

CARE NEPAL

Child Survival XV Project

Kanchanpur District

Cooperative agreement number FAO-A-00-99-00028-00

**First Annual Report
October 1999 to September 30, 2000**

Submitted by: Child Survival Project, Kanchanpur

Contact person: Dr Sanjay Sinho, CARE-USA headquarters

List of Acronyms

ALRI	Acute Lower Respiratory Infection
ARI	Acute Respiratory Infection
CDC	Community Development Committee
CHV	Community Health Volunteers
CIB	Community Institution Building
CPR	Contraceptive Prevalence Rate
CS	Child Survival
DCM	Diarrhea Case Management
DDC	District Development Committee
DHO	District Health Officer
DIP	Detailed Implementation Plan
FCHV	Female Community Health Volunteer
FPAN	Family Planning Association of Nepal
HA	Health Assistant
HIS	Health Information System
HMG	His Majesty's Government
HP	Health Post
HPMC	Health Post Management Committee
HPU	Health and Population Unit
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
KPC	Knowledge, Practice and Coverage
LCHSSP	Logistics in Child Health Support Services
MCHW	Maternal and Child Health Worker
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NDHS	Nepal Demographic and Health Survey
NMIS	Nepal Multiple Indicator Surveillance
NNSWA	Nepal National Social Welfare Association
ORS	Oral Rehydration Solution
PCM	Pneumonia Case Management
PEM	Protein Energy Malnutrition
PIR	Project Implementation Reports
PLA	Participatory Learning Assessments
SHP	Sub Health Post
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TSO	Technical Support Office
VDC	Village Development Committee
VHW	Village Health Worker

I. INTRODUCTION:

This is the first Annual Report of the BHR/PVC funded Child Survival Project that started in Kanchanpur district in the Far Western region of Nepal in October 1999. Kanchanpur is a Terai district with a population of more than 343,000 and geo-politically divided into 19 Village Development Committees (VDCs) and one municipality. Each VDC, with a population ranging from 5,000 to 17,000, is further divided into nine wards, each of which comprises a cluster of 3-4 villages or communities. The project covers the entire Kanchanpur district with a total beneficiary population of 53,306 children under five years of age and approximately 66,630 women of reproductive age.

a) Project goals and objectives:

The *impact goal* of the project is to reduce the maternal and child mortality in Kanchanpur district.

The *specific objectives* are

- 1) Behavioral: Caregivers of children below five years of age, particularly mothers, will be practicing healthy behaviors and seeking medical care from trained sources when needed.
- 2) Increased access to services and supplies: Families will have increased sustainable access to health education, quality care, and essential medicines.
- 3) Institutional: Local and community based institutions and local NGOs with capacity to support sustainable child survival activities will be developed and strengthened.
- 4) Quality of Care: Ministry of Health (MoH) personnel, Female Community Health Volunteers (FCHVs), Traditional Birth Attendants (TBAs) and other service providers practicing appropriate case management of diarrhea, pneumonia, malnutrition, maternal and new born care.

b) Strategies:

The project has the following four major strategies:

- 1) Generating community demand: Awareness creation at community and household levels, including key decision-makers.
- 2) Improving access and availability of health services: Recruiting, training and mobilizing Female Community Health Volunteers (including training of additional FCHVs), capacity building of private health providers, pharmacists, and traditional healers.
- 3) Improving quality of health services: Quality assurance training for health facility staff; health facility assessments for quality of services; capacity building of health facility staff, volunteers and private health care providers, and Health Post and Sub Health Post Management Committees.

- 4) Increasing sustainability: Identifying and developing the capacity of local institutions (at village, ward, VDC and district level) to implement and sustain the activities, systems and structures.

II. MAJOR ACCOMPLISHMENTS AND CONTRIBUTING FACTORS:

In the first year, the project was mainly involved in collecting and analyzing baseline information, developing the Detailed Implementation Plan (DIP), sharing the implementation plan with the community and local authorities, establishing working relationship with the communities, government health facilities and local government, and implementing some training activities. Continuous involvement of local government (both at district and VDC level) and Ministry of Health authorities (at center, district and Health Post level) has greatly facilitated the start up and implementation of the project.

