



Bal Bachau (Child Survival in Nepal)

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List of Abbreviation

AHW	:	Auxiliary Health Worker
AICBO	:	Assistant Institutional Capacity Building Officer
AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	Antenatal Clinic
ANM	:	Auxiliary Nurse Midwife
BCC	:	Behavioral Change Communication
CATCH	:	Core Assessment Tool in Child Health
CB-IMCI	:	Community Based Integrated Management of Childhood Illness
CBO	:	Community Based Organization
CDD	:	Control of Diarrheal Disease
CDP	:	Community Drug Program
CHD	:	Child Health Division
CHMC	:	Community Health Management Committee
CHS	:	Community Health Specialist
CS	:	Child Survival
CSHGP	:	Child Survival and Health Grant Program
CSP	:	Child Survival Project
CSSA	:	Child Survival Sustainability Assessment
D(P)HO	:	District (Public) Health Office(r)
DACC	:	District AIDS Coordination Committee
DDC	:	District Development Committee
DEO	:	District Education Office
DHC	:	District Health Coordinator
DHO	:	District Health Office(r)
DHS	:	Demographic and Health Survey
DIP	:	Detailed Implementation Plan
DoHS	:	Department of Health Services
Dr.	:	Doctor
DT	:	District Team
EDP	:	External Development Partner
EPI	:	Expanded Program on Immunization
FCHV	:	Female Community Health Volunteer
FCHV CC	:	Female Community Health Volunteer Coordination Committee
FEDO	:	Feminist Dalit Organization
FWR	:	Far Western Region
GIPA	:	Greater Involvement of People living with HIV AIDS
GIPA	:	Greater Involvement of People Living with HIV AIDS
GoN	:	Government of Nepal
HA	:	Health Assistant
HDR	:	Human Development Report
HFI	:	Health Facility In-charge
HFOMC	:	Health Facility Operation and Management Committee

HIV	:	Human Immuno Deficiency Virus
HMIS	:	Health Management Information System
HP	:	Health Post
HS	:	Health Supervisor
HSC	:	Health Sector Coordinator
HW	:	Health Worker
IEC	:	Information Education & Communication
IGA	:	Income Generation Activities
IMCI	:	Integrated Management of Childhood Illness
INGO	:	International Non Governmental Organization
KPC	:	Knowledge Practice and Coverage survey
LDO	:	Local Development Officer
LMIS	:	Logistic Management Information System
LQAS	:	Lot Quality Assurance Survey
LRP	:	Local Resource Person
M&E	:	Monitoring and Evaluation
MCHW	:	Maternal and Child Health Worker
MG	:	Mother Group
MNH	:	Maternal & Neonatal Health
MOH	:	Ministry of Health
MTE	:	Mid Term Evaluation
NFE	:	Non- Formal Education
NFHP	:	Nepal Family Health Program
NGO	:	Non Governmental Organization
NTAG	:	National Technical Assistance Group
ORC	:	Out Reach Clinic
P&AS	:	Partnership and Advocacy Specialist
PAC	:	Project Advisory Committee
PCM	:	Pneumonia Case Management
PD	:	Positive Deviance
PDQ	:	Partnership Defined Quality
PHCC	:	Primary Health Care Center
PLWHA	:	People Living with HIV/ AIDS
PM	:	Project Manager
PMT	:	Project Management Team
PSC	:	Partners Selection Committee
PVO	:	Private Volunteer Organization
RBA	:	Rights Based Approach
RHD	:	Regional Health Directorate
RM&DS	:	Research Monitoring and Documentation Specialist
SHP	:	Sub Health Post
SL	:	Saving Loan
SPA	:	Seven Party Alliance
STA	:	Senior Technical Advisor
SWC	:	Social Welfare Council

TH : Traditional Healers
TOT : Training of Trainers
TS : Training Specialist
UNICEF : United Nations Children's Fund
USAID : United States Agency for International Development
VDC : Village Development Committee
VHW : Village Health Development Worker

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1. Introduction

1.1 Background

In Nepal, most of the health indicators particularly those related to mothers and children are very poor. As per the current estimate, Infant Mortality Rate is 64/1000, Under five Mortality Rate is 91/1000, Neonatal Mortality Rate is 39/1000 and Maternal Mortality Ratio is 539/100,00 live births. It is estimated that nearly 50,000 children under one year of age die each year from preventable or treatable diseases that include pneumonia, diarrhoea, and measles. Malnutrition remains the dominant underlying cause of death among Nepalese children. (DHS 2001)

Currently, adult literacy rate in Nepal is 49%, the per capita is US \$ 244, and life expectancy at birth is 61.9 years. Nearly 40% of the population lack access to basic primary health care and education. Nepal ranks 143rd out of 175 countries on the Human Development Index and is classified as a Low Human Development country. (HDR 2004, UNICEF 2005)

Geographically, Nepal is divided into three ecological zones (Mountain, Hills, and *Tera*), five development regions (East, Central, West, Mid West and Far West) and seventy five districts. District is further divided into Village Development Committees (VDCs) and Municipalities. The population of a district is served by a District Hospital, in addition to Primary Health Care Centers (PHCC) at Electoral Constituency level, Health Post (HP) at *Ilaka* level and Sub Health Post (SHP) at VDC level. Each VDC is sub-divided into nine wards with at least one Female Community Health Volunteer (FCHV).

Though the child and maternal morbidity and mortality rates are still high in Nepal, substantial improvement has been observed in maternal and child health indicators during the past few decades due to the implementation of programs focusing on mothers and children.

CARE Nepal, Ministry of Health (MoH) and Social Welfare Council (SWC) are jointly implementing Child Survival XIX (locally known as *Bal Bachau*), a four-year (Sept 2003 - Oct 2007) program funded by CSHGP/USAID Washington in four (Kanchanpur, Doti, Dadeldhura and Bajhang) of nine districts from Far Western Development Region. The project aims at contributing to improve the health of under five children (under age five) and pregnant and lactating mothers from these project districts. The project is designed under the "expanded impact category" to promote the promising lessons Child Survival (CS XV) Project in Kanchanpur during Sept 1999 – Oct 2003. The project targets to benefit 146,514 under-five children and 47,484 pregnant and lactating women among total population of 932,054 from four project districts.

The project adopts the rights-based approach to address both needs and rights of women and children for health with special emphasis on poor and marginalized families. Project activities have been implemented in partnership with District (Public) Health

Offices, health facilities and local NGOs/CBOs. Most of the project activities are based on the framework of Community-Based Integrated Management of Childhood Illness (CB-IMCI). The CB-IMCI program has also remained a priority program of Ministry of Health of Government of Nepal (MoH/GoN).

The project is based on the framework of CB-IMCI, the foundation of child health services adopted by MOH Nepal. Since 1997 MOH is seeking support from various bilateral and multilateral donors in order to expand CB-IMCI coverage throughout the country. CARE Nepal's Child Survival Project is supporting CHD/MOH in the implementation and strengthening of CB-IMCI in four districts of Far West Nepal. The project focuses on increasing community-based management and control of health services through the coordination of health facility management committee, health workers, volunteers and committees along with other local institutions.

1.2 Program Description by Objective, Intervention and Strategies

The overall goal of the project is to *reduce child and maternal mortality and morbidity* by strengthening community, local NGO and MOH capacities in the Far Western Region of Nepal.

The program objectives are:

Objective No.1, Access to Services and Supplies: Families have increased access to health education, quality health care services, and essential medicines at the community level.

Objective No.2, Quality of Care: Community level MOH personnel, Female Community Health Volunteers (FCHVs), and other service providers practice appropriate case management of pneumonia and diarrhea, and other key IMCI interventions.

Objective No.3, Behavioral Change: Caregivers of children below five years of age practice healthy behaviors and seek medical care from trained medical providers when needed.

Objective No.4, Building Local Capacities: Local and community-based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis.

To achieve project objectives, the project has adopted following cross cutting strategies:

- Linkages with other line agencies of GoN and stakeholders

- Focus on disadvantaged (ethnic or low-caste groups)
- Integration with other CARE projects¹
- Promotion of community cohesion
- Focus on gender and child rights issues

The overall project is based on the framework of CB- IMCI, but the effort to be spent by the intervention is as follows:

- Micronutrients (35 % in Doti / Dadeldhura / Bajhang and 25% in Kanchanpur)
- Control of Diarrhoeal Diseases (30 % in Doti / Dadeldhura / Bajhang and 25% in Kanchanpur)
- Pneumonia Case Management (35% in Doti / Dadeldhura /Bajhang and 25% in Kanchanpur)
- Maternal and Newborne Health (25% in Kanchanpur from project resources and from complementary resources elsewhere)
- Malaria (from complementary resources in Kanchanpur)

Key strategic approaches of the project are:

- A. To demonstrate successful and sustainable implementation of CB-IMCI (especially for management of pneumonia and diarrheal disease) through improved quality of care strategies,
- B. To strengthen linkages between local government and civil society participants in health care management at the Health Post (HP), Sub Health Post (SHP) and District Health level; The key activities undertaken will include HFMC strengthening in all four districts and supporting CDP training in Bajhang
- C. Develop a sustainable program implementation model in Kanchanpur through strengthening community support (i.e., FCHV-CC, VDC/DDC) and linkages with line agencies of GoN
- D. Strengthening of project staff and other stakeholders capacity (especially marginalized communities and women) to operate in existing environment of insurgency in Nepal
- E. Evidence-based advocacy to increase support for CB-IMCI by regional and national MOH Child Health Division.

¹ In line with the Multi Sectoral Platform (MSP) approach

2. Major Accomplishments of the Project during Year Three

The overall performance of the project during this reporting period (Oct 2005 – Sept 2006) has been found impressive, despite the escalated conflict in Nepal. During the year, CS XIX attempted to build in core priority activity – Community Based Integrated Management of Childhood Illness (CB-IMCI) in all three new program districts (Doti, Dadheldura and Bajhang) in close coordination and collaboration with local health systems. The project continues with CB-IMCI and its complementary activities – Community Drug Program (CDP), Health Facility Operation and Management Committee (HFOMC) strengthening program, female community health volunteer (FCHV) strengthening program and mothers group (MGs) extension program.

A part of improving the recording, reporting and regular planning at *llaka* and peripheral and district level health facilities. Support was provided for strengthening the Health Management Information System (HMIS) at *llaka* and district level.

The project carried out Mid Term Evaluation (MTE) during January 2006. The project adopts the lot quality assurance sampling (LQAS) technique to monitor progress on periodic basis. These surveys employ and generate information on Rapid CATCH indicators for each supervision areas in each district. Project partners discuss findings, identify problems, and recommends remedial action, based on the findings of the LQAS Survey. Findings from LQAS and other information collected show that the project is stimulating positive behavior change at the community level as well as both improved outreach by peripheral health facility staffs and increased ownership of the program at both the community and district levels. In addition, the project is adopting the Child Survival Sustainability Assessment (CSSA) Framework in Kanchanpur and planned to apply the tool as an assessment methodology in other project districts.

The project has already achieved some of the targets by mid-term that it aimed to attain by the end of the project and others are in track to achieve by the end of the project. Mothers' knowledge and practices related to diarrhea, pneumonia, child spacing, and pregnancy have improved substantially. The project's major accomplishment are highlighted in the following tables by project's objectives and interventions. See "Monitoring and Evaluation" Section for the status of project by Rapid CATCH and key DIP indicators as per the last LQAS report.

2.1 Major Accomplishments by Project Objectives

Table 1: Major accomplishment of the project by Project Objectives

Project objectives	Key Activities (as outlined in DIP)	Status of Activities	Comments
<p>1. Access to services and supplies:</p> <p>Families have increased sustainable access to quality health care services and essential medicines at the community level.</p>	<p>1. CB-IMCI Implementation in health facilities and outreach workers- CS-XIX aims to work closely with health systems to support and strengthen the FWR Health Directorate, D/PHO and local health institutions to make them able to provide optimum quality health service and supplies. To achieve this, the project has accomplished the CB-IMCI training for – health facility staff, outreach staff (MCHW/VHW), community level volunteers (FCHV/THs) training.</p> <p>2. Strengthening of FCHV programs- Community level health volunteers and mothers groups are more focused to sustain their voluntary spirit and engagement with multifold programs such as introducing savings/credit programs, peer support by establishing FCHVCC and improved supervision & monitoring mechanism.</p> <p>3. Increased access to drugs through Community Drug Program strengthening- The project supports the CDP in Bajhang & Kanchanpur to ensure year-round supply of essential drugs/medicines in subsidized rates through greater involvement of the communities. This program also promotes the rational use of medicines and improve people's access to medicines through exemption for poor.</p>	<p>1. Completed/Ongoing: The CB-IMCI training for HF staff and outreach staff has been completed. First phase training of the volunteers has been accomplished and second phase training is ongoing in all the districts. Review and follow-up of HF staff and outreach staff is ongoing. As a result, communities' access to diagnosis and treatment of childhood illness particularly diarrhea and pneumonia, has been improved as quality health services is being available from local health workers and volunteers.</p> <p>2. Ongoing: Health matters (specifically essential supplies availability) are regularly discussed in MG meeting, FCHV's monthly meeting, peer support among FCHVs, exposure visits and supportive supervisory visit from the district as well as Ilaka level health facilities to take corrective action promptly.</p> <p>3. Ongoing/Initiated: District level TOT on CDP has been completed in Bajhang in close coordination with MoH/Logistic Management Division. VDC level training is ongoing. To engage community in management of health facilities and to ensure availability of essential medicines, HFOMC Training focusing on participatory capacity assessment was carried out in 21 out of 47 VDCs in Bajhang. The project is continuously supporting monitoring and follow-up of CDP in Kanchanpur and currently operational in all health facilities. Project initiated</p>	<p>1. Training at community level was difficult in mobility as an effect of conflict situation in project area. All training activities are expected to be completed by Dec 2006.</p> <p>2. Mobilization of FCHV and LRP² in monitoring, sensitizing and advocating with local health institutions was helpful to improve community's access to health services and supplies.</p> <p>3. CDP could not be initiated in Bajhang in scheduled date due to conflict. The CDP training at all level is expected to complete in Bajhang by Dec 06. The program has contributed to ensure year round availability</p>

² Local Resource Person (LRP) is a person developed to work as a leader for enhancing capacity of community volunteers for health improvement and empowerment. Most of the LRPs are Female Community Health Volunteers. (See "Result Highlights" for more details)

