please specify the program function to which the research is related, and the type of research. Program function codes 1-17 are listed in question 14a and research type codes 1-7 in 14b. (Use additional sheets if necessary.)

Title: _____

Year: BEG: _____ END: _____

Program Function Codes _____ Type Code _____

Name _____

Institution _____

Address _____

Project: 93HADRA/03

No Titles For This Project

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

HIGHLIGHTS

- 15. Given the diligent reporting efforts of PVOs in the past, information to describe project activities is readily available. The USAID Health and Child Survival Project Questionnaires, PVO Annual Reports and other routine reporting provide valuable descriptive information which is regularly used in Congressional reporting and other USAID documents. Please take a moment here to provide us lessons learned, success stories, or other highlights of your project's activities during the reporting year.

ADRA/Nepal CS VI Project:

Lessons learned, highlights, successes:

1. The project introduced minilap and Norplant services into the district during 1993. Response to Norplant has been very good with over 100 acceptors during the period; the majority are rural women. In 12 months there have been no infections and no requests for removals.
2. A referral system for clients from the Health Posts to Scheer Memorial Hospital (the district hospital) was established in June 1993 and is functioning.
3. CHVs in Banepa (urban area) have been reactivated leading to an increase in the numbers of visits of pregnant mothers for antenatal care, and their children in the PHC clinic.
4. A computerized Health Information System at the District Health Office was set up during 1993; it is now generating monthly data on FP and C/S.

- 16. Because photographs can often communicate important concepts to busy decision makers much more quickly than words, can you include photographs to supplement the above text? (If yes, please include credit/caption information, including the location and year of the photo on a separate sheet and place picture, slide, or negative in an envelope.) Do not write on photos.

Photographs included? 1 - Yes 2 - No

Schedule 1 DEMOGRAPHIC CHARACTERISTICS

1-1 What is the geographic area in which this project is delivering and/or promoting health or child survival services?
(CIRCLE ONE ANSWER)

- 1 - The entire country
- 2 - A geographic area smaller than the entire country
- 3 - None. The project does not deliver or promote services.
- 9 - Don't know

} COMPLETE ITEMS 1-2 THROUGH 1-5

} CONTINUE DIRECTLY TO NEXT SCHEDULE

1-2 In this space, state the geographic location of the project so that areas with project activities may be located on a national map.

Kavre District, Central Region, Nepal

1-3 What is the total population of the area in which the project is operating? 168,000 (1991 data)

1-4 Potential Beneficiary Population

Provide the number of potential beneficiaries in each age group:

- a. 0 - 11 months _____
- b. 12 - 59 months _____
- c. Women 15 - 44 years _____
- d. Other (please specify) _____

5,208
24,869
36,309
—

Definition: Potential beneficiaries refer to the number eligible to receive services for a given age group. This includes only potential recipients of direct services (i.e. immunizations or family planning).

e. In this space, briefly describe any other target groups on which project services/activities are focused.

N/A

1-5 Is the population served living primarily in an urban or rural area? (CIRCLE ONE)

- 1 - Primarily urban
- 3 - Mixed
- 2 - Primarily rural
- 4 - Don't know

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Schedule 2 DIARRHEAL DISEASE CONTROL

FOCUS AND ACTIVITIES

2-1 For the Diarrheal Disease Control component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1993.