A. MAJOR ACHIEVEMENTS

The following matrix shows the major achievements against the planned activities as per the DIP during its first year.

Table 1- Project Accomplishment against Work Plan for First Year

Activities Planned for First Year	Achievement
Project start up	
Staff recruitment/placement	Completed
Office establishment/procurement	Completed
Staff orientation	Completed
KPC Survey	Completed
Quality of Care Assessments	Completed
DIP preparation	Completed
Qualitative data collection	Completed
Strengthen / Expand health services	
Coordination and team building with MOH	On going
Training needs assessment of MoH staff	Partially completed
Training MOH staff as per the identified needs (DPHO, HA, CMA, ANM, VHW , MCHW)	Postponed for next year
Training VDCs/HPMCs and ward level committees	Postponed for next year
Training FCHVs, (Basic training)	Completed
Develop and test supervision systems for HP/SHP staff, FCHVs, TBAs, VHWs, communities	Postponed for next year
Organize NGO federation workshop	Completed
Develop an inventory of the partners	Completed
Form a partnership management committee (Project Advisory Committee)	Completed
Develop partner selection criteria	Postponed for next year
Call for letter of interest from organization	Postponed for next year
Screening of organizations	Postponed for next year
Request for applications sent to selected NGO	Postponed for next year
PMC decides on partner NGOs	Postponed for next year
Partnership MOU signed with partners	Postponed for next year
Community mobilization	
Community orientation meetings for attaining social sanctions at district,	Completed

VDC and ward level	
Training of staff in PRA / PLA and community empowerment concepts for project and partner staff	Completed
Formation or reactivation of mothers' groups	Completed
Strengthening of mothers' groups	On going
Mobilization of community volunteers	
Orientation meeting for FCHV and TBAs	On going
Development of FCHV association at VDC level	On going
Capacity building of project staff & MOH staff	
Training on IMCI to health facility level staff (CMA, ANM)	Completed
Training on IMCI to community level worker (VHW , MCHW)	Completed
Training of FCHVs in combined CDD/ ARI	Postponed for next year
Training for TBAs	Postponed for next year
Refresher training for facility level staff	Postponed for next year
Refresher training for community level workers	Postponed for next year

As the training needs assessment could not be completed in the first year, most of the training was postponed for the next year. Some of the partnering activities were postponed due to the delay in forming the Project Advisory Committee, which was beyond the control of the project. The details of the major activities completed in the reporting period are given below.

a) Staff recruitment /Placement

There is a good mix of staff in the project, in terms of education, gender, experience and cultural diversity. A total of 33 staff members were recruited/assigned to implement the CS project in Kanchanpur district. Of these, 25 (76%) staff (Community Health Extensionist, Family Health Extensionists and Health Supervisors) are based at the field or at Village Development Committees. The project office-based staff are: Project Manager (Post-Graduate in Public Health), Community Health Officer (BSC Nursing) and six administrative support staff. Eight staff were recruited locally and the rest were transferred from other CARE Projects. Of the total staff, 39% are men and 61% are women.

At the start of the project and after writing the DIP, all staff were oriented on project goals, objectives, and operational strategies. Orientation was also given on CARE Nepal's Long Range Strategic Plan and the generic Monitoring and Evaluation system adopted by CARE Nepal.

The core responsibilities of each field staff member were identified and finalized based on the project objectives and activities and after a discussion with individual staff members. Each Community Health Extensionist (Nurse Midwife) and Family Health Extensionist (Community Medical Assistant) is responsible for implementing project activities in one VDC. One Health Supervisor (Staff Nurse) is responsible to support the CHE/FHE and project activities in 3-5 VDCs. The project proposal and selected portions of DIP translated into local language (Nepali) were distributed to the field staff. Staff found the orientation program and the Nepali documents very helpful in understanding project objectives and working approaches.

b) Knowledge, Practice and Coverage (KPC) Survey

With the help of an external consultant, baseline information on mothers' knowledge and practice was collected on five key intervention areas (Diarrhea Case Management, Pneumonia Case Management, Malaria, Nutrition/Breastfeeding and Maternal and Newborn Care) in January 2000. The generic survey questionnaire developed by the PVO Child Survival Technical Support Project was adopted for this KPC survey using a 30 cluster random sampling method. Similarly, baseline information on quality of government health facilities and service providers was also collected by assessing MoH health facilities (Health Post and Sub Health Posts). The standard WHO questionnaire for IMCI was used (including equipment and supplies checklists, health worker interviews and exit interviews with the mothers of sick

children under 5 years attending health facilities). The details of the survey methodology and results were included in the DIP.