Project objectives	Key Activities (as outlined in DIP)	Status of Activities	Comments
		establishment of "Cotrim Fund" in Dadeldhura and Doti to ensure availability of cotrim and ORS, in health facilities where CDP is not implemented.	of essential medicines.
<p>2. Behavioral Change:</p> <p>Caregivers of children under 5 years practice healthy behaviors and seek medical care from trained source when needed</p>	<p>1. Community mobilization through MG (and MG extension strategy in Kanchanpur) - MGs have been mobilized to disseminate key behavior change messages in all project districts. In Kanchanpur, additional efforts were made to expand MGs to bring in new members especially from <i>dalit and marginalized</i> families and to conduct mobile MG meetings in dalit clusters. FCHVs and outreach workers (VHW/MCHW) helped these MGs to convey BCC messages through monthly meetings.</p> <p>2. Positive Deviance/Hearth (in Kanchanpur) for improving feeding practices - The project supported implementation of PD Hearth on pilot basis in three VDCs of Kanchanpur with an aim of changing feeding, child caring and care seeking practices.</p> <p>3. Involvement of District Education Office in disseminating BCC messages: The project is collaborating with District Education Office for school health program in Doti to promote BCC</p>	<p>1. Ongoing: The project is supporting in behavior change through MG mobilization in Doti, Dadeldhura and Bajhang and expansion of MG in Kanchanpur based on the BCC Strategy. Project also contemplates to reach non-MG group members through mobile MG meetings. Interaction workshop between positive behavior practicing mothers/caretakers and non – positive behavior practicing mothers/caretakers were conducted. Recent LQAS survey has shown improvement in key behaviors as compared to baseline. Project continues promoting and re-enforcing key targeted behavior change using existing networks and forums under the District Health System.</p> <p>2. Completed: The project has implemented PD/Hearth Sessions in nine sites of Kanchanpur (from two VDCs and Municipality). Out of total 155 children enrolled in the Hearth Sessions, 89 (57%) were graduated (gained their status to normal status from malnutrition status). The Hearth sessions were found effective approach for disseminating behavior change message focusing on child caring, feeding and health seeking practices.</p> <p>3. Ongoing - The project facilitated the process of preparing district level joint plan for school health education program in Doti and Dadeldhura. Based on the plan, the</p>	<p>1. Mobilization of mothers in educating families and informing others about healthy practices and adapting health seeking behavior through MG activation was found effective.</p> <p>2. PD/Hearth intervention was found effective in managing malnutrition in community and personal and household level behavior change, project. Based on the learning from this pilot, CARE will include this program in upcoming new project as appropriate.</p> <p>3. BCC interventions are targeted at mothers and caretakers, especially</p>

Project objectives	Key Activities (as outlined in DIP)	Status of Activities	Comments
	<p>message through "CHILD to child" approach and establishment of student health education clubs.</p> <p>4. Use of digital radio to disseminate BCC message in Kanchanpur - The project partnered with FOLD Nepal (a local NGO partner of CARE working on digital radio broadcasting in Far West) to disseminate BCC messages through digital radio program. The</p>	<p>project has involved DEO and other district level line agencies to promote behavior change through education and other sectoral program. This resulted to expanding the coverage of health education in the family and community.</p> <p>4. Ongoing – The project supported local NGO for disseminating of BCC message through digital radio, which was found effective in informing mothers for better child caring practices and informed about harmful practices in project and outside the project districts with listeners group discussion and broadcasting their voices and publication of selected issues.</p>	<p>through Mothers Group and CHILD to child approach in School health program.</p> <p>4. Though the information disseminated through digital radio was effective among the listeners group. Obtaining wider participation of mothers and communities is the major constraints.</p>
<p>3. Quality of care:</p> <p>Community level MOH personnel, FCHVs, and other service providers practice appropriate case management of pneumonia and diarrhea, and other key IMCI intervention areas.</p>	<p>1. Capacity building of health staff as well as FCHVs around CB-IMCI, using standardized modules by national trainers - The project collaborates and builds capability of regional, district & community level health institutions to sustain child survival activities. Proven standard guidelines and accredited organizations (NEPAS, IRHDTC and IMCI Section of CHD) were used as consultants/resource persons to provide training to district-based health offices and community-based health institutions, CBOs and the volunteers.</p> <p>2. Partners Defined Quality – The project supported the follow-up activities at PDQ implemented sites in Kanchanpur district with an aim of facilitating interaction between health workers and communities for defining, measuring and improving health delivery system through joint actions.</p> <p>3. Supportive Supervision and Joint</p>	<p>1. Completed on target: CB – IMCI training (both clinical, management and follow-up) to Doctors, DHO supervisors, Health workers and outreach health workers is accomplished in all districts (refer to the table number 1 hereunder). The follow-up after training has been completed in Dadelhdhura and planned to complete in Doti and Bajhang by the Dec 2006. The training to newly transferred-in staffs in Doti, Dadelhdhura and Bajhang has also been planned in this year. The first phase FCHV level Basic CB-IMCI training has been accomplished throughout the project districts.</p> <p>2. Ongoing – Project supported in follow up and strengthening of PDQ in Kanchanpur initiated by CARE-NFHP project. The PDQ process helped for better understanding on the issues, need and challenges of both service providers and communities in providing better quality services.</p>	<p>1. After CB-IMCI training for community level health workers and volunteers, case identification has been increased and due to better quality of services, health service utilization has also increased.</p> <p>2. Project is continuously monitoring and supporting PDQ activities in Kanchanpur.</p>

Project objectives	Key Activities (as outlined in DIP)	Status of Activities	Comments
	<p>Monitoring - Adopting joint review meetings, facilitative supervision & monitoring at the district and community levels has supported to track program performance.</p> <p>4. Cross visits to Kanchanpur and other districts: Project aims to organize cross visits of project team, staffs from D(P)HO and health facilities, outreach health workers, community level volunteers to replicate the success of Kanchanpur to other project areas.</p>	<p>3. Completed and ongoing: Monitoring and evaluation (M&E) workshop was organized to develop integrated checklist for joint supervision. Bimonthly review meeting of FCHVs has enhanced their skill to deliver quality services as well as recording and reporting. The project has supported D(P)HO Doti to develop a computer based reporting templates, which was appreciated by the district health team and RHD and suggested to expand in other districts.</p> <p>4. Ongoing: Project organized exposure visit of FCHVs, LRPs, health workers from DPHO and health facilities, partners as well as community pressure groups (e.g. dalit groups) to Kanchanpur to encourage them to initiate similar initiatives in their areas. Those visits were found motivating visitors. Kanchanpur has been recognized as "living university" to learn successes as well as challenges for community based initiatives for health promotion as well as community empowerment.</p>	<p>3. Joint supervision and monitoring helped to track the progress as well as constraints and take immediate corrective actions. These activities supported to ensure the quality of services and supplies at HF and community level.</p> <p>4. The visits to Kanchanpur motivated for strengthening HFOMCs, organizing and empowering FCHVs to replicate the good practices of Kanchanpur.</p>
<p>4. Local capacity building: Local and community-based institutions and local NGOs are strengthened with capacity to support CS activities on a sustainable basis</p>	<p>1. Community capacity strengthening - by HFOMC, support to DDC/VDC for health monitoring through district council meetings, joint visits etc were some of the activities of the project. Project is also working jointly with regional and district health authorities (e.g RHD, DPHO, DDCs, VDCs) and Project Advisory Committee (PAC) to build capacities of the local bodies to monitor and support community health activities.</p>	<p>1. Ongoing: Project is supporting in capacity strengthening of local, district and regional level health authorities and institutions through regional review meetings, technical support, and integrated monitoring and supervision support. The project advisory committee also played remarkable role in coordinating all these activities and gain ownership. Project also worked to strengthen the capacity of HFOMC through capacity assessment, strengthening training and follow-up. These activities are ongoing in all districts and towards completion. Different action plan has been developed to enhance their access to the quality health services.</p>	<p>1. Several initiations taken to strengthen the capacity of the community, placed project a community-owned as well as complimentary to reinforce the GoN health service delivery system.</p>

Project objectives	Key Activities (as outlined in DIP)	Status of Activities	Comments
	<p>2. FCHV Strengthening – FCHV CC support and supporting supervision. Training for various level community institutions i.e., mother's groups, –FCHV-CC on social analysis (Reflect model) and decentralization/governance/empowerment (power package)</p> <p>3. Local NGO/CBO Support - with special focus on <i>dalit</i> partnerships. The project is implementing its activities through partnership development in line with multi-sectoral approach with at least 2 Civil Society organizations – NGOs in each district (one <i>dalit</i> affiliated) In addition in Kanchanpur, it has partnership with FCHVCC as well.</p>	<p>2. Ongoing: A total of five of 20 FCHVCCs of Kanchanpur are registered as CBOs. Similarly, 11 FCHVCC in Doti and 10 FCHVCC in Dadeldhura have been formed spontaneously. These FCHVCC are approaching to other authorities for mobilization of funds at local level on their own initiation.</p> <p>3. Ongoing: Project has established partnerships with six local partners in Doti, Dadeldhura and Bajhang, among those three partners are <i>dalit</i> membership based local NGOs. Project has put special efforts in strengthening the technical and managerial capacity of these partners. In Kanchanpur, project has worked with all FCHV Coordination committees and two NGO partners (FOLD and SSA) for BCC and RBA initiatives. Partnership with <i>dalit</i> membership based NGO enabled project to introduce interventions focused on inclusive and respectful participation of <i>dalits</i>.</p>	<p>2. After the learning from Kanchanpur, FCHVCC has become a driving force to mobilize the community for betterment of the basic health services at the community and being replicated to other project districts.</p> <p>3. These activities helped to gain self-respect and gradual reduction of discriminatory practices against <i>dalits</i> in society.</p>

2.2 Major Accomplishments by Project Interventions

Table 2 : Major accomplishment of the project by Technical Interventions

Technical Intervention	Key Activities (as outlined in DIP)	Status of Activities and Progress	Comments
Nutrition	<ul style="list-style-type: none"> - CB-IMCI training and follow-up for HWs, CHWs and FCHVs - Promotion of Exclusive Breastfeeding through FCHV and MG meetings - Promotion of optimal complementary feeding through FCHV and MG meetings - Ensuring availability and utilization of iodized salt - Positive Deviance/Hearth 	<p>Overall progress of the project in nutrition component is fair. Project activities were focused on promoting growth-monitoring visits, proper counseling at health facility and adoption of good practices at household and community level.</p> <p>Project also implemented Positive Deviance/Hearth in three sites of Kanchanpur district on pilot basis. The preliminary results have shown that the PD/Hearth activity would contribute in management of protein calorie malnutrition and to bring positive change in feeding behaviors.</p>	<p>Apart from ongoing support to DPHO in micronutrient program, this year project will actively support in iron intensification program in Doti and Kanchanpur.</p>
Pneumonia Case Management	<ul style="list-style-type: none"> - CB-IMCI training and follow-up for HWs, CHWs and FCHVs - Mobilization of FCHVs and Mothers Groups - Promoting standard case management through IMCI protocol - Ensuring availability of ARI timers and Cotrim for quality case management - Promoting timely care seeking and proper home care practices 	<p>Major activities under CB-IMCI are almost completed and follow-up activities are ongoing.</p> <p>Project is also mobilizing communities (including FCHV-CCs, mothers group, THs) for disseminating information on health seeking and caring practices of child with pneumonia. Most of the FCHVs have adequate stock of Cotrim.</p> <p>Project made remarkable efforts and achieved significant results in pneumonia case management component after IMCI training. As a result, care seeking for pneumonia from health facilities, outreach workers and community volunteers has been improved.</p>	<p>Project efforts to ensure regular availability of Cotrim and functioning ARI timer also contributed significantly in pneumonia case management.</p>
Control of Diarrhoeal Disease	<ul style="list-style-type: none"> - CB-IMCI training and follow-up for HWs, CHWs and FCHVs - Mobilization of FCHVs and 	<p>Major activities of CB-IMCI is almost completed and follow-up activities are ongoing.</p> <p>Project is also mobilizing communities (including</p>	<p>Project also contributed in quality case management, ensuring availability and use of ORS and promoting appropriate care</p>

Technical Intervention	Key Activities (as outlined in DIP)	Status of Activities and Progress	Comments
	<p>Mothers Groups</p> <ul style="list-style-type: none"> - Promoting standard case management through IMCI protocol - Ensuring availability of ORS for quality case management - Promoting timely care seeking and proper home care practices 	<p>FCHV-CCs, mothers group, THs) for disseminating information on health seeking and caring practices of child with diarrhea, and personal hygiene and sanitation.</p> <p>Most of the FCHVs have adequate stock of ORS.</p>	<p>seeking including home care. Project needs to focus on retention of those positive behaviors.</p>
Maternal and Newborne Care	<ul style="list-style-type: none"> - Promotion of delivery assisted with skilled personnel - Promotion of use of safe home delivery kits - Promoting antenatal and post natal checkup practices 	<p>In Kanchanpur, the project supported in promoting delivery conduction through skilled personnel, use of safe home delivery kits for home deliveries as well as antenatal and postnatal visits.</p> <p>Community level health workers and volunteers were mobilized for disseminating information, promoting behaviors and facilitating them to utilize services.</p> <p>Role of HFOMC and FCHV CC was remarkable in disseminating these information and services.</p>	<p>The project partnered with other stakeholders (e.g. NFHP, SC US) in Kanchanpur for Maternal and Newborne care component. Achievement till date under this component is satisfactory.</p>
Malaria Control (Complementary)	<ul style="list-style-type: none"> - FCHV training in malaria prevention and control - Mobilizing children for disseminating malaria prevention and control message through school health program - Establishment and strengthening community health laboratory services for improved access to diagnosis and treatment of malaria 	<p>All activities planned under malaria control program have been completed. Fund for these activities was received from NFHP/JSI/USAID. These activities helped to improve communities' access to timely diagnosis and treatment as well as improved awareness on malaria prevention and control.</p> <p>With the support from the project, communities are being able to establish and operate community health labs.</p> <p>Project made especial attempt to seek local resource for malaria control program.</p>	<p>Community was involved in the management of malaria control through community health labs. This initiative helped in controlling malaria epidemics.</p> <p>Community is prepared to continue this efforts to sustain in future with local resource mobilization.</p>

2.3 Description of activities during this reporting period

2.3.1 Regular meeting of Project Advisory Committee

District project advisory committee at all project districts and a regional level Project Advisory Committee (PAC) has been formed to contribute in the project monitoring and provide meaningful guidance and evaluate the process of implementation and monitor the progress. The committee meets every six months to update, review and discuss the progress of the project. The committee also provides constructive feedback to the program, help to link and coordinate with available local resources for synergistic impact and most importantly, take ownership and accountability of program outcomes.