	Project activity during FY93?	
	Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of dehydration	<input checked="" type="radio"/>	N
2. Enable mothers to recognize when prompt medical treatment is necessary	<input checked="" type="radio"/>	N
3. Encourage proper personal hygiene/food handling practices	<input checked="" type="radio"/>	N
b. Case management of diarrhea through:		
1. Promotion of home-based practices:		
- recommended home fluids	<input checked="" type="radio"/>	N
- sugar/salt solutions <i>cereal based ORT</i>	<input checked="" type="radio"/>	N
- continued breastfeeding during diarrhea	<input checked="" type="radio"/>	N
- other appropriate feeding during and after diarrhea	<input checked="" type="radio"/>	N
2. Promotion/Distribution of ORS packets	<input checked="" type="radio"/>	N
3. Strengthening referral mechanisms for severe cases	<input checked="" type="radio"/>	N
c. Upgrading of clinical services including the rational use of drugs	<input checked="" type="radio"/>	N
d. Training		
1. Training of health care professionals	<input checked="" type="radio"/>	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	<input checked="" type="radio"/>	N
e. Other activities		
1. Improved disease surveillance systems	<input checked="" type="radio"/>	N
2. Improved water or sanitation	<input checked="" type="radio"/>	N
3. Other (specify) _____	<input checked="" type="radio"/>	N

ADDITIONAL BACKGROUND INFORMATION

2-2 Please provide any other background information which would enable us to better understand the unique nature of the project's diarrheal disease component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

- Cereal based ORT is more practical in the rural village situation.

CHILD SURVIVAL INDICATORS

2-3 What is the ORT use rate in the project area?

a. ORT use rate _____	<i>rural</i> <i>urban</i>
b. Date(mo/yr) data was collected _____	<i>34%</i> <i>56%</i>
c. Source of the data used to make the estimate	<i>Aug. 1993</i>
	<input checked="" type="radio"/> DC <input type="radio"/> BG <input type="radio"/> DK

The definition of ORT use rate is "the proportion of all cases of diarrhea in children under five treated with ORS and/or recommended home fluid. In surveys, this rate is generally estimated as the proportion of diarrhea episodes occurring in the last two weeks treated with ORT."

d. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistics, and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

30 Cluster Survey

Schedule 3 IMMUNIZATION

FOCUS AND ACTIVITIES

3-1 For the Immunization component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1993.

	Project activity during FY93?	
	Yes	No
a. EPI promotion and services		
1. Activities directed to promote use of services	Y	N
2. Delivery of vaccination services through:		
- Mass campaigns	Y	N
- Fixed centers	Y	N
- Mobile vaccination teams	Y	N
- Outreach and follow-up services	Y	N
3. Vaccination of women with tetanus toxoid	Y	N
4. Vaccination against measles	Y	N
b. Training		
1. Training of health care professionals	Y	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	Y	N
c. Other activities		
1. Improved surveillance for vaccine preventable diseases	Y	N
2. Equipment and training for improved cold chain	Y	N
3. Other (specify) _____	Y	N

ADDITIONAL BACKGROUND INFORMATION

3-2 Please provide any other background information which would enable us to better understand the unique nature of the project's immunization component, including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. Due to the newly announced measles initiative, we are particularly interested in hearing about any measles activity undertaken through this project. (Attach additional sheets if necessary).

CHILD SURVIVAL INDICATORS

3-3 What is the vaccination coverage rate (see instruction guide for information on definitions) in the project area?

	BCG		DPT3		Polio3		Measles		Tetanus for Women	
	rural	urban	rural	urban	rural	urban	rural	urban	rural	urban
Percent vaccinated (children by 12 months, or women)	37%	28%	91%	79%	77%	57%	73%	57%	49%	39%
Date (month/year) data was collected	Aug. '93		Aug. '93		Aug. '93		Aug. '93		Aug. '93	
Source of information (CIRCLE ONE)	DC		DC		DC		DC		DC	

d. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc).

30 Cluster Survey - Data based on women + children with EPI cards.

USAID HEALTH AND CHILD SURVIVAL
PVO PROJECT QUESTIONNAIRE - FY93

Country: _____ Project Number: _____

Subproject Number: _____

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Schedule 4 NUTRITION

FOCUS AND ACTIVITIES

4 - 1 For the Nutrition component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1993.