The project also coordinated with Environmental Health Project (EHP) in conducting a comprehensive baseline survey for malaria. The data collection process is being completed now. Once the survey results are released, further discussion will be held with EHP and appropriate strategies will be developed for program intervention on malaria and operations research on the use of impregnated bed-nets.

c) Detailed Implementation Plan (DIP) Preparation

During this reporting period, the DIP was prepared with an active support from the Child Health Specialist from CARE-Atlanta and the Health Sector Coordinator from Country Office at Kathmandu. Prior to the DIP preparation, a three days' DIP design workshop was organized at Kanchanpur involving key stakeholders. Participants from government included representatives from Child Health Division -Department of Health Services, Social Welfare Council, Regional Health Directorate, District Hospital and District Public Health Office. Representation from other national and International NGOs included the district NGO coordination committee as well as PLAN International, JSI, Red Cross, Family Planning Association and NNSWA (a local NGO). Elected representatives of local government (District Development Committee and municipality) as well as the project staff were actively involved. The DIP design workshop was followed by the actual writing of the DIP, which was again discussed with stakeholders to get their suggestions for further modifications.

d) Qualitative Study on Child Feeding Traditions, Practices and Beliefs

Qualitative research in the child feeding practices and beliefs was undertaken in March-April 2000 in two VDCs with four population categories (rural high caste, rural low caste, Tharu and urban). The research aimed to assess patterns of child-feeding practices and other nutritional behaviors of mothers and caretakers, in order to identify underlying beliefs, taboos and social causes for nutritional behaviors. A secondary aim was to improve the skill of project staff in qualitative-research techniques. The study was conducted by an independent consultant, working with a team of CARE field-staff members. On the basis of the resulting information, recommendations on appropriate messages for nutrition education at the community level were made.

Findings show that malnutrition, as perceived by the community, is surrounded by traditional beliefs that inhibit the community from relating it to child-feeding practices. Children are generally breast-fed for a period of three years or longer, if no pregnancy occurs. Giving colostrum to the newborn is still controversial, however a growing awareness of the importance of colostrum and the early initiation of breast-feeding is evident. The tradition of hill migrants to smear the mouth of the baby (after the birth and before breast-feeding) with honey and ghee (clarified butter) is becoming less common. Children are fed throughout the day, but only when they cry. Breast problems such as engorgement, inflammation and abscess are recurrent and cause mothers to feed other liquids to their children.

The introduction of a complete family diet often occurs only after the second year. Children are thought to have reduced digestive powers up to this age and to be more influenced by 'hot' and 'cold' food. Restriction of certain food items is practiced widely; however, change is taking place. During childhood illness, food restriction is practiced more strictly. In some cases, no solid food, liquids or breastmilk may be given to the child.

Based on the findings, three types of recommendations have been made: general recommendations concerning project activities and procedures, recommendations on the nutrition messages to be publicized by the project and lastly, recommendations for further research.¹ The project will refer to these recommendations while conducting behavioral analysis and developing details of behavior change

¹ Child Feeding: Traditions, Practices and Beliefs; Child Survival Project, Kanchanpur District; Qualitative Research Report, page ii-iii.

communication strategies in the second year. The detailed study report is attached with this annual report.

e) Coordination and Team Building with the District Health Office

Meetings have been organized regularly (almost once a month) with the District Health Office (DHO) and DDC to discuss and develop action plans for the training of Health Post staff and FCHVs on IMCI and to follow up on supervision of health post staff and FCHVs. In order to strengthen the capabilities of the government health staff in supervision and monitoring, the joint development of a supervision plan will happen in the second year. The project supported the District Health Office in the bi-annual supplementation of mega-dose Vitamin A capsules to children under five years old.