During the period, the PAC meeting in Doti was held twice. During the time, focus on discussion was on the projects' special initiative - School Health Program and prepared the monitoring and supervision plan for the PAC's supervisory visit. In Dadeldhura, the PAC reviewed the project's progress and identified focus area of intervention where as, in Bajhang, the members presented their annual program and discussed the previous Fiscal Year's progress.

2.3.2 CB-IMCI Training

The third year focused on completion of the Basic CB-IMCI training at all levels. Follow-up training for the health facility staffs, clinical training for transferred-in health facility staffs has been planned and is ongoing in the project districts.

Till date, the project has trained 184 health workers using seven days standard module and 204 community health workers using five days standard module on clinical CB-IMCI training. A total of 38 health workers received training of trainers and were involved in training other health workers and 23 health workers received supervisory training, and 191 received management training. Except few transferred in staff, the project already trained all health workers in its project area on the standard CB-IMCI module.

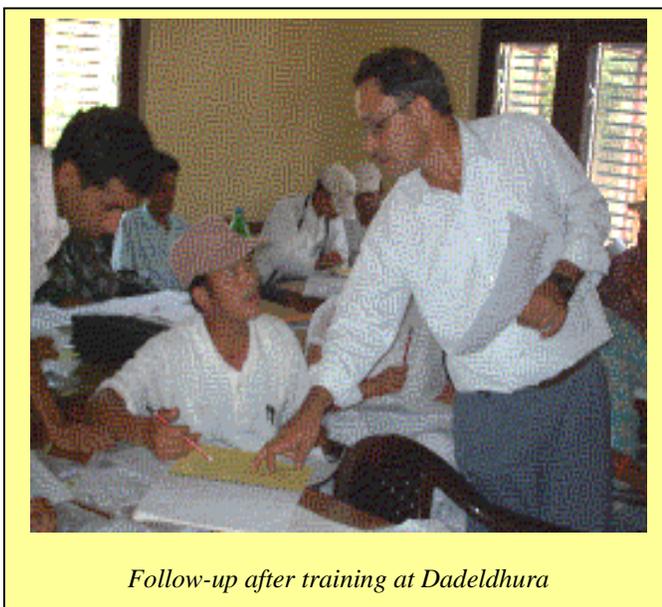


Table 3: Status of CB-IMCI Clinical and Management Training

Training	Bajhang	Dadeldhura	Doti	Kanchanpur	Total
Program planning, orientation and advocacy	23	25	22	--	70
District Level Training of Trainers (Seven days module for Community level IMCI training facilitation)	12	10	16	--	38
Clinical CB-IMCI Training (Seven days module for HF level clinical health workers)	55	47	60	22	184
Clinical CB-IMCI Training (Five days module for outreach health workers)	75	39	90	0	204
Supervisory Training (Five days module for non-clinical staffs)	6	8	9	0	23
Management Training (Two days module for all health staffs)	40	61	72	18	191
IMCI Training for Senior Managers (Seven days module for Senior Health Managers and Pediatricians)	--	--	--	--	8

Likewise, community level training (Basic CB-IMCI training for FCHV and Refresher CB-IMCI training) were held in project districts in collective management of District Health Office (DHO) and the project. The training adopted standard protocol and proven teaching learning methodology including demonstration of practical exercises. A total of 1313 FCHVs from Doti, Dadeldhura and Bajhang has been trained on first phase Basic CB-IMCI training.

Table 4: The number of participants per districts in FCHV level CB-IMCI training

District	Bajhang	Dadeldhura	Doti	Total	Remarks
Total FCHVs	423	462	625	1510	
Basic CB-IMCI training (First Phase)	413	346	554	1313	Completed
CB-IMCI Refresher (Second Phase)	239	149	120	508	Ongoing

Table 5: Orientation on CB-IMCI to traditional healers

District	Bajhang	Dadeldhura	Doti	Total	Remarks
Total target (THs - persons)	188	100	200	468	
Achievement	184	00	71	255	
Remarks	Completed	Planned	Ongoing	Ongoing	

CB-IMCI Program Review

CB-IMCI Focal Persons' meeting was organized by the Child Health Division at Pokhara in May 2006 and attended by the Training Specialist of the project. The meeting was focused on reviewing the progress of CB-IMCI program and cross learning from different IMCI districts. This meeting also identified the constraints of the program and the areas of support needed from the Child Health Division.

Staff Capacity Building in CB-IMCI

The DHCs of Doti and Dadeldhura participated in the seven days CB-IMCI Clinical training at Surkhet, organized by the Child Health Division. The training has supported CSP to enhance the skills in supportive supervision and monitoring. The supervisory visit to different health facility after the training has supported to verify the health facility level CB-IMCI OPD register and give feedback accordingly for further improvement. Further, the training has also helped to analyze the CB-IMCI reporting at the district level and guide the DHO in tracking towards the goal of the overall CB-IMCI program.

2.3.3 Performance review with local partners

The project organized a three days partner's performance review workshop in all districts to assess the progress of partnership activities, identifying constraints and worked out appropriate modality of partnership to work even in the poor operating environment.

This workshop was beneficial to amend partnership agreement and implement the program activities with special focus on social mobilization. The meeting updated the progress, discussed organizational strengths and the implementation challenges to develop cordial relationship and interdependence. The participants of the workshop included the executive of NGOs in the different district were as follows:



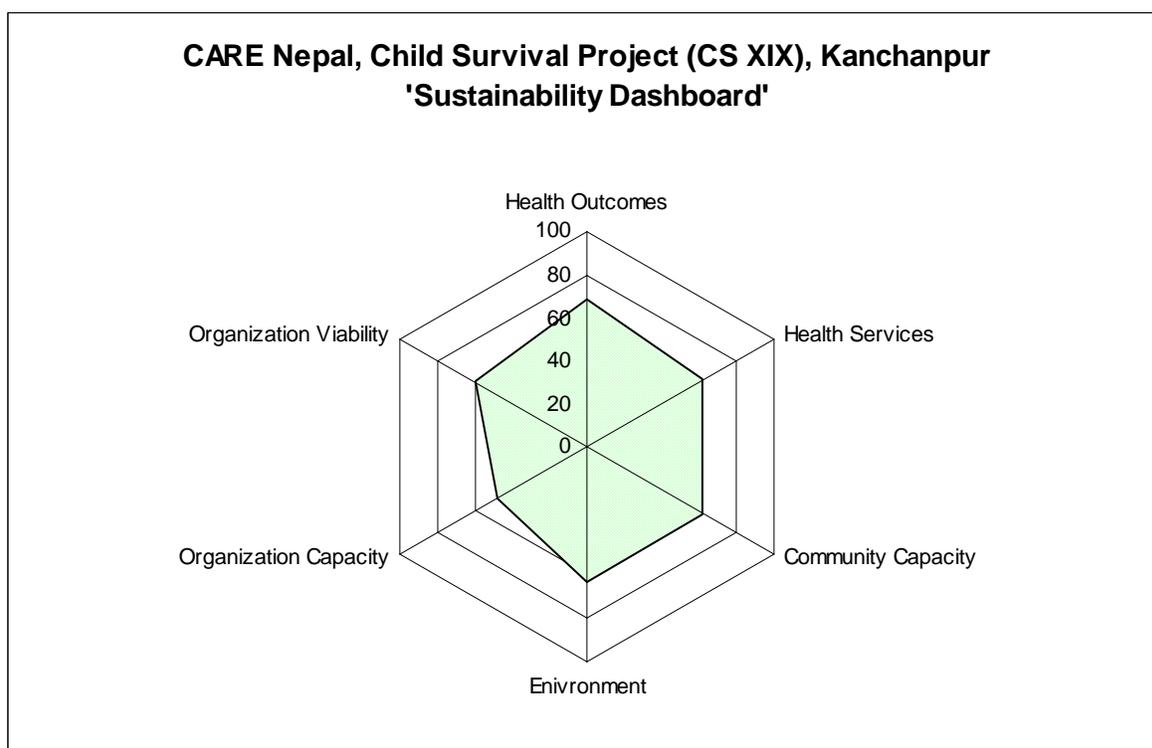
Table 6: Participants in the NGO performance review workshop

District	Participation from			Total
	DHO	Partner NGOs	CSP	
Bajhang	2	10	7	19
Dadeldhura	2	17	4	23
Doti	2	12	5	19

2.3.4 Sustainability assessment in Kanchanpur

The project organized a CSSA workshop having participants from the project districts, District Public Health Office, District Development Committee, Municipality, Female Community Health Volunteers, local NGO partners, and media. The workshop identified the local system, program vision and indicators for sustainability assessment for each component for the Child Survival project in Kanchanpur. Based on the list of indicators identified and their score value from different sources, a sustainability dashboard has been prepared for Child Survival Kanchanpur.

Fig 3: Sustainability Dashboard of CARE Nepal, Child Survival Project, Kanchanpur



Based on the analysis of the dashboard, following actions are recommended for moving Child Survival project, Kanchanpur more towards sustainability.

- The progress of the project towards health outcomes, health services and community capacity was found encouraging.
- Efforts should be made to ensure that the progress made on health outcome, health services and community capacity be sustained over the period of time.
- For the remaining period, project should focus on strengthening systems to improve organizational capacity, organizational viability and enabling environment. For this, project should identify actors that have roles on creating

enabling environment and to strengthen organizational viability and mobilize them for sustainable health outcomes.

- Project should regularly monitor its progress based on the CSSA framework and take appropriate actions. This system should be institutionalized within district public health system.
- Based on the learning from Kanchanpur, the project aims to explore ways to apply CSSA in other CS project districts.

The application of CSSA framework was found useful in thinking the sustainability perspective in project implementation especially to sensitize project stakeholders regarding their roles and responsibilities in sustaining the results of the project. This will also help to monitor the project progress not only from the perspective of technical outcomes but also from the perspective of sustainability.

2.3.5 Local Resource Person (LRP)³ mobilization

A total of 47 Local Resource Persons mainly from FCHVs were selected, trained and mobilized by the project in 20 VDCs in Dadeldhura and 27 VDCs in Doti. The LRP were selected from the community by themselves to work as a local leader. The trained LRP are mobilized to provide guidance and support to enhance the performance of FCHVs and mothers' group by regularizing monthly meeting. The HFOMC, FCHVCC and the respective health facility are providing supportive supervision and are taking accountability of mobilization and continuity of local resource person. The regularization of the MG meeting through the support of LRP has encouraged the mothers to practice healthy behavior and seek medical care to address their child illness from FCHVs to the health facilities. Mobilization of LRP was found effective means to reach un-reached population especially during the conflict situation.

2.3.6 Operational Research

Documentation and dissemination of lessons learned and conducting special projects has been considered as an integral component of the Child Survival Project. Following topics were identified for operational research in the project and preliminary information collection is ongoing:

- I. Using CHILD to child approaches in behavior change (Doti)
- II. PD/Hearth for malnutrition management; OR Mother's group extension to reach mothers of marginalized communities (Kanchanpur)
- III. Promoting Child Rights through mobilizing Child Clubs (Dadeldhura)
- IV. Social Analysis for working with Disadvantaged Groups (Bajhang)

³ LRP is local resource person or to say coordinator/supporter of FCHVs and mothers

2.3.6 National Program and Day Celebration

The project is continuously supporting during the celebration of national days and campaigns such as national immunization days, FCHV day, World AIDS Day, National Vitamin A Day etc. These activities were found fruitful in raising awareness on related public health issues and building linkages with communities and other stakeholders in the project districts.

FCHV Day Celebration

Based on the national FCHV strategy paper 2004, the Nation declared 1st October for celebrating FCHV day. In the third year, project supported celebration of FCHV Day. The support included awarding three 'best FCHVs' in each VDCs, organizing rallies, quiz contest and other games/competitions. A total of 408 FCHVs from the project districts were awarded. The slogan of this year was, "*Mahila Swastha Swyam Sebika ko Sewa, Swastha Samaj ko Lagi Tewa*", i.e. "The services of the FCHVs are the pillars of the healthy society". The Health workers carried playcards and took out separate rallies in the district centres. Song competition, and quiz contests on CB-IMCI were organized to express gratitude to FCHVs and promote volunteerism, which has tremendously encouraged FCHVs to work more effectively in the community, for the community and with the community.

National Vitamin A Day

The project staff supported and participated in the National Vitamin A Day where every child aged 6 – 59 months old and 1 – 5 years old children were provided with the Vitamin A capsule and de-worming tablet.

World AIDS Day

December 1st has been celebrated as the World AIDS Day. The District AIDS coordination committee (DACC) headed by D/PHO at project districts, collectively organized activities to fight against the stigma and discrimination to people with HIV/AIDS. Greater involvement of people living with HIV/AIDS in every social, political and economic activity is reinforced at this day.

2.3.7 Supporting FCHV Program

The roles of the FCHVs are mainly focused on motivation and education of local mothers and community peoples for the promotion of safe motherhood, child health, family planning, and other basic health services. With support of health personnel from the SHPs, HPs, and PHCCs, the FCHVs are expected to promote available health services by educating local mothers and other community members. Additionally, the FCHVs re-supply pills and distribute condoms, ORS packets and vitamin A capsules; and in IMCI programme districts, they also treat pneumonia cases and refer more complicated cases to health institution. Similarly, they also distribute iron tablets to pregnant women in Iron Intensification districts.

Following activities have been carried out during the reporting period:

FCHV Review Meeting

CS XIX collaborates with DHO and has supported 3 additional review meetings that were organized alternately after the DHO's regular quarterly review meeting. This has resulted in the frequent reviewing of FCHV's performance, collecting service data, updating knowledge & skill and providing morale encouragement. Thus the meeting is conducted six times per year in each district (3 times by the DHO and 3 times by the project). Furthermore, the project takes this meeting as an opportunity to review FCHV's performance and strengthening their capacity.

FCHV Status Update

To channel child survival activities directly to community level, the project reviewed the FCHV status and updated their number, training status and progress. The review identified altogether 323 FCHVs (out of total 1510 FCHVs) are without basic training at the project districts however; they are active in serving their community. This issue has been discussed with RHD and respective DHO and prepared joint action plan to address the issues by the end of the year. To date, FCHV basic training is on process and other minor issues ID card distribution, in coordination with GTZ, lobby to local government DDC/VDC to allocate FCHV endowment fund and support FCHV in National program are being addressed.