	Project activity during FY93?	
	Yes	No
a. Breastfeeding		
1. Exclusive breastfeeding for first 4 - 6 months	<input checked="" type="radio"/>	N
2. Initiation of breastfeeding within 1 hour after birth	<input checked="" type="radio"/>	N
3. Increased duration of breastfeeding	<input checked="" type="radio"/>	N
4. Continued breastfeeding during diarrhea	<input checked="" type="radio"/>	N
5. Development of support groups or mechanisms for home visitation to counsel and assist mothers	<input checked="" type="radio"/>	N
6. Revised policy for hospitals and maternity centers	<input checked="" type="radio"/>	N
7. Policy dialogue in support of a favorable environment for breastfeeding	<input checked="" type="radio"/>	N
b. Weaning and child feeding		
1. Community education for proper child feeding practices	<input checked="" type="radio"/>	N
2. Emphasis on correct feeding during and after diarrhea and other infections	<input checked="" type="radio"/>	N
3. Development and promotion of locally acceptable weaning foods	<input checked="" type="radio"/>	N
c. Growth monitoring		
1. Use of growth monitoring as a tool for counseling mothers	<input checked="" type="radio"/>	N
2. Use of growth monitoring as a means of nutritional status surveillance	<input checked="" type="radio"/>	N
3. Strengthening of health worker skills in growth monitoring and counseling	<input checked="" type="radio"/>	N
d. Vitamin A and other micronutrient deficiencies		
1. Assessment of levels of vitamin A deficiency	<input checked="" type="radio"/>	N
2. Case detection and treatment of vitamin A deficiency	<input checked="" type="radio"/>	N
3. Vitamin A supplements for children and/or post partum women	<input checked="" type="radio"/>	N
4. Inclusion of vitamin A in treatment of measles	<input checked="" type="radio"/>	N
5. Communication activities to promote increased dietary intakes	<input checked="" type="radio"/>	N
6. Food fortification	<input checked="" type="radio"/>	N
7. Home and community gardens	<input checked="" type="radio"/>	N
8. Iron and folate supplements for women of reproductive age	<input checked="" type="radio"/>	N
e. Training		
1. Training of health care professionals	<input checked="" type="radio"/>	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	<input checked="" type="radio"/>	N
f. Other		
	<input checked="" type="radio"/>	N

SUPPLEMENTAL FEEDING TARGET GROUPS

4 - 2 If the project sponsored supplementary feeding during FY93, which groups were targeted? (CIRCLE ALL THAT APPLY)

- 1 - All ages
- 2 - Children under 12 months
- 3 - Children 12 - 23 months
- 4 - Children 24 - 35 months
- 5 - Children 36 - 60 months
- 6 - Pregnant or lactating women
- 7 - Other women
- 8 - Other _____
- 9 - None
- 10 - Don't know

Schedule 4 NUTRITION (continued)

ADDITIONAL BACKGROUND INFORMATION

4-3 Please provide any other background information which would enable us to better understand the unique nature of the project's nutrition component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

CHILD SURVIVAL INDICATORS

4-4 a. What is the rate of malnutrition in the target group served by the project?

Define: Rate of malnutrition is the percentage of children whose weight-for-age is below two standard deviations of the norm established by the National Center for Health Statistics (the norm endorsed by the World Health Organization).

	Group 1	Group 2	Group 3	Group 4
Target group	Children 0-11 months	Children 12-23 months	Other Specify	Other Specify
Estimate rate of malnutrition		rural 47% urban 30%	/	/
Date (month/year) of estimate		Aug. '93	/	/
Source of information (CIRCLE ONE)	*DC BG DK	<input checked="" type="radio"/> DC BG DK	*DC BG DK	*DC BG DK

* Source Codes: DC Data Collection System, BG Best Guess, DK Don't Know

b. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

30 Cluster survey - Armband - Midarm circumference was used as indicator of nutritional status.

Schedule 5 HIGH RISK BIRTHS

FOCUS AND ACTIVITIES

5-1 For the High Risk Birth component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1993.