DHO was active in helping the project select 506 additional FCHVs. Community members, especially mothers' groups and Health Post staff were also involved in the selection of the new FCHVs. Before selecting a new FCHV, the Health Post, project staff and VDC members would form a mother's group made up of 400 mothers. Due to the increase in number of FCHVs (allowing for one FCHV for every 400 persons), 168 old mother's groups were also re-organized.

DHO also worked with the project to organize the basic training (15 days) of 534 FCHVs (506 new and 28 old FCHVs). The basic training covered topics such as maternal and child health, health education principles, diarrheal diseases control, nutrition, family planning, AIDS, common colds and pneumonia.

The District Health Office organized training of all health facility level staff (94 persons) on IMCI, in close collaboration with the project, the Child Health Division of Ministry of Health, JSI and WHO using the standard WHO/government curriculum. All Health Supervisors (5), Community Health Extensionists (15) and Family Health Extensionists (5) also received the training on IMCI. Seventeen project staff and 3 DHO staff were also trained on Participatory Learning and Action methods (6 days).

f) Partnership with Local NGO

In order to provide overall guidance and support to the project in project implementation and partnering activities, a "Project Advisory Committee" (PAC) has been constituted. The Chairperson of the District Development Committee is the Chair of this committee along with representatives from the District Administration Office, Mayor of the Municipality, the District Health Officer, an NGO Federation representative and the Project Manager. In the second year, the local partner NGO to work in Municipality area will be selected through a competitive selection process by the PAC. PAC is in the process of issuing a call for letters of interest from the local NGOs.

In collaboration with the NGO Federation of Kanchanpur, CARE conducted a one day meeting with local NGOs in order to share the goals, objectives and program activities of different NGOs active in the district, discuss issues related to partnering while implementing development activities and identify potential areas for collaboration and linkages. A total of 76 representatives from 47 local NGOs were present at the meeting. Participants prepared an inventory list of the 19 local NGOs in the district, consisting of their program profiles, organizational goals, objectives, strategies and structures. This information will be used in the upcoming selection of the partner NGO.

g) Project Orientation Meetings

Prior to the DIP preparation, project orientation meetings were organized at district (1), VDC (19) and ward (108) levels, involving district officials, local NGOs, local government representatives and community members. These meetings were useful for:

- sharing the goal, objectives, strategies, and interventions of the CS project based on the initial proposal
- collecting necessary information regarding the priorities of different stakeholders and discussing their roles in implementing the project

- presenting an opportunity for CARE to solicit commitment and support for project implementation.

B. CONTRIBUTING FACTORS

Factors that contributed for the accomplishments include the following.

a) Collaborative Approach with Government and Other Agencies

The CS project has been designed within the framework of government's comprehensive health program at the community level. Inter-agency coordination meetings with the Department of Health Services, the Child Health Division, JSI, EHP and LINKAGES helped to identify complimentary roles in implementing project interventions. The Child Health Division helped by providing technical training on IMCI. JSI will offer support in logistics management for IMCI. EHP will provide technical assistance with malaria training and the selection appropriate intervention strategies. LINKAGES will help in nutrition training (e.g. TIPS).

The inputs received from the Social Welfare Council, Department of Health Services, Child Health Division and the District Development Committee was very useful in shaping the start up activities and writing the DIP. The District Development Committee and District Health Office have continuously shown a high level of interest in project activities. DHO and VDCs were also actively involved in forming mothers' groups and selecting FCHVs and orientation at community level. Support from DHO was also received for FCHV basic and IMCI training.

b) Staff Training during Baseline Survey

Training of staff on quantitative methods during the KPC baseline survey and on qualitative (PLA) techniques during the Child Feeding Practices Study greatly enhanced staff skills and developed a better understanding of the social and health issues in the working areas.

c) CARE's Involvement in Other Remote Districts

Because of its long involvement in health programs in other rural, remote districts, CARE was able to hire competent, qualified and experienced staff right at the start of the project. The Project Manager was involved in preparatory activities one month in advance of the October start-up. All this led to a smooth start up of the activities.