Basic FCHV training

The unexpected number of FCHVs without Basic FCHV training in the region challenged the CB-IMCI program. Bajhang, in coordination with DHO and SAPROS, a local NGO working in food for work, organized first phase Basic training for 120 FCHVs. In Doti, the DHO minuted that the CB-IMCI training, to the newly selected FCHVs, can be organized and the DHO will explore ways for the Basic FCHV training to them.

FCHV Reward program

FCHV's volunteerism, hard work, commitment and generosity on health service delivery at community level is recognized and rewarded every year by GoN, and is supported jointly with EDPs (like CARE Nepal). The project supports felicitation program, initiated by D/PHO, DDC and local community. This has contributed a lot to build community cohesiveness and values to the volunteerism leading to enhance FCHV's morale and build trust on FCHV's works in the community.



FCHV excursion visit

"You are suppose to reside at health facility and deliver primary health services in community because you are civil servant and accountable for tax payer", FCHV Bhumirajmandu presided to health facility in-charge breaking culture of silence on immediate arrival back home to Doti from 2nd excursion visit to Kanchanpur. Furthermore, FCHV are making health worker (VHW/MCHW) accountable to perform their duties by increasing awareness in community and asking strategic question.

Altogether 30 FCHVs from 9 VDCs from Doti participated in the excursion visit to Kanchanpur. Primarily, the cross learning matter constitute of: Mother group (MG) - regular meeting & saving credit program, FCHV and mobile MG meeting, FCHV - coordination committee (FCHV-CC) formation, role & responsibility, and CB-IMCI cotrim fund. On interaction Doti district FCHV realized unity of FCHV itself is power that can weave the fabric of health consciousness in community.

After the exposure visit, the FCHVs from Doti became self motivated to organize a coordinating body to support the FCHV program. In total 6 FCHV-CC were formed in Doti and 6 FCHV-CC in Dadeldhura during this reporting period. FCHV are also in process of forming FCHV CC in Bajhang and other VDCs of Doti and Dadeldhura. These FCHVCC were backstopped by the project through support in their regular monthly meeting, in their initiation of implementing health activities such as celebration of World AIDS Day, World Health Day, Breastfeeding week, etc. The project planned to conduct capacity assessment of the FCHVCC and to support them in strengthening their capacity.

Management training for FCHV CC

The project organized two days management training for FCHVCCs in 6 VDCs of Doti. The training helped the FCHVCC and the partner organizations to understand the importance of the coordination committee, clarify roles and responsibilities of the members of the FCHVCC, organization of an effective meeting, establishment and mobilization of FCHV Endowment Fund, local level coordination and resource tapping etc.

2.3.8 School Health Program (SHP)

In Doti, a concept note of the school health program was prepared based on the framework of CHILD to Child approach. The Budget of the program was also revised as a pilot special initiative of the district under the unrestricted fund of CARE. A consultative meeting with DHO, DEO and Save the Children Norway was also organized that came to a consensus that the child development centre will be linked with the child club addressing the issues of the child survival and development. Based on the concept note, district level line agencies are being mobilized to disseminate BCC

messages for behavior change at community level by mobilizing school children.

2.3.9 Strengthening Health Facility Operation and Management Committee (HFOMC)

In Doti, the project in coordination with District Health Office (DHO) and District Development Committee (DDC) organized a joint meeting before initiating the HFOMC activities within the district. The meeting decided to communicate at VDC level by the DDC regarding the reactivation and reformation of the HFOMC as per the protocol of the Government of Nepal.

The project organized a District TOT on assessment and strengthening of the capacity of the HFOMC during June 2006. A total of 9 participants from DHO and health facilities, one from DDC and six from the project participated in the training. After the TOT, a VDC level HFOMC training plan was prepared and endorsed by Office of District Development Committee (DDC) and forwarded to the VDC secretary through the DDC.

The HFOMC is being revived as per the Nepal government protocol that was oriented to the VDC secretary during their regular monthly meeting. By the end of September 2006, a total of 21 VDC level HFOMC training has been accomplished and planned to be completed by February 2007 in the remaining VDCs.

2.3.10 Pressure group formation, orientation and mobilization

Dalits – referred as a socially backward caste in Nepal are religiously, culturally, socially and economically oppressed. In far western region *Dalits* population is more than 40% of total national *dalit* population. Discrimination to *dalits* – castes from whom water is not accepted and whose touches requires sprinkling of holy water have been a strong social norms and practices in FWR. The government clearly mentions discrimination is serious guilt. Recognizing the fact, the project united Doti *dalits* homogeneous groups at community to unite their voice for establishment of fundamental human rights – social inclusion, rights to reduce caste based discrimination, living with dignity.

The project has facilitated the groups to conduct their interactions, plan and implement advocacy initiatives, strengthening their networking at district level. Altogether, there are 22 pressure groups formed with the support of the project. In Doti district, the project supported formation and operation of 12



DABI session at Mudegaon, Doti

dabi advocacy groups. Each group comprise 20 – 25 members including members from *dalit* and marginalized communities. All *dabi* members' meets regularly to discuss on concurrent social and health issues and unite for advocacy. Recognizing socio-cultural transformation as a challenge, whilst advocating social issues, often these groups members increases in number and builds networks between inter pressure groups at different location to amplify the claim. Inclusion of *dalits* in social, political and economic activities in conventional society is challenge; however, these groups have achieved considerable change in their hamlets. Besides, the DABI centre also raises the issues related to regular supply of outreach health services such as EPI/ORC clinics, availability of the health workers regularly from 9:00 to 5:00 in the health facility, supply and access to safe drinking water and sanitation, abolishing the consumption of alcohol in public and hence creating havoc in the society, etc.

2.3.11 Support in DHO Annual Review Meeting

The CSP district offices supported in the DHO's Annual Review Meeting. During the meeting, the project staffs supported the Ilaka incharges to verify the HMIS data, calculate different indicators of the Ilaka and present them. The project presented the status of CB-IMCI and reviewed the CB-IMCI update including the reporting status. The presentation sensitized the Ilaka incharges regarding the status of CB-IMCI and the Ilaka incharges were made clear about the reporting system that needs to include the reports from FCHVs too, which was mostly missing. The issue of regularity of reporting was also raised in the meeting.

2.3.12 Greater Involvement of People Living With AIDS

The prevalence of HIV has been found to be alarming in the Far-Western Region of Nepal, where the migration rate is very high - at least one male member from 80-90 percent households migrates to India in search of work. About 10% of the migrants returning from Mumbai, India have been tested HIV positive.

In Doti, nearly 50 percent of the cases (34 out of 71 cases) were tested HIV positive who visited voluntary counseling and testing (VCT) center at the district hospital during June-July 2004. Almost all the positive cases (33 out of 34 cases) were widows in their twenties and thirties. About sixty percent of them were having breast-feeding infants. The in-depth interview with HIV infected women revealed that the young widows find difficulties to cope with their life circumstances. The study suggested that there might a large number of women in reproductive age groups who have been suffering from HIV and AIDS. This led to a conclusion that unless and until we address the issues of HIV and AIDS, reduction in maternal and childhood mortality remains unattainable.

To respond the situation, the project implemented GIPA (Greater Involvement of people Living with HIV and AIDS) Initiative as a complementary activity to CSP with the financial support from CARE Asia Regional Management Unit. The project aimed at

promoting wellbeing of people infected and affected by HIV and AIDS in Doti district. The project had focused on facilitating the formation of networks of women PLHA (People Living with HIV/AIDS), strengthening their knowledge base, and enhancing leadership skills to advocate for their rights.

The project helped women PLHA build their technical as well as leadership capacity through providing training on vulnerability, treatment literacy, rights institutional development and leadership. It also assisted HIV infected and affected people to form community support groups (CSGs), facilitate networks among these groups and mobilize them through different community action and advocacy. This has helped PLHA to develop confidence and leadership skills ensuring their greater participation on advocacy initiatives. The project also assisted women PLHA in moulding their behavior through communication and counseling.

As a result, District Health Office started providing free medicine to PLHA while District Education Office has decided to offer free education to AIDS orphan. But the availability and access to anti-retroviral (ARV), treatment of opportunistic infection and economic options remained unanswered, which is crucial to improve quality of life of PLHA.

2.3.13 HF level Program Review Meeting

The project organized program review meeting in all project district. The objective of the review meeting was to review IMCI and other project activities and develop further strategies for effective programme implementation. It was good forum for sharing of learning and experience as well as getting feedback for necessary improvement.

Lack of adequate cotrimoxazole with FCHVs, lack of training for transfer-in staffs, dropout FCHVs, and quality supervision were the genuine concerns raised and discussed in the review meeting. The meeting suggested DHO to purchase adequate cotrimoxazole from the annual drug procurement budget. It was discussed and agreed that HF In-Charges should coordinate with VDC to get fund to purchase cotrimoxazole and to establish mechanism to replenish cotrim to FCHVs.

2.3.14 Promoting child rights through birth registration

In Dadeldhura, the project has selected a special initiative to study and investigate problem faced in child right. The proposed initiative is being implemented with local NGO collaborating with local government and line agencies. The project facilitated to form and mobilize five Child Clubs in two VDCs enhancing their advocacy capacities to claim for ensuring child rights, started with birth registration issues. This initiation was piloted during second year period, which found effective to sensitize school children and enhance their advocacy skill and confidence. This helped to pressurize community people and government authority to ensure child rights. Children found very sincere to work on child right issues as a result many of local issues of domestic violence of children, school enrollment have been addressed and solved in the pilot area. Child club pressurized to reduce delay penalty fee and to regularize registration of vital events.

The practices of pilot areas have been replicated throughout the district i.e. reduce of delay fee and regular registration services at community.

2.3.15 Dabi (Claiming rights) for community awareness and advocacy

*Dabi*⁴ (Claiming rights in English) is a new initiative of the project for empowering communities through awareness raising and sensitization on their rights and to support them in advocacy efforts.

In Kanchanpur, *dabi* forums are operating in all VDCs of Kanchanpur. Altogether, 55 *dabi* centers – comprise of homogeneous group (identical caste, class and issues focused target groups), are in operation. All member meets regularly to discuss on issues and unite for action at the local level.

Major issues that are brought under advocacy are; Chhaupadi, PHC/ORC management, use of Safe Home Delivery Kit (SHDK) for safe home delivery in Dabi Kendra and advocacy with local drug shop and HF to make the availability of SHDK at the community level alcohol management, financial transparency in different cases, physical infrastructure construction, caste discrimination, provision of safe drinking water, insecticidal spray for controlling malaria, child birth registration, women right and domestic violence, earlier marriage and equal labor wages.

During the reporting period, a review meeting was organized for 16 *dabi* facilitators to enhance capacity to select/identify local issues, preparing advocacy plan and build network with like-minded stakeholders, media, bar association, and line agencies. Participants also shared their endeavors, experiences, challenges and risks with one another in the course of enhancing and promoting their understanding about prevailed socio-cultural and system related issues of their communities.

The initiative continued critical participation and mass gathering is necessary. This is possible only if the community people take the ownership of the program. The spontaneous development of second-generation *dabi* facilitators is an indication of communities ownership on the program. In total 46 second generation *dabi* facilitators were identified who have already established or are in the process of establishing *dabi* centres on their own initiation within their community. The project provided training to the second generation *dabi* facilitators on the issues of RBA.

2.3.16 Orientation to MG on iodine consumption

An Orientation to MG in Rauteli Bichawa of Kanchanpur was conducted where all together 164 participants including 45 *dalit* women participated. The orientation covered the importance of iodine consumption, locally available sources of Iodine and the demonstration of iodine content of salt to motivate the mothers to consume iodized salt.

⁴ *Dabi* – a local name given to REFLECT program so as to make program itself, users friendly and appealing.

2.3.17 Mobile MG meeting

In Kanchanpur, the FCHV's noticed that the traditional practices of conducting Mother's group meeting has always left out a certain portion of mothers, especially those from marginalized group caste. In order to include them in the regular meeting, they came to a common consensus that a complementary meeting should be designed to cover those groups of mothers too. This helped to bring at the concept of mobile MG meeting. Almost all FCHVs conducted at least one mobile MG meeting in their community. Basically in these mobile MG meetings, the FCHVs follow the seasonal calendar for the participatory identification of the health issues to be discussed and addressed. The other vested objective of the mobile MG



Discussing in Mobile MG meeting

meeting is to inform those mothers about the importance of being in a group and motivate them to participate in the core MG of the area. The Mobile MG meeting has encouraged the marginalized groups (*dalits*, ex-bonded labors) to seek health education and health care for themselves and their under five children. During the period, FCHVs provided health education on diarrhea to about 1500 mothers and school children.

2.3.18 Behavioral change communication workshop

In Kanchanpur, a one-day district level workshop was conducted in active leadership of the DPHO for endorsing the behavioral change communication strategy to all of the health organization of Kanchanpur district. During the workshop DPHO, INGO, NGO and other local clubs were participated. All together 21 person were participated among them 11 were women representatives. All the participants received a copy of BCC strategy and committed to work in the line of strategy for BCC. A Nepali version of the strategy has been shared at peripheral health facility and FCHV level.

2.3.19 Malaria Control Program

Considering the repeated epidemic of malaria in Kanchanpur, the project explored funds for malaria control program. With the financial support from JSI/NFHP/USAID, the project conducted several activities for malaria control program in Kanchanpur. The project carried out baseline survey to assess the level of knowledge, attitude and practices related to malaria using LQAS approach.

The project supported DPHO Kanchanpur in establishment of community health labs in seven sites. The establishment of lab helped to improve people's access for early diagnosis and treatment of malaria.

The project organized training on malaria prevention and control was organized for 804 FCHVs of Kanchanpur. The training was conducted in close coordination with DPHO. After the training, FCHVs provided health education to mothers on malaria prevention through MG meeting and mobile meetings.

In addition, school health education program on malaria prevention was conducted in 49 schools through the active support of DPHO. This is specially aimed at raising community awareness on malaria prevention through school children.

2.3.20 Positive Deviance/Hearth Pilot Program

The project implemented PD/Hearth as a pilot program in Kanchanpur for community-based management of malnutrition and behavior change related to child caring, feeding and health seeking practices.

As a special initiative program – Positive Deviance/Hearth is accomplished in Kanchanpur to promote feeding of locally nutritious foods available within community. The program was implemented in two VDCs (Krishnapur and Tribhuvanbasti) and Mahendranagar municipality. A total of 155 (male 86, female 69) moderate and severe malnourished children have been rehabilitated by through nine PD/Hearth centers. However, the change in behavioral practice in child care and feeding practice of post PD/Hearth session is being assessed focusing on home visit, making interaction among healthy babies and unhealthy babies' mothers. The PD/Hearth Centre has been motivating mother to consume local available food reach in micronutrient with more feasible and sustainable Health education to mother on positive behavior on nutrition in the PD center.