	Project activity during FY93?	
	Yes	No
a. Community education to:		
1. Raise awareness of the importance of preventing high risk births	Y	N
2. Promote modern contraceptive methods for child spacing	Y	N
3. Promote breastfeeding as a method for child spacing	Y	N
4. Promote other natural family planning methods	Y	N
b. Strengthening of service delivery by:		
1. Developing a system to identify and refer high risk women for family planning services	Y	N
2. Training medical staff in clinical and counseling skills for child spacing methods	Y	N
c. Activities specifically directed at one or more of the following high risk groups:		
1. Women under age 18	Y	N
2. Women age 35 or older	Y	N
3. Women who have given birth within the previous 24 months	Y	N
4. Women with 4 or more children	Y	N
d. Training		
1. Training of health care professionals	Y	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	Y	N
e. Other (please specify)	Y	N

ADDITIONAL BACKGROUND INFORMATION

5-2 Please provide any other background information which would enable us to better understand the unique nature of the project's high risk birth component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

Detailed planning with the District Health Office is necessary due to recent reductions in MOH staff available to give services.

CONTRACEPTIVE PREVALENCE RATE

7-1 What is the Contraceptive Prevalence Rate in the target area?

- a. Contraceptive prevalence rate in area
- b. Date(mo/yr) data was collected
- c. Source of the data used to make the estimate

rural	urban
16%	40%
Aug. '93	
DC	BG DK

The definition of Contraceptive Prevalence Rate is the proportion of women aged 15-44 years, or in some countries 15-49 years, who are or married, currently using a modern method of contraception.

d. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

30 Cluster Survey

Schedule 6 HIV/AIDS ACTIVITIES

6-1 Does this project provide funding or otherwise support activities in HIV/AIDS prevention? YES NO

If your answer is YES, please use the table below to define the scope of the HIV/AIDS activities supported under this project. Provide your data in columns B through G on the basis of the Activity Categories identified in Column A.

- Column B Attribute to each specific Activity Category the corresponding percent from the total FY93 obligations to HIV/AIDS programs as listed in Question 9j of the main schedule. Column B should add to 100%.
- Column C Estimate the percent of resources supporting research for each activity reported in Column A.
- Column D From page 1, please list the organizations which were involved in HIV/AIDS activities supported under this project. Abbreviate if necessary.
- Column E Use the numbers corresponding to Target Population descriptions as appropriate for each activity.
- Column F Indicate by Y or N (Yes or No) whether activities listed in Column A are community-based with target community involvement in the design, implementation, and/or evaluation of the activities.
- Column G Please cite the number of individuals reached by prevention efforts in each activity area. Use your best guess if no data has been collected for this variable.

A Activity Category	B % of AIDS Attribution	C % Research	D Organizations Supported	E Target Population	F Community- based	G Nos. Reached FY93
BER						
CSP						
CPD						
PNR						
STD						
PDM						
OA1						
	100%					

ACTIVITY CATEGORY CODES:

- BER - Behavioral Research
- CSP - Condom Supply
- CPD - Condom Protection and Distribution
- PNR - Partner Number Reduction
- STD - STD Management and Control
- PDM - Policy Dialogue/Modeling
- OA1 - Other (please specify) _____

TARGET POPULATION CODES:

- 1 - General Public
- 2 - Community Leaders
- 3 - Children (0-8 years)
- 4 - Youth (9-14 years)
- 5 - Female Sex Workers
- 6 - Male Sex Workers
- 7 - Other Women at Risk
- 8 - Other Men at Risk
- 9 - IV Drug Users
- 10 - Health Service Providers
- 11 - STD Patients
- 12 - Other (please specify) _____

6-2 The AIDS Division of R&D/Health needs descriptive information on all Mission sponsored HIV/AIDS programs for the Agency's Report to Congress. We would encourage you to attach to this questionnaire a brief but comprehensive description on the HIV/AIDS programs your project sponsors. Providing this information now would eliminate the need for further requests for such summaries.