III. FACTORS THAT HAVE IMPEDED PROGRESS

a) Political Problems:

The Maoist movement affected two Village Development Committees in the southern part of the district. This has caused difficulty with staff presence and movements in the communities. Similarly, project staff and community members experienced difficulties during the selection of new FCHVs; a conflict arose when some politically influential VDC members nominated people who did not meet the selection criteria (which had been defined as a literate mother above 30 years of age residing in the same village). With a lot of persuasion by the field staff and the use of strong negotiation skills, the selection of FCHVs was made according to the criteria. In one VDC, the selection process went up to two rounds.

b) Delayed Training on IMCI

Due to various administrative and logistical challenges, the Child Health Division of Department of Health Services and District Health Office could not complete the IMCI training of health facility level staff as per plan. This delayed the training of health facility level staff and affected the training schedule of FCHVs. This has also delayed FCHVs initiating community level activities; the training of FCHVs will be conducted only in the second year of the project.

c) Relationship with Local Level Health Personnel

While relations with the Child Health Division, District Health Office and some Health Posts/Sub Health Posts are very good, the project has experienced problems with some Health Post and Sub Health Post staff (especially VHW and MCHWs). There is still some resistance among some of them to respond to the community demands for their services and collaborate with CARE field staff to provide intensive support to FCHVs and mothers' groups. This is partly due to low motivation and concerns related to the increase in workload (which are quite valid). A process of sensitizing Health Post and Sub Health Post staff to the benefits of working with FCHVs and mothers' groups has been initiated. This was also jointly discussed between DHO and Health Post staff at their quarterly meeting. Similarly, DHO also sent an official letter to all Health Post and Sub Health Posts requesting them to work collaboratively with CARE field staff.

IV. FUTURE TECHNICAL ASSISTANCE

As this is the first CS project for CARE Nepal, there are needs for technical assistance in a number of areas. Attempts have been made to identify both areas in which assistance is immediately required and the appropriate resources for responding. Some of the areas identified are as follows:

a) Monitoring and Evaluation

In November 2000, the project is planning to further refine its monitoring and evaluation plan by defining operational indicators at effect and output level, identifying data needs and determining how they will be collected (data sources). The project will also refer to CARE Kenya's Monitoring and Evaluation plan while developing its own monitoring and evaluation plan. Once this is done, the project will use Monitoring, Evaluation and Reporting (MER) Project Management Software to automate data entry, processing, analysis and reporting results. Designed by CARE Honduras, the MER Project Management Software is a complete project management information system. The MER Core Team of the Country Office will take the responsibility of training and setting up the system for MER.

The project staff also need to be trained in LQAS techniques to be used for supervision and monitoring of project activities, primarily of FCHVs. CSTS is considering the possibility of supporting the project by providing training to key staff.

b) Behavior Change Communication Training

The project is planning to develop behavior change communication strategies based on available information from the Child Feeding Practices Qualitative Study Report, the KPC Survey results and knowledge gained by staff while working in Kanchanpur. The project will be using tools developed by the

CHANGE project to conduct behavior analysis and develop communication strategies. The project has initiated dialogue with Lonna Shafritz from CHANGE to explore possibilities in training/technical support in developing communication strategies. Additionally, training from LINKAGES India on Trials of Improved Practices to the Project Manager and Community Health Officer the first week of November will also help in this process.

c) Support for IMCI implementation

Inputs and continuous support from the Child Health Division, JSI and WHO would be sought for training and follow up of FCHVs and operationalizing IMCI in the project area.

d) Support for Designing Malaria Intervention Strategies

Technical support from EHP is planned for training health post staff and FCHVs on malaria prevention and appropriate case management, developing appropriate community level intervention strategies on malaria and conducting operations research on impregnated bed-nets. The project will make good use of the EHP baseline survey results and community interests in developing malaria interventions.

V. CHANGES IN PROJECT DESIGN

No significant changes have been made in the project design that would require modification of the cooperative agreement.