Table 7: Impact of six months graduation of PD/Hearth

Period of PD/Hearth	Severe Underweight		Underweight		Normal	Total children
	Male	Female	Male	Female		
Baseline	24	15	62	54	0	155
After Hearth Sessions (Six month graduation)	12	5	20	29	89	155

2.3.21 Community Drug Program

In most of the health facilities are facing shortage of essential drugs at health facilities. It has seriously affected in the quality of health services. It has resulted to promote irrational use of drugs and mostly VDCs have private practitioners who mostly sell third generation of antibiotics and drug resistance is increasing in community level.

Realizing the need, the project initiated the Community Drug Program in Bajhang with support from CDP/LMD/DoHS. Till date, district level ToT has been accomplished and community level training is ongoing.

In context of Bajhang, CDP program is quite crucial to implement to make the health facility self-dependent and ensure community participation for the consistent availability of essential drugs, to improve the quality of services, to strengthen the system of rational prescribing of drugs, to make pro-active HFMC and community accountability and responsibility, at last to make the health facility self-dependent.

Following activities were carried out during this reporting period:

- **District Orientation & district ToT on CDP:** A five days district orientation & ToT on CDP had been completed (25 participants) – August 2006
- **Participation of Regional Review Meeting:** Participation of AICBO in the CDP regional review meeting in Nepalgunj to review problems, issues and functional status of Community Drug Program (CDP).
- **Health Workers training on CDP:** All health workers were trained on four days CDP training in coordination with CDP/LMD/DoHS. (71 participants)
- **VDC Orientation & HFOMC training on CDP:** In total 10 VDCs & HFOMCs of Bajhang had been oriented & trained on CDP. The training in the remaining VDCs is planned to be conducted in the first quarter of the succeeding year.

The project has produced training and implementation materials necessary for the CDP in Bajhang. These manuals include CDP Trainer's guide, CDP Participant manual, Posters, and Brouchers, Ledgers, Bill and Receipt pads.

In addition, the project supported in monitoring and follow-up of Community Drug Program in Kanchanpur. As Community Drug Program is not functioning well in Doti and Dadeldhura, the project facilitated the process to establish "Cotrim Fund" to ensure year round availability of cotrimoxazole and ORS.

3. Impeding factors and action taken (Challenges)

Far and Mid West Region of Nepal are the most affected areas where the project districts exist. At present, there is call for cease-fire by Maoist. Several agreements on different points have been made between the Maoist and the Seven Party Alliance (SPA). The national protest demanding peace and political stability through constituent assembly has created a transformation in political situation in the country where the King has handed over the rule to the SPA. The political scenario is still unstable and unpredictable though the cease-fire is pertaining. But the repeated reports of unexpected detention and abduction has still raised confusion among the people. Strategies adopted are less effective in conflict transformation and resolution.

It is well known fact that all works are in conflict vis-à-vis commitment to fight against poverty and improve optimal health of mother and children have become a challenge. Implementation of planned activities at desired timeline went through repeated revising. Hence accomplishment of some activities hindered.

3.1 Unstable security situation at project districts

Nation's security situation was unstable and challenging until third quarter of the this reporting year. Before the national protest part 2 all governmental service delivery institutions (partly health) were dysfunctional and thus, centralized at district head quarter. Developmental activities of INGOs (including CS XIX) in collaboration with government counter part and civil society were not in full fledge functioning.

Despite of the difficult situation, the project has done considerable effort to work in conflict in a strategic way. Staff security at field was the prime concern and dealt without any compromise. Conduction of regular meeting with staff and making required changes in working strategy was proven strategy to build moral and confidence to work continuously during conflict.

Immediately, after the announcement of cease-fire and the handover of the rule by the King to the Seven Party Alliance, the major pending activities ran in full fledge in all the districts. As usual, during this reporting period, the project has maintained its low profile in field.

CARE security manual is distributed and mission stance regarding conflict is oriented to all staff. Field staffs were given authority to make logical decision on security matters at any location. Staffs were prepared to apply "Do No Harm" approach to maintain transparency, impartiality and neutrality. Partnership with local institution and local staff at project/partner organization has decreased the risk. Transparencies in programming and participation of civil society in project implementation and progress review have proved to be successful approach.

Work during conflict and unstable situation was time consuming therefore, the project progress was not at the desired level, but the project made especial and cautious efforts

to carryout project activities as much as possible.

3.2 Absence of local government

Early July 2002 Village development committees dissolve; administrative clerk replaced locally elected executive bodies and they are functioning and representing government at local level. Threat and intimidation to government representative fear secretaries to stay in working station hence, services like citizenship certificate, revenue collection and postal services at local level are full of challenge and dysfunctional. Consecutively, suspended local election and absence of local representative has posed serious problem in local developmental activities. In many instances, Village Development Committee's annual budget is under spent.

4. Technical Assistance

CS XIX works with the technical assistance of CARE Country Office, Kathmandu and CARE USA Atlanta, Health unit. Significant technical assistance was received for conducting the Mid Term Evaluation of the project. A process has started with the technical advice from CARE USA, the project is in process of mapping out RBA integration in Child Survival and expected to be completed by Dec 2006. In the final year of the project, the project requires technical assistance for following activities:

- Final evaluation of Child Survival Project
- Documentation and dissemination of major lessons learned in the Child Survival Project
- Dissemination of findings from RBA mapping in Child Survival

4.1 Mid – term evaluation

Bal Bachau project on completion of its half life span period, attempted to a) evaluate and measure overall project progress, b) assess interventions are sufficient to reach desired outcome and c) identify barriers to achievement of objective. Evaluation put greater emphasis on project process so that to ensure the project sustainability.

It was done in effective learning approach through the participation of total 47 representatives. They were from FWRHD, D(P)HO, PAC member, Local partner organization, FCHVs, project staff and consultant. Information was collected from different stakeholders of project namely



Group interview during Mid term review

mothers group, FCHV group, FCHV group, *dabi* group, VHW/MCHW, health facilities, DHO, partner NGO, PAC members and municipality of Kanchanpur. The evaluation was carried out during Dec 2005 - Jan 2006.

On immediate completion of information collecting the evaluation finding was presented at project and central level in USAID local mission, CHD, SWC, CARE Management team and the project team. Major highlights of MTE findings are mentioned in the table below. The participants at the meeting had given feedback and suggestion to strengthen the essential health supplies at health facilities.

Table 8: Strengths and areas of improvements identified by MTE

Strength	Area of improvement
1. Excellent working relationship and networks with community & partners organization	Low participation of dalits and marginalized community in mother group
2. Promising community level activities viz. active MG, effective coordination between CHW, FCHV and MG	Provision of essential supplies at health facilities and FCHV level
3. Progress towards targets is satisfactory - mothers' knowledge is increased for diarrhea treatment, immunization and pneumonia treatment.	Monitoring and evaluation; LQAS monitoring has long list of indicators (>17).

Following the recommendations of MTE a action plan was prepared immediately and actions have been taken. Below is a list of recommendations and status of the project's actions.

Table 9: Action taken against MTE Recommendations

MTE recommendations	Actions taken and Progress status
1. Capacity building of partner NGOs and FCHVs for organizational development with special emphasis on social inclusion (especially for CS program)	The project has organized one event of social inclusion training for project staff and partners. Those staff were also involved in training other staff including the partners staff. Some of partners have reviewed their organizational policy and made it inclusive. The project team has incorporated the inclusiveness concept into the program interventions and the processes.
2. Encourage and ensure FCHVs to	FCHVs were oriented on social inclusion issue

target dalit and marginalized cluster and strengthen MG capacity to act accordingly.	during their monthly meeting and motivated them to cover more dalit and marginalized mothers. After the orientation, FCHVs are enrolling more dalit and marginalized mothers in MG meetings. FCHV are also conducting mobile MG meeting in dalit and marginalized clusters.
3. Strengthen district level NGOs	This recommendation of MTE has basically indicated for cross-fertilization and resource tapping capacity building of NGOs. A meeting was organized with partner NGOs to review their policies and practices and has agreed to organize a separate training on it, as well as to facilitate for linkage building.
4. Document the best practices and transfer the learning to other CSP district.	The project has documented 4 best practices i.e. Dabi, HFOMC strengthening, LRP mobilization, FCHV-CC strengthening (see result highlights) and recommended to adopt learning for the rest of the project period..
5. Clear roles and responsibility between NGO partners and CSP	The project has conducted an assessment of CSP partnership program as recommended by MTE. The meeting reached to the consensus that it is a joint responsibility of both partners, but intensity of involvement will be different for different roles and for target group, as demands by context during implementation phase. Partners were agreed to meet on monthly basis and prepare a joint action plan based on project AIP, and to carryout periodic review of the progress and plan actions for ahead.
6.LQAS: Use a short list of indicators for discussion with project partners.	Project identified short list of indicators and developed a concise questionnaire to carryout next round of LQAS Survey.
7.A national advisory group need to be formed to review the project performance and advocacy at national level for project successes, alternatively CARE joins or form an already functional group with other NGOs and donors for the same vision	The project started dialogue with concerns authorities (USAID and CHD) to form national level project advisory committee. National level stakeholders have positive response in this proposal.
8. Incorporate local dialect in project training and educational materials	The project is exploring possibilities.
9. Thorough investigate if the drop in immunization rate is correct as seen in the LQAS finding and thoroughly investigate the cause if any.	The project is planning to verify the situation of immunization through an in-depth study by Dec 06.

5. Changes in Program Description and DIP

No significant changes in the program description and DIP have required modification of the Cooperative Agreement.

6. Monitoring Plan

The project used 11 Rapid CATCH Indicators and seven DIP Indicators as a monitoring indicators. Those indicators were monitored using LQAS Survey. Based on the latest LQAS Survey carried out in May 2006, project achievement is remarkable except in few indicators as indicated below:

In Kanchanpur,

Except vaccination rate (full vaccination or measles coverage) and care seeking during pneumonia, progress of the project is remarkable. The vaccine coverage rate remained the same in the baseline level in Kanchanpur whereas care seeking during pneumonia has gone significantly down. This might be due to limited sample size of the LQAS. So, the project will explore ways to verify these data with other sources and will try to focus on these areas in rest of the project period.

In other districts (Doti, Dadeldhura and Bajhag)

Exclusive breastfeeding, vaccine coverage, feeding during illness and treatment of diarrhea by using oral rehydration fluid either did not improve or even worsen as compared to baseline. Except these indicators, the project has already achieved the target of final evaluation or very likely to achieve target – if current trend of progress continues. Project will focus on monitoring and follow-up of the activities related to those indicators where project is less likely to achieve its target – if current rate of progress continues.

Table 10: Project achievement by Rapid CATCH and key indicators from the DIP

ID	Indicator	Kanchanpur			Other districts		
		Baseline KPC	LQAS	Target for FE	Baseline KPC	LQAS	Target for FE
		Aug 03	May 06	Sept 07	Jan 04	May 06	Sept 07
1	Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	68	89	80	75	68	80
2	Percentage of children age 0-23 months whose births were attended by skilled health personnel (Note: Includes doctor, nurse, ANM, MCHW)	24	31	40	10	29	40
3	Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child (by card or reported verbally by mother)	65	88	85	46	56	65
4	Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	50	70	75	67	60	75

ID	Indicator	Kanchanpur			Other districts		
		Baseline KPC	LQAS	Target for FE	Baseline KPC	LQAS	Target for FE
		Aug 03	May 06	Sept 07	Jan 04	May 06	Sept 07
5	Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	83	93	85	71	77	80
6	Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	74	74	85	45	26	75
7	Percentage of children age 12-23 months who received a measles vaccine	87	88	92	69	75	80
8	Percentage of children age 0-23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night	2	21	25	0	NA	NA
9	Percentage of mothers with children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and a after attending to a child who has defecated (washed hands in all four conditions)	16	82	30	2	15	20
10	Percentage of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	84	95	85	58	84	80
11	Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	58	89	65	10	12	60
Additional indicators from DIP (log frame)							
12	Percentage of children aged 6-23 months who received a Vitamin 'A' dose in last six months	74	93	95	0	87	75
13	Percentage of children age 0-23 months with diarrhea in the last two weeks who were continued breastfeeding during the illness	84	94	90	68	84	75
14	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received Oral Rehydration Solution (ORS) and/or recommended home fluids (RHF)	34	61	50	36	32	50
15	Percentage of children aged 0-23 months with pneumonia in the last two weeks who were taken to health facility	40	11	75	32	56	50
16	Percentage of mother who received iron supplement (at least 90 tabs or 3 months) while pregnant	26	77	55	6.3	32	20
17	Percentage of mothers who received a Vitamin 'A' dose during the 45 days after delivery	64	84	90	34	57	65
18	Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	38	67	65	10	28	65

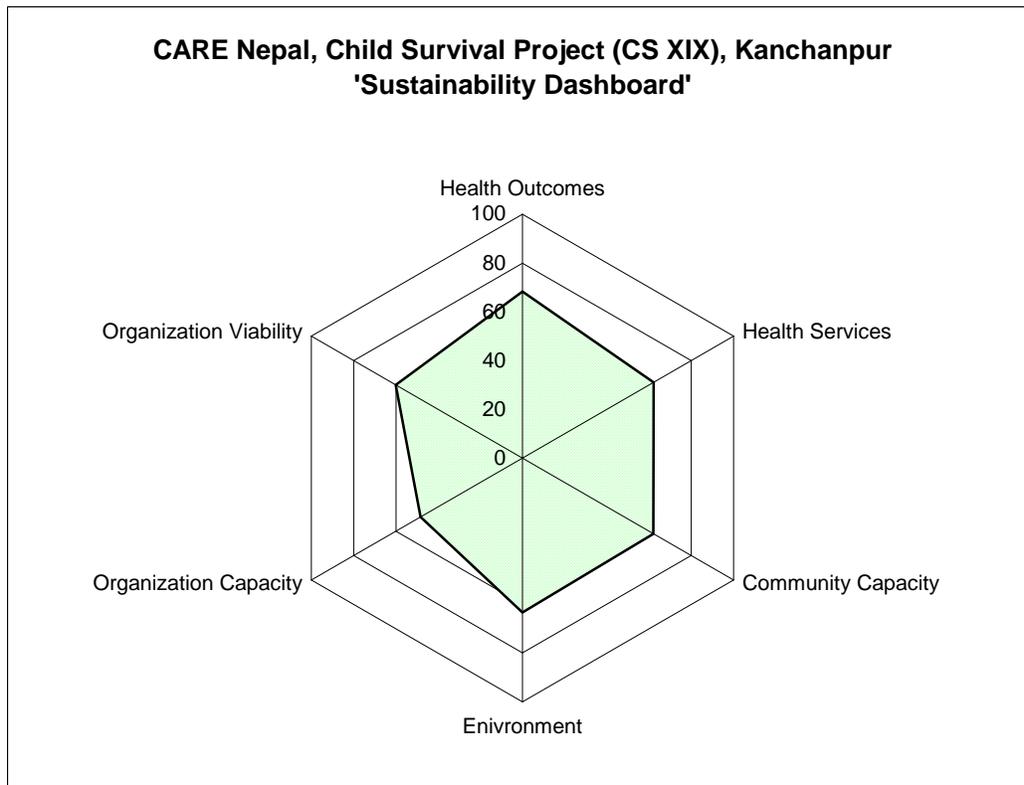
As per the Monitoring and Evaluation Plan, the project will carryout next round of LQAS in November/December 2006. The project progress will be reviewed based the updated data from LQAS and other secondary sources. Finally, the project will be evaluated using 30 cluster KPC Survey and qualitative survey during July/August 2007.