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Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

This schedule is designed to record information about health and child survival interventions other than those identified in schedules 2 through 6

IDENTIFICATION OF OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

7-1 What type(s) of "other" health and child survival interventions received funding or other support through this project? (CIRCLE ALL THAT APPLY)

- 1 - Acute Respiratory Infection (answer 7 - 3)
- 2 - Maternal Health (answer 7 - 4)
- 3 - Health Care Financing (answer 7 - 5)
- 4 - Malaria (answer 7 - 6)
- 5 - Water and Sanitation
- 6 - Elderly/Adult Health
- 7 - Prosthetics
- 8 - Tuberculosis
- 9 - Other (please specify) *Literacy for Women*
- Income generation for Women

7-2 Please provide any other background information which would enable us to better understand the unique nature of the project's other health and child survival activities, including those not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

FOCUS AND ACTIVITIES

For the interventions specified, please indicate which of the following activities are major elements of the life-of-project implementation strategy (in terms of project funds and human resources committed for this intervention); and 2) whether or not the project sponsored, promoted or participated in each activity during fiscal year 1993.

PLEASE ANSWER 7 - 3 ONLY IF YOU CIRCLED "1 - Acute Respiratory Infection" IN RESPONSE TO 7 - 1.

7-3 Acute Respiratory Infection Strategies	Project activity during FY93?	
	Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of acute respiratory infection	<input checked="" type="checkbox"/>	N
2. Enable mothers to recognize when prompt medical treatment is necessary	<input checked="" type="checkbox"/>	N
b. Case management of respiratory infection:		
1. Training of clinical staff in case management and treatment	Y	N
2. Training of community workers in case management and referral	<input checked="" type="checkbox"/>	N
3. Provision of equipment and timers for diagnosis	Y	N
4. Provision of appropriate drugs for pneumonia treatment _____ (specify drugs)	Y	N
5. Education of health staff and pharmacists to encourage rational use of antibiotics	Y	N
c. Other _____ (please specify)	Y	N

OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES (continued)

ANSWER ONLY IF YOU CIRCLED "2 - Maternal Health" IN RESPONSE TO 7 - 1.

7-4 Maternal Health Strategies

- 1. Communication activities to increase women's healthy practices during pregnancy, and use of prenatal care and maternity services
- 2. Training and equipment for traditional birth attendants (TBAs), midwives, and other health workers:
 - training in screening and referral of high-risk pregnancies
 - training in life-saving delivery skills
 - provision of safe delivery kits
- 3. Strengthening referral systems between TBAs, health centers, and hospitals
- 4. Integration of maternity care with family planning
- 5. Treatment of infections, especially sexually-transmitted diseases

Project activity during FY93?

Yes	No
<input checked="" type="radio"/>	<input type="radio"/>

ANSWER ONLY IF YOU CIRCLED "3 - Health Care Financing" IN RESPONSE TO 7 - 1.

7-5 Health Care Financing Strategies

- 1. Fees for health services
- 2. Income generation to support project activities: _____
(please specify)
- 3. Other _____
(please specify)

Project activity during FY93?

Yes	No
<input type="radio"/>	<input checked="" type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

ANSWER ONLY IF YOU CIRCLED "4 - Malaria" IN RESPONSE TO 7 - 1.

7-6 Malaria Strategies

a. Prevention

- 1. Public education to:
 - increase awareness of malaria and methods of prevention
 - enable mothers to recognize when and where to seek treatment
- 2. Prevention of disease transmission through:
 - personal protection methods (impregnated bednets, etc.)
 - vector control (against adult mosquitos, against larvae, etc.)
 - environmental management

Project activity during FY93?

Yes	No
<input type="radio"/>	<input checked="" type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

b. Case management of malaria

- 1. Standardization of protocols for case management
- 2. Training of community workers in case management and referral
- 3. Training of clinical staff in case management and treatment
- 4. Provision of antimalarial drugs

<input type="radio"/>	<input type="radio"/>

c. Other

_____ (please specify)

<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------