VI. RESPONSES TO QUESTIONS MADE DURING THE DIP REVIEW

The Detailed Implementation Plan (DIP) Review process offered the CARE Nepal CS team many constructive suggestions that could enhance the project approach. The DIP reviewers had two major comments: (a) fine-tune the monitoring and evaluation plan – which includes revisiting the indicators in the project logframe and (b) develop a substantive communication strategy.

a) Fine tune the Monitoring and Evaluation Plan

In response to the comments on revisiting the indicators in the logframe and addressing the mismatch between some of the objectives, activities and indicators, the project has revised the logframe making the following changes:

Goals	Old Indicators	Revised Indicators
Behavioral: Caregivers of children under 5, particularly mothers and pregnant women practice appropriate health behavior and seek medical care from trained sources when needed	Nutrition Increase the % of mothers who initiated breastfeeding within 8 hours of birth from 90% to 95% Control of Diarrheal Disease Increase the % of children under 2 who had diarrhea in the past two weeks who were treated with ORS from 2% to 50% Maternal and Newborn Care Increase % of families having a birth plan from 28% to 75% Malaria Increase the % of household having bed-nets and using them for all household members fromto..... in the operations research area.	Increase the % of mothers who initiated breastfeeding within 1 hour of birth from 49% to 70% Increase the % of children under 2 who had diarrhea in the past two weeks who were treated with ORT from 4% to 50% Increase % of families having a birth plan from 28% to 40% Increase the % of household having bed-nets and using them for young children and pregnant women from toin the operations research area. (% to be defined based on EHP survey results).

All the activities related to these indicators remain the same.

Based on the revised indicators, the project has planned to develop a detailed Monitoring and Evaluation Plan involving the District Health Office in November 2000. Based on the data needs identified in the monitoring and evaluation plan, the project will develop formats to be used for data collection and analysis at community level, keeping it in line with HMIS. Only those data that can be used for decision making at community level will be collected by FCHV and CHE/FHE will be responsible for data collation at VDC level. The data will be analyzed at VDC level and shared with the Health Post/Sub Health Post Management Committees. In order to avoid duplication of data collection, the project will be focus primarily on improving and using facility level data from the government health management information system for monitoring purposes.

b) Developing a Substantive Communication Strategy

In the second year, the project has planned to further refine the behavior change communication strategy for each intervention based on the behavioral analysis using the matrix suggested by the CHANGE Project. The matrix consists of analysis of ideal, current and feasible behaviors and the major barriers and motivations. The behavior change strategy is to be developed (a) by level of actions (at individual/family levels, community level, health workers/institutional level and (b) by type of activity (communication, training, improvements in health norms and systems, community participation and products). The project will use qualitative reports (child feeding practices study and EHP baseline survey report), KPC survey results, health facility assessment results, staff knowledge and other information gathered by field staff in formulating the detailed behavior change communication strategy.

c) Other Comments

The technical reviewers' other main suggestions regarded FCHVs' motivation and their supervision plan, the establishment of linkages with CHANGE and USAID's Infectious Disease Program and considering using "trials of improved practices (TIPS)" based approach.

The CS project staff at the VDC level have just started forming/reactivating mothers' groups to support and monitor the FCHVs' activities. In the second year, the project will develop a FCHV supervision plan jointly with the DHO. The project has also planned to monitor the FCHVs' satisfaction in terms of supervision support, fund raising and MoH relations through periodic interviews and focus group discussions, document FCHVs' outputs by organizing monthly meetings along with mothers' groups. The local Village Development Committees have expressed their commitment to provide continued support to FCHVs by electing women leaders to be the Ward Coordinators for health activities and supporting monthly meetings of the mothers' groups.

The project has initiated a dialogue with FCHVs, VDC and DDC members about the association of FCHVs at VDC level. All of them fully support the idea of FCHV association at VDC level and federation at the district level. The project will start mobilizing FCHVs to form their Association in the second year. Once the FCHV Association is formed, the Association will be assisted in providing guidance and supportive supervision to the FCHVs.

As stated earlier, the Project Manager and Community Health Officer will attend the training on TIPS planned for early November.

Areas for collaboration with CHANGE and USAID Infectious Disease Program will be explored in the second year.