7. Sustainability Plan

The project considered sustainability issues in implementation, monitoring and evaluation. Central level PVO personnel (Program Coordinator-Health, and Community Health Specialist) participated in the workshop on Child Survival Sustainability Assessment (CSSA) organized by USAID/ORC Macro/New Era. Following this, the project team members (from Kanchanpur district and regional backstop) were oriented on the concept, importance and process of sustainability assessment.

During the month of May (28-29 May 2006), the project carried out the assessment of sustainability in Kanchanpur district in presence of local stakeholders through the technical support from New Era, the local agency for supporting CSSA process for PVOs in Nepal. The CSSA workshop was participated by staff from CS project, District Public Health Office, District Development Committee, Mahendranagar Municipality, Female Community Health Volunteers, local NGO partners, and media. The workshop identified the local system, program vision and indicators for sustainability assessment for each component for the Child Survival project in Kanchanpur. Based on the list of indicators identified and their score value from different sources, a sustainability dashboard was prepared for Child Survival Kanchanpur.

Fig 1: Sustainability Dashboard of CARE Nepal, Child Survival Project, Kanchanpur



Based on the exercise of participatory Child Survival Sustainability Assessment, following actions are recommended for moving Child Survival project, Kanchanpur more towards sustainability.

- The progress of the project towards health outcomes, health services, organizational capacity and community capacity was found encouraging.
- Efforts should be made to ensure that the progress made on health outcome, health services, organizational capacity and community capacity be sustained over the period of time.
- For the remaining period, project should focus on strengthening systems to improve organizational viability and enabling environment. For this, project should identify actors that have roles on creating enabling environment and to strengthen organizational viability and mobilize them for sustainable health outcomes.
- Project should regularly monitor its progress based on the CSSA framework and take appropriate actions. This system should be institutionalized within district public health system.

Through the process, all stakeholders realized the importance of different stakeholders in sustaining the results of the project at community level and expressed their commitment to contribute through their capacity. Based on the learning of Kanchanpur, the project will develop “exit or phase-out strategy” for child survival project for other three districts.

8. Specific Information Requisition

No specific information was requested in this reporting period.

9. Phase out plan and preparedness

The project has completed its most of the activities as planned for the third year. The detailed procedure of phasing out of key project activities/program from three new districts with a timeframe within the project life is yet to finalize. Based on the work completed till the third year, a quick assessment will be carried out throughout the project districts to assess the current situation and plan for phase out in three districts.

It was envisaged that a comprehensive exit strategy will be developed with multiple-stakeholders and partners during the period due to above described constraints and instability in the country, the frequent change and suspended works schedule caused delay in the process of preparedness for phase out plan. Within the first quarter of year four of the project, a multi-stakeholder workshop will be conducted to discuss the progress of the project and to further refine remaining activities and prepare a plan for phasing out from all project districts.

In Kanchanpur, the project was able to carry out the activities through DPHO, local NGOs and FCHVCCs and the project is in the process of phase out by Dec 2006. So far, the project activities have been phased out from 13 out of 19 VDCs. Certain facilitating activities are being carried out in selected areas with the NGOs and FCHVCC. It is also possible for the project to hand over a certain activities to the VDC, DDC and municipality and other NGOs that are working in the same districts. Currently in Kanchanpur, the project has a team of three staffs for the periodic monitoring and provides necessary backup support the activities but not necessarily place staff at the site. The project has done an assessment prior to phase out from the VDCs in coordination with DPHO, DDC, VDC, HFOMC and FCHVCC.

10. Program Management System

Project manager leads the project from regional office based in Doti. Technical and administrative team of region provides guidance and support to district team to implement planned activities.

In order to maintain consistency in programming and build strong coordination between the districts and partners, each district organizes a monthly meeting to discuss on progress, reviews working strategies, challenges, and lesson learned and shares valuable information. Prime concerns are given to security issues, and its challenges. A project management team (PMT) meeting consisting of DHCs and AICBO from all project districts is held in the regional office (Doti) every quarter to build the linkage between district team meeting and PMT, and discusses project issues, tracks progress in line with the log frame and takes corrective actions.

The project progress review is done periodically through two channels a) PAC in every six months and b) regional review meeting with participation of district teams and representatives from D/PHO, DDC, partner NGOs and FCHVs.

10.1 Financial Management

Towards the end of third year, when the cease fire was called and peace process started in the country, the project gained a momentum, the project activities were speed up as a result the budget expenditure was in line with the time spent, which is 61.57 % of expenditure in total time span of 71%.

Financial procedure in distance management is found to be challenging and time taking. However, authority delegation to DHC for financial transaction, partial settlement of program advances, and monthly support visit to district team by admin & finance team has eased financial management. Quarterly budget review in PMT meeting with individual district budget details – tracking of budget burnt rate & time span alerted the project team and took up timely actions.

Referring to the table no. 2, the expenditure of more than 61.57% against the time elapse by 71% even during in conflict situation is remarkable achievement.

Starting Date: 01 October 2003 Ending Date: 30 September 2007 Reporting Period: 01 October 2005– 30 September 2006 Grant # GHS-A-00-03-00014-00

Table 11: Detail description of Budget (Oct '05 – June '06)

SN	Description	Total Budget	Total expense as of July '06	Budget Balance as of July '06	Burn Rate
1	Personnel	699,534	421,985	475,985	60.32 %
2	Fringe Benefit	428,355	243,937	184,418	56.95%
3	Travel		1,860	(1,860)	0.00%
4	Equipment		2,457	(2,457)	0.00%
5	Supplies (Tech/logistic/Procurement)	124,030	87,795	36,235	70.78 %
6	Contractual (Baseline)	26,000	27,328	(1,328)	105.11 %
7	Other				
	Program/Activities cost	655,959	438,322	217,637	66.82%
	Operation Cost	101,461	107,408	(5,947)	105.86%
	Total Direct Cost (1-7)	2,035,339	1,331,091	704,248	65.40%
8	Indirect Cost	159,367	102,922	56,445	64.58%
	Total USAID's Cost Sharing	2,194,706	1,434,014	760,692	65.34%
9	Total Matching Fund	731,391	367,485	363,906	50.24%
	Grand Total	2,926,097	1,801,499	1,124,598	61.57%

Time elapsed 70.83%
Budget Burnt Rate 61.57% (including matching)

Total cost sharing	Total budget	July '06	Balance	% Spent
Total Federal (USAID)	2,194,706	1,434,014	760,692	65.34%
Total Matching	731,391	367,485	363,906	50.24%
Grand Total	2,926,097	1,801,499	1,124,598	61.57%

10.2 Human Resource Management

Project Manager leads the CS XIX project. Regional team is comprised of 3 specialists and admin staffs. Whereas, district team comprises of 5 – 7 health supervisor, one Assistant Institutional Capacity Building Officer and one District Health Coordinator. CS staffs regularly meet at district and region to update their progress assess their current status and recommend taking necessary action for correction. Sufficient exposure at work, yearly performance appraisal and recognition of work performance is done in project on yearly basis.

Staff retention and maintaining staffs' morale at consistent level in remote district has always been a challenge. Furthermore, staffs transition is also high in this project. This year few key staff have left for better career opportunity, they were: One Research

Monitoring and Documentation Specialist, One DHC have left for better options, and the one AICBO has resigned. The efforts have been to fill the vacant positions on timely manner.

10.3 Local Partners' Relationship

The project works in partnership with government counterparts, with other technical institutions, and NGO partners at various levels. In this, the project works closely with Child Health Division (CHD) and its various at central level, Far Western regional Health Directorate, District Public Health Offices. During the reporting period, the project obtained technical assistance from private organizations such as Nepal Pediatric Society (NEPAS), Integrated Rural Health and Development Training Center (IRHDTTC) and networking with National Technical Assistance Group (NTAG). The project has worked with the district and local NGOs/CBOs including the FCHV – CC in various community empowerment related activities and implementing partners local NGOs and CBOs.

Each project district organized two rounds of project Advisory committee meeting and provided the updates on project progress, carried out joint supervision and monitoring visits on quarterly basis. The PAC has been quite helpful in recommending for improvements and facilitating for open discussion. This has contributed to the strengthened relationship with government counterparts at district and regional levels.

10.4 PVO collaboration/coordination in Country office

The Country office health team has established a strong network with the Department of Health Services, the Child Health Division (CHD) and its units, and Family Health Division (FHD). CARE Nepal is a member in various national level working groups and committees that work on FCHV programs, IMCI Working Group, Nutrition Working Group, CDP Networking committee. As a member of the various working groups, CARE Nepal participates in meetings that provide all partners with shared experiences and lessons learned. CARE Nepal actively participated in the review of the IMCI training package, FCHV day celebration, etc. CHD, NHTC, NHEICC and CARE Nepal keep in close contact and now maintain better communication and networks.

CARE Nepal also worked with Nepal Family Health Program (NFHP/JSI/USAID) on malaria control interventions and technical assistance to the IMCI program. Since NFHP was a collaborative partner with CARE in another health project, the programs jointly explored means for financial and technical support of the complementary intervention on malaria control and designed by the CSP. CARE Nepal has also relationships with other PVOs especially with Save the Children US and Plan Nepal for sharing of experiences and expertise in the field of child and maternal health.

11. Mission Collaboration

CSHGP is placing increased emphasis on coordination with USAID Missions and their bilateral programs for improved in-country complementarity of programming. Following this requirement, CARE CSP has been maintaining the coordination with local mission through various ways, and contribute to mission's other bilateral efforts in Nepal.

Annual updates on the project progress is done regularly with the local mission officials. Moreover, sharing and discussions on complementary initiatives, such as integrating HIV/AIDS issues in CSP, promising practices such as REFLECT technique of Rights Based Approach, are done with mission's health personnel on various occasions. Information is provided and sharing is also done when there is any request by the mission, or when CARE has some information to share with. The interactions are also held with the mission personnel together with Child Health and Family health Division during various working group meetings, such as CDP, IMCI, FCHV, working groups organized by the CHD and FHD periodically, and mission led annual meeting of SO2 partners in Nov 2005.

In March 2006, we participated in the mission led annual interaction program on Sustainability Framework and shared our experience in working towards sustainability. Following on this workshop, CSP has already adapted the Sustainability framework in its Kanchanpur district program monitoring process.

As always, meetings with the local mission are based on the necessity on either side. During the period when conflict was escalating in the country, our interactions were more frequent especially on security related issues to ensure the safety of staff and smooth operation of the program activities. Our regular sharing of CSP modality to work in conflict situation has been quite useful for the local mission in reviewing their working modalities and updating themselves.

As CARE-Nepal is gaining more competencies with several innovative practices in Child and maternal health programming, it's frequent interactions and sharing with local missions for possible replication of good practices and giving continuity to those practices become more significant. In this, CARE Nepal expects the local mission as well as the CSHGP to participate in such sharing, give recognition and response to CSP's achievements and work out possible ways to achieve the scale at country level.

Given the evidence based promising practices, and the technical competencies in IMCI and Maternal health, CARE Nepal would also like to initiate dialogue with local mission to build synergies with mission's priority in the field of child and maternal health care for Nepal. The support from CARE USA and CSHGP in this regard will be vital.

12. Substantial changes from the DIP or MTE

The project has adapted some new working modality, which was not described adequately in project document and the DIP. The adaptation of new modality was partly due to CARE International's programming principles in which all the CARE projects should have rights perspective and geared towards sustainability through making the

local community more accountable to retain the changed positive behaviors both at utilizes as well as service provider's level. In this we adapted few techniques to adapt RBA, ensure Gender equity and social inclusion in its overall implementation processes. It is quite encouraging to share all those new techniques showing positive results in the project areas. Some of those tools and techniques are described separately under the "Innovative ideas", and "Promising Practices".

These changes were more about software nature; therefore it didn't require additional budgets. The project has been quite able to manage with the available budgets. The project has also discussed and shared the new modality and its outcomes with the local mission. Therefore the project doesn't consider it as major changes that require modification in the Corporate Agreement.

13. Specific Information for response from the review of previous report and MTE

Not any specific information was requested from the previous report or MTE.

14. Result Highlights

The result highlights of the project have been categorized as innovative ideas and promising practices. The section also describes how the project contributed in scale up, promoting equity and governance at local level.

14.1 Innovative ideas

14.1.1 CHILD to child approach

Knowledge and practice of children caretaker is important to improve health and nutritional status of children. Older siblings care took 13.3% children of Doti district. (Source: Baseline survey report, March 2004). HIV/AIDS is found a major problem in Doti district (about 45 – 50% of suspected cases are found HIV positive), which has affected for basic education and livelihood security of orphans. The "CHILD to child" is a peer education approach that helps to educate caretaker children sensitizing on preventive measures.

The project first collected baseline information related to knowledge and practices of school children on preventative measures, school drop out ration, birth registration status. Based on the compiled base line a concept paper was prepared to implement CHILD to child program.

The project helped to form Child Clubs of school children in selected schools in Doti and Dadeldhura districts for piloting. A training package on working modality of “CHILD child program” was developed incorporating key health messages, community health system, promoting healthy school environment and basic concept of right-based approach status. This training provided to leader children of child club, school teacher, health facility staffs, VDC secretary and project/partner staffs. Moreover, regular supportive monitoring visit is being carried out to coach child club to implement program effectively. Trained schoolteacher and HF staffs are conducting health session in weekly basis in the selected school. The Child Club member organizes regular interaction in their home-cluster to sensitize them on key health behavior and the issues of child rights. The child club members carried out two major activities, awareness raising for vital event registration and pressurizing local administration to reduce delay penalty fee and to provide vital registration services effectively at community level.

Result/changes observed

After the implementation of “CHILD to child” approach awareness and confidence level of children has been increased, and are implementing Child Club initiations independently. Because of enhanced knowledge on health and advocacy capacities, they have been able to implement advocacy to maintain healthy school environment and quality of teaching in the school. Currently the children are advocating integrating their learning into district level education plan to replicate throughout the district. This has helped to increase coverage of information dissemination on health education and child rights. After start of child club advocacy, the trend of registration vital events, birth, death, marriage has increased even outside the pilot area.

14. 1. 2 Integrating HIV AIDS issues in CS

The prevalence of HIV has been found to be alarming in the Far-Western Region of Nepal, where the migration rate is very high – at least one male member from 80-90 percent households from the district such as Doti, migrates to India in search of work (CARE-Nepal, 2002). Many of them were found to be engaged in unsafe sexual practices during work and become vulnerable to contract HIV and serve as bridge of infection to their spouses and new borne. About 10% of the migrants returning from Mumbai, India have been tested HIV positive (Poudel K.P, 2001).

CARE-Nepal commissioned a study in 2004 to understand the situation of HIV and AIDS in Doti district where CSP being implemented. The study found that nearly 50 percent of the cases (34 out of 71 cases) were tested HIV positive who visited voluntary counseling and testing (VCT) center at the Doti district hospital during June-July 2004. Almost all the positive cases (33 out of 34 cases) were widows in their twenties and thirties. About sixty percent of them were having breast-feeding infants. The in-depth interviews with HIV infected mothers revealed that the young widows, all of them are from the most marginalized and poorest conditions, find difficulties to cope with their life circumstances. They are burdened with multiple problems, taking care of themselves, their young children, earning for family livelihood and facing the stigma and

discrimination. Clearly, it is a fact that unless and until we address the issues of HIV and AIDS, any efforts to reduce maternal and childhood mortality remains unattainable.

Realizing the greater need to respond the situation, CARE Nepal - under the broader child survival framework - piloted GIPA Initiative (**Greater Involvement of people Living with HIV and AIDS**) between April 2004 and September 2006 in Doti district with the financial support from CARE Asia Regional Management Unit. The effort was primarily focused on promoting wellbeing of people infected and affected by HIV and AIDS in Doti district. The project had focused on facilitating the formation of networks of women PLHA (People Living with HIV/AIDS), strengthening their knowledge base, and enhancing leadership skills to advocate for their rights. The project helped PLHA mothers build their technical as well as leadership capacity through providing training on vulnerability, treatment literacy, rights institutional development and leadership. It also assisted HIV infected and affected people to form community support groups (CSGs), facilitate formation of networks among these groups and mobilize them through different community actions and advocacies. The current efforts are to advocate for the availability and access to anti-retroviral (ARV), treatment of OI and economic options for the PLHA mothers.

Results/changes observed

The initiatives under GIPA framework in selected VDCs of Doti has helped PLHA mothers to develop their confidence level and leadership skills with their greater participation on advocacy initiatives and local level decision-making processes. The District Health Office, Doti started providing free medicines to PLHA while District Education Office has decided to offer free education to AIDS orphan, and children of poor PLHA mothers.

The PLHA mothers' overall health status, and social status have been found improved. The mothers, before, used to be frustrated, depressed and did not have willingness to live. They were only worried about their children's future, and due to fear for Stigma, they were not taking initiatives to explore income earning options. They also had appeared negligence in taking care of young children and infants. Now, after the piloting of GIPA in 4-6 VDCs of Doti, mothers, regardless of their HIV AIDS status, are able to lead a positive life and taking care of children quite well. As a result the morbidity of children has reduced and positive thinking and healthy behaviors is adapted. They also have established a community support system to help the PLHA women and children in any emergency.

This is an innovative idea, has gained lots of appreciations from the district health and community. However, due to limitation of financial resource, the idea couldn't be replicated in other CSP districts despite its' visible and positive effects in the lives of young mothers and their children

14.1.3 Ensuring year-round availability of essential drugs

The project has initiated alternative way to ensure availability of cotrim in IMCI district where CDP is not effective and does not have coverage. The project together with FCHV-CC in five VDC of Dadeldhura have established the revolving cotrim scheme by mobilizing VDC fund. The FCHV-CC has planned to explore local resource for generating adequate fund for year-round supply of must essential drugs (cotrim, ORS etc.) needed for effective implementation of IMCI. This idea is being gradually replicate into other project districts as well. Though, the initiative has just started, it is found effective to enhance FCHV's motivation and their service. The project is optimistic to see the positive result, which can be appropriate and low cost way out for regular supply of essential drugs in the rural communities.

14.2 Promising Practices

14.2.1 Dabi- a forum of women and marginalized to analyze their health conditions and social position.

A: The Problem

Access over basic need and services has been declared as basic civil rights by the government of Nepal in its tenth five-year plan. Nepal Health Policy 1992, Long-term Health Policy (1998-2017) and Mid-term Health Policy have specifically mentioned that basic health services are civil rights and the strategy taken to extend partnership with civil society organizations and to collaborate with multi-sectoral development programming under the line ministries of Nepal government. The poor health situation of Nepal has been combined with multiple deficiencies. It has been rooted with social phenomena; poverty, discrimination, exclusion, insecurity of basic needs. Considering the complexity of the problem, CSP initiated right-based approach as an attempt to address the multi facet problems associated with the health care needs and the actual service provisions among the communities in project districts. It enables the community to raise and discuss the critical concerns which have direct or indirect effect over their health status and reach to those people who are, in various ways, excluded from the basic livelihood service delivery mechanism and overall development processes.

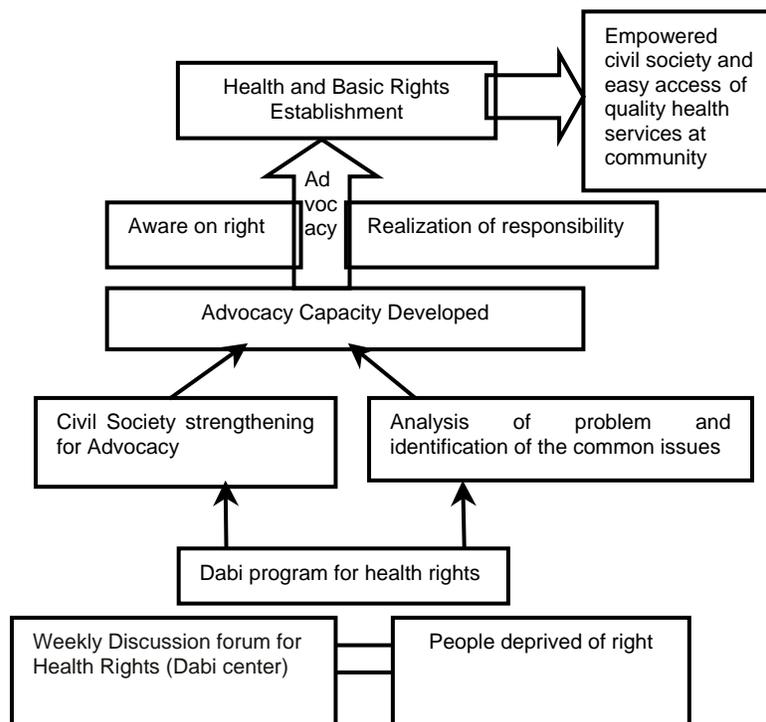
The CS project has contributed many positive changes in service quality and delivery mechanism and family's health seeking behaviors and preventive measurers. The project's one of the major challenges is to retain those positive changes so that the project's contribution becomes sustainable. The project also realized the need for making community empowered for meeting their health care needs as a basic rights by making the service providers more accountable and reaching out to the most vulnerable, excluded and poor communities for basic health service accessibility.

In order to address those challenges, the project put efforts in enabling the communities to analyze local context in terms of power relations, resource availability and accessibility to ensuring equitable access to quality health services as a process of social transformation through adapting the empowerment tool DABI. This way the project took up gradual shift from traditional technical focus interventions to

strengthening solidarity with the poor and marginalized to look at the issues of their reach over services and resources and enabled the communities to claim for their rights that are denied from the state and from contextual interpretation of statutory, religious and customary laws.

What is "Dabi" ?

The "Dabi is used as a RBA tool which was tested first in 2004 in Child Survival, Kanchanpur. The project adapted the original concept of "REFLECT" (Regenerated Frerian Literacy through Empowering Community Technique) to address community health issues through social analysis and advocacy actions. The "REFLECT" is a new approach to adult literacy which fuses the theory of Paulo Freire and the practice of Participatory Rural Appraisal (PRA). It starts with probing historical and philosophical analysis of literacy, and the weaknesses of current practices. In a REFLECT programme there is no textbook, no literacy 'primer' – no pre printed materials except a manual for the literacy facilitators. Each literacy circle develops its own learning materials through the construction of maps, matrices, calendars, and diagrams that represent local reality, systematize the existing knowledge of the participants and promote the detailed analysis of local issues. The project has adopted REFLECT to integrate right based approach in the child survival program by CARE Nepal.



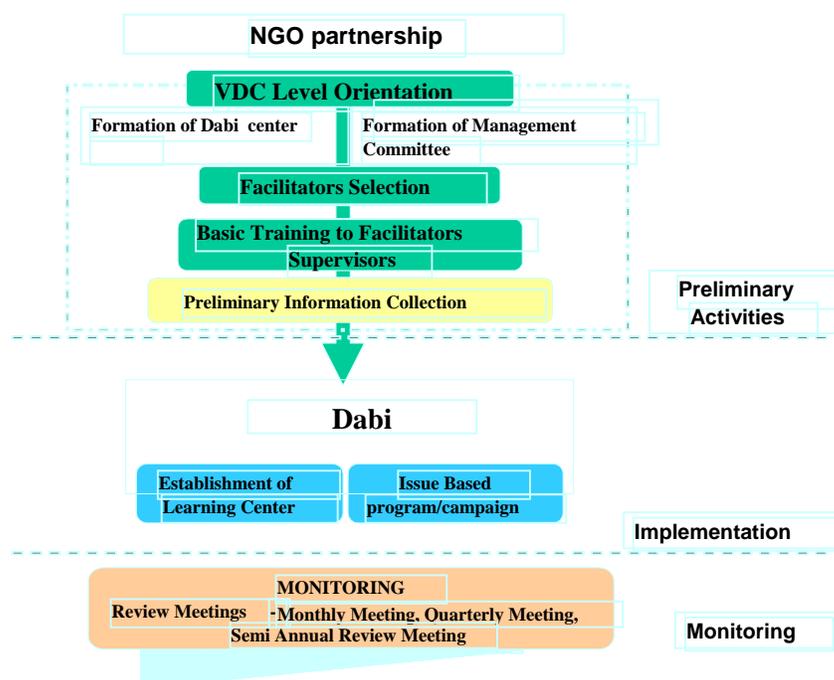
The project has adopted REFLECT to integrate right based approach in the child survival program by CARE Nepal.

The framework given aside explain the process of "Dabi" process. The "Dabi" is a community-level interaction forum of common interest groups basically of vulnerable communities; dalit, women, and children. The community people used it as a critical tool to open the culture of silence. The "Dabi" facilitates a critical analysis of social conditions and positions among the community and enable them to be aware about their rights and responsibility. The "Dabi" be critical while facilitating the empowerment process in micro level to get changed in our traditional practices (believes, behaviors, values) and to accelerate social transformation process in a totality. It becomes more important in the present context of political conflicts and transitional process, leading the state adequately not responding to its people's basic need.

Dabi has also been useful for social inclusion. Though the project focuses on disadvantaged groups (ethnic and 'lower-caste', women, children), it is often difficult to reach those excluded and enable them to benefit from opportunities that improve their health condition and overall livelihoods. The proposed RBA initiative has helped to increase participation of Dalits/'lower-caste' groups at least by 30 per cent during the project period.

B: Project inputs

Project inputs to achieve above stated objectives; details of interventions and result are given below in section C and D respectively. The framework given below explains sequential process of project inputs.



Advocacy capacity building training: The project has organized advocacy training for a total of 165 participants, among them 72 are working as a local activist through Dabi Centers and remaining staff/members are also supporting to implement the district initiatives. The project organized separate social inclusion audit training for project/partner staffs and DPHO.

To give exposure for facilitators on advocacy activities, the CSP organized four events excursion visits (one for each project district) for Dabi facilitators. All together 100 participants including project and partner staffs and community activists participated the program.

Establishment of Dabi Centers: A total of 84 Dabi Centers have been formed in different four project districts; eleven advocacy centers respectively in Bajhang and Doti

district, 45 in Kanchanpur, 5 Child Club in Dadeldhura. In addition to this, around 20 community representatives (two from each Community Support Groups (CSGs) of PLHAs and non PLHAs) have been trained in Dabi concept to work on the issues of PLWHA. Members of these centers meet regularly, discuss on various issues and implement the plan of action that includes advocacy in organized manner at different level through interaction, rally, press meet, and dialogue with different authorities, political leaders and so forth.

Guidelines, strategies and resource materials developed/prepared: In order to systematize advocacy initiatives and for wider coverage through constituency building, the project has developed different guidelines, strategy papers and resource materials and disseminated which are given below.

- The project has developed a *Dabi Center Operational Guidelines* incorporating experiences of different advocacy centers and disseminated it throughout the project for wider application/implementation.
- The project has prepared 2 edition of *Dabi Samachar*, as wall paper news of ongoing advocacy activities, and shared it throughout project districts and other projects. This *Dabi Samachar* contributed to motivate other dalit and marginalized to participate in Dabi activities and for constituency building on common issues.
- The project has documented *Paribartit Aabajharu*; case studies and its publication. All together 60 cases of success stories of Dabi centers have been documented and disseminated, as it is being used as a resource material in other Dabi Centers for constituency building on the issues.
- The project has prepared *Agadi Badheka Pailaharu*, an audiovisual documentary (of 26 minutes) of Dabi learning of Kanchapur district and shared in 11th Annual Child Survival Meeting, held at Atlanta on 26-31 July, 2006.
- The project published a *Bal Bachau*, CSP News Bulletin, as a special edition on RBA experience of CSP and disseminated widely within and outside CARE, partners, INGOs and GOs.

Institutional networking: For constituency building on common issues, the project has facilitated the process of institutional networking with common interest group/organizations. With this support, different community-based groups/advocacy center, local campaigners, Dalit member-based NGOs worked together to identify and prioritize their demands (claim) and come up with advocacy plan with alternatives. These networks have been strengthened with the capacities to pressurize the district planning process to allocate adequate resources to address the issues of marginalized

C: Result/change observed

Dabi exercises are showing some intangible but important changes in the lives of general population of the project area. The community became aware on their health needs and their rights to quality health services. Both, service providers and utilizers

have analyzed the underlying causes of poor health services rather than limiting their expectations to obtain immediate measures to resolve their problem. Through the enhanced capacity of front line workers, the practice of assessing the local context, the existing power relation, and practice of disaggregating information related to the access to services and control over resources. The project and the community leaders/activists have started reaching to the most marginalized and vulnerable community. The CBOs and community groups, (FCHV-CC, MGs, CSGs, HFOMCs, LRPs) formed by different disciplines have now started to pressurize service providers to be more accountable towards equitable and quality service deliveries, and the community users to become responsible for their own health needs and health care.

Following are some examples of advocacy issues identified and actions taken by the Dabi Center. The status of results vary on clusters and district; The advocacy process is ongoing to resolve all issues locally.

- **Stop Chaupadi practice:** Chaupadi is traditional practice that isolates women during the menstruation period and during the child deliveries period. This is one of most harmful cultural practices that directly affects new borne and maternal health. Dabi worked to sensitize community people and also pressurized to traditional believers to stop such practices. In Kanchanpur, 200 Chaukudi (*a small hut to stay during chau*) are destroyed and approx. 70% household have stopped such harmful practices, ongoing the same process in other project district.
- **Registration of vital events, such as birth registration, at community:** Many of VDC level secretarial office in project districts, have been closed due to the conflict situation of the country that are suppose to provide registration services at community. At present, VDCs are providing services from district head quarter and this has resulted to be delay for registration, but the local government is charging penalty to community people that actually is happening due to the absent of government service. Child Club of Dadeldhura district, organsied with support from CSP, pressurized local government body to reduce delay-penalty and to regularize service at community and succeed to reduce penalty from Rs 50 to Rs 15. Now, almost all VDC secretaries in Dadeldhura, are providing this services at the community level.
- **Regularise outreach health clinic service throughout the district:** Outreach health clinic was one of the weakest performance areas of government health services, which plays a vital role to improve basic health care services such as immunization, ANC/PN. Dabi initiatives have pressurized to regularize the clinics. As a result, in Kanchanpur district, almost all ORC are functioning regularly. Other CSP districts have also started the same process.
- **Quality health service delivery:** Dabi Center raised voice to HFOMC and DPHO to make the HF services a full time, Filling of vacant position in the HF, regularizing the supply of medicine and maintaining the adequate stock and succeed to resolve in most of HFs of Kanchanpur district, the same process is going on into other district, as well.
- **Other social issues (alcoholism, gambling, domestic violence, etc):** Apart from health issues, Dabi is also working on addressing other social issues which have negative impact on community's health. Dabi centers also introduced various

beneficial practices. These practices include declaring alcohol free zone, compulsory social audit of local level construction works, organising through saving credit program, no practice caste-based discrimination. Following two issues have been identified for regional level constituency building and for "micro-macro" policy advocacy that includes;

- a) Implement the recent decision of Supreme Court to stop chaupadi pratha effectively with clear implementing strategy and action plan of government,
- b) Pressurising the district planning process to approve development activities only after ensuring access of Dalit in the services and suspend development project if dalit have no access because of caste based discriminations.

- **Access and affordability to health services and livelihood security of PLHA:** The project has worked closely with GIPA piloting in Doti district, to advocate for increasing the access to Opportunity Infection Treatment services, ARV facilities, scholarship for children's school education, integration of HIV AIDS infection/prevention session/program in all sectoral programs in the districts.

14.2.2 Organizing and empowering the Female Community Health Volunteer Coordination Committee:

A: The Problem

The concept of Female Community Health Volunteer (FCHV) Program in nepal was introduced in the year 1988. It was established as a national program, managed under the Public Health Division of MOH. At present, a total of 48,549 FCHVs are acting as a bridge between community and government health services to provide primary health care to the community. In CSP districts, there are altogether 2338 FCHVs with whom the project works quite closely.

It has been found that FCHVs have deeper understanding about health problems of their communities. They are highly committed human resources, have demonstrated willingness and commitments to their voluntary services. In order to extend outreach services, FCHVs can play important roles through health education and counseling for positive behavior change, which is an effective strategy for sustainable change. Moreover, FCHVs have also demonstrated their capacity to lead the social transformation process; starting from their respective community gradually to network across the country. FCHVs are highly respected and supported by the communities and with this gained image they can easily lead community mobilization process particularly building local ownership in diverse initiatives.

As described above, there is a high potentiality to expand FCHVs' role for diverse sectors rather limiting only in traditional work, but they are already overburdened by different organizations (GOs/NGOs) seeking their roles in almost all of community level extension work. FCHVs are often overburdened while working in the designed frame of development projects and MOH priority. Maintaining the quality in their services,

participating in other development activities in the community becomes a challenge for them. There are also found to be worried about losing their image, and get demotivated.

B: Project Inputs

Organizing FCHV and self-mobilization

Keeping in views the strength of FCHV in program, the CS project-Nepal strengthened FCHVs through their organization and empowerment. *Some of activities that have driven FCHVs to be organized in the support of project are listed below.*

- *FCHVs of Kanchanpur started to: meet "regularly" once in a month and compile records and report it into HFs to incorporate in HIMS, sharing of different experiences between each other, review health problems of particular VDC and identify possible solution locally, develop joint action plan to resolve the problems and worked together on it, monitor performance of colleague FCHVs and provide onsite coaching for weak FCHVs, provide replacement support in the absence of colleague FCHVs, pressurize to HFs for regular supplies of essential commodities.*
- *Over the time they started to deposit regular saving and to re-lend it at community for implementing different income generating activities. They provides subsidized loan for health caring e.g. medical treatment, sanitation and nutritious feeding, especially while referring patient into the hospital/HFs/private practitioner. Such initiative of saving credit activities has contributed as a binding force for group development and to generate resources locally to meet their emergency need in time.*
- *FCHV-CC have started to prepare and distribute supper flower in the neighboring villages that contributed to improve nutritious status of children and group entrepreneurship development.*
- *After developing such a foundation, they formed VDC level Coordination Committee as a lose structure and started to implement community level CS activities such as health educational orientation, campaigning, quiz contest in health knowledge, which helped them to enhance knowledge and program management capacities and also for gaining support of colleague FCHVs and communities to organize as a CBO.*
- *FCHVCC developed linkage with VDC and other local funding sources and to seek support for health as well as for other community development activities.*
- *In the second phase period of CSP, the budget portfolio of FCHVCC become increased; latter on they felt the need of legal identity of their organization and registered it as a VDC level FCHVCC under the NGO registration act. 2034 in District Administrative Office.*
- *To date, five VDC level FCHVCC have been registered; the constitution of all registered FCHVCC has been prepared almost with a similar provision so that become easy to amalgamate as a network organization at district and even at higher level over the time.*

- *Despite these, FCHVCC has been implementing organizational development plan that they periodically develop conducting "participatory organizational diagnosis" using a systematic tools.*

Based on the experience of piloting the concept of organizing FCHVs (FCHV-CC), in the Kanchanpur district, the new districts first observed the process through exchange visits and after they realized the importance, volunteered to replicate the practice in selected VDCs. These districts have just started forming the FCHV-CC as a loose forum of discussions on maternal and child health issues and improving the quality of health service delivery at the community level. Objectives set by FCHV-CC throughout the project is as follows.

- i. To develop the forum as a network organization of community based volunteers and activists, sharing of experience, exchange of learning "between each other" at different level (VDC, district, regional and national) in a regular basis.
- ii. To enhance advocacy capacity of FCHVs, particularly focusing on improving services quality of FCHV by providing social recognition, appropriate incentives and complimentary facilities to retain their motivation for continued voluntarism;
- iii. To develop as an advocacy forum for "people's voice" to influence policy makers for good governance in the government health system and to ensure equitable access to basic services, and inclusion of marginalized community in different issues (social, political, basic livelihood-need, environmental).
- iv. To mobilize FCHVs as change agents for community health and other development activities particularly the empowerment of women and the most marginalized groups of people in the communities.

C: Project result/changes observed

There are many evidences that the FCHV-CC had contributed significantly to improve service accessibility and quality thereby achieving project targets in a short period of time. The initiatives of organising FCHVs through FCHV-CC has helped enhancing the capacities of FCHVs through cross learning, obtaining community ownership towards FCHVs and their works. Some of example of project result through this initiative is given below.

- Contributed to ensure quality health services with their strong "organized" mediator role between health services providers and communities.
- Developed a functional organizational structure for effective managing and mobilizing a trained and committed resources in a sustainable manner and to

influence policy makers to incorporate community needs and voices adequately. FCHV-CC now representing district planning process and raising voice to allocate adequate resource for health program, particularly for FCHV program.

- Contributed to increase quality service demands through positive behavior change communication and with advocacy capacities as traditionally HF was working in top down approach, and most of community needs were negligent.
- Got an organizational legal identity to work on their prime interest and community as well.
- Developed functional network for experience sharing at different level that contributed to enhance organizational capacities and in overall program effectiveness in general.
- Improved program ownership and community participation with their active and leading responsibilities.
- Contributed to sustain FCHVs' motivation with their autonomous status and community's admiration maintaining quality performance by addressing communities' priorities as a prime "one".

14.2.3 Developing and Mobilizing Local Resource Persons for increased service outreach

A: The Problem

The concept of Local Resource Person mobilization was envisioned to provide on-site coaching for FCHV who plays a vital role for child survival activities at community level. The CSP has been implementing CB-IMCI module to address the five key killer-diseases and FCHV works as a first contact person for treatment and referral services. FCHV conduct health education session in MG meeting and provide counseling for caretakers adopting healthy behavior. Most of FCHV were selected a long back and are not literate thus the standard event of training-coach would not be sufficient to enhance their knowledge and skills at appropriate level. The performance of HF staffs (VHW/MCHW) is found weak for intensive coaching, as their technical capacities, motivation is also poor. To boot, staff number is not adequate to provide coaching for a large numbers of population-based FCHVs.

Moreover, the concept of LRP was introduced to contribute for local capacity building and for community ownership of CS program. Most of them are from FCHV who have extra capacities (facilitation skills, education, fast-learner) to assist other colleague FCHV. Such LRP were selected through the consensus of FCHV group meeting and are being mobilized by the FCHV-CC.

Staffing pattern of CSP was designed to reach community through government service structure, assisting to enhance capacities of staffs. Allocated number of field staffs of CSP is not sufficient to provide intensive assistance at community level. The concept of LRP thus became an important to address immediate and longer-term effect.

B: Project inputs

The CS project provided seven days basic training for all LRP. The training was designed as a job-training module and content included basic concept of community mobilization and development, community health system, health problem/context assessment from right-based perspective, facilitation techniques, role of different stakeholders of community health systems, recording and reporting, leadership development, saving and credit mobilization, basic health knowledge etc. In addition, quarterly review meeting to assess performance and refresher coaching was done periodically. The project and NGO partner staffs along with HF's staffs provided on-site coaching during the regularly monitoring visit of field.

The project provided basic educational materials, training aids and necessary equipments that they do need to perform their roles. For a motivation as well as to compensate the cost of daily wages they get working outside or need to pay others to make their household work done, the project provided daily remuneration as the rate of Rs. 150 not exceeding 7 man-days per months.

All together 47 LRP are being mobilized through out the project district; 20 in Dadeldhura, 27 in Doti.

C: Result/changes observed

The concept of LRP mobilization demonstrated a successful example to improve knowledge and skills of FCHV in a very short duration through a practical and intensive coaching at the field. This has proven a low cost and sustainable capacity building approach developing local capacities. Beside, the LRP also contributed performing led role for community empowerment process organizing regular interaction event on different local issues and community sensitization, further than the traditional job of health education and treatments. The LRP also took led role to regularize FCHVs' monthly meeting; this has facilitated the process of FCHVCC formation and its' organizational development. The LRP played a facilitating role to expand linkage of FCHV-CC with local government and other support organizations and mobilizing local resources in health activities with a high priority. Following are some of highlights of qualitative results achieved by the project through mobilizing the LRP.

1. The LRP worked as a local facilitator and provide regular on-site coaching that helped to enhance motivation, knowledge and skills of FCHVs and been able to perform qualitative work.
2. The LRP assisted FCHV to conduct MG meeting effectively through doing supportive monitoring visit: counseling, model demonstration, cross-learning.
3. With the support of LRP, the project has been able to form FCHV-CC in the new project district in a very sort period; CSP first phase took almost the whole project duration to achieve the same. The LRP facilitated to have critical interaction, problem identification, planning and implementation of local initiatives that encouraged FCHV to be organized and to perform an evolving role.
4. The LRPs are working as a local activist making a meaningful participation of community to ensure quality service from the HF's. They demonstrated an

excellent performance playing mediator role between community and HFs. Beside, they have facilitated to link FCHV program with Dabi initiatives.

14.2.4. Using Spider Web technique to strengthening Health Facility Operation and Management committee

A: The Problem

Government of Nepal, Ministry of Health and Population in collaboration with Ministry of Local Development has laid out a policy to devolve management and operation of health facilities by the Local Government under the amended decentralization policy of government. National Health Training Center (NHTC) is working as the focal point unit to operationalize it. Since 2002, this process has been initiated in phased manner, gradually from Sub Health Posts (the lowest unit of primary health centers), later on: Health Post (HP) and Primary Health Care Centers (PHCC).

The overarching goal of decentralized governance is to promote good governance and to strengthen democracy, thereby to contribute for poverty reduction: as the reason behind to poor health is rooted with multiple deficiencies. An operational guideline is developed and operationalized to handover health facility in line with the Local Self-Government Act and Decentralization Policy, Plan and Strategy of GON.

Despite having policies at place, there are various operational level constraints (*conflict situation, absence of elected political bodies, inadequate capacity building inputs*) that have affected for smooth operation of HFs and to bring out expected result. HFOMC meeting is irregular, because of absence of committee members are displaced due to conflict. HFOMC are only provided with limited administrative authority, not fully authorized to mobilize financial resources. In order to address the priority problems of the community especially of excluded group (*women, dalit, ethnic community*) and plan accordingly, HFOMC are not adequately strengthen.

The CSP supports HFOMC to strengthen local health system to increase community participation, access of quality health services and developing community ownership for project sustainability.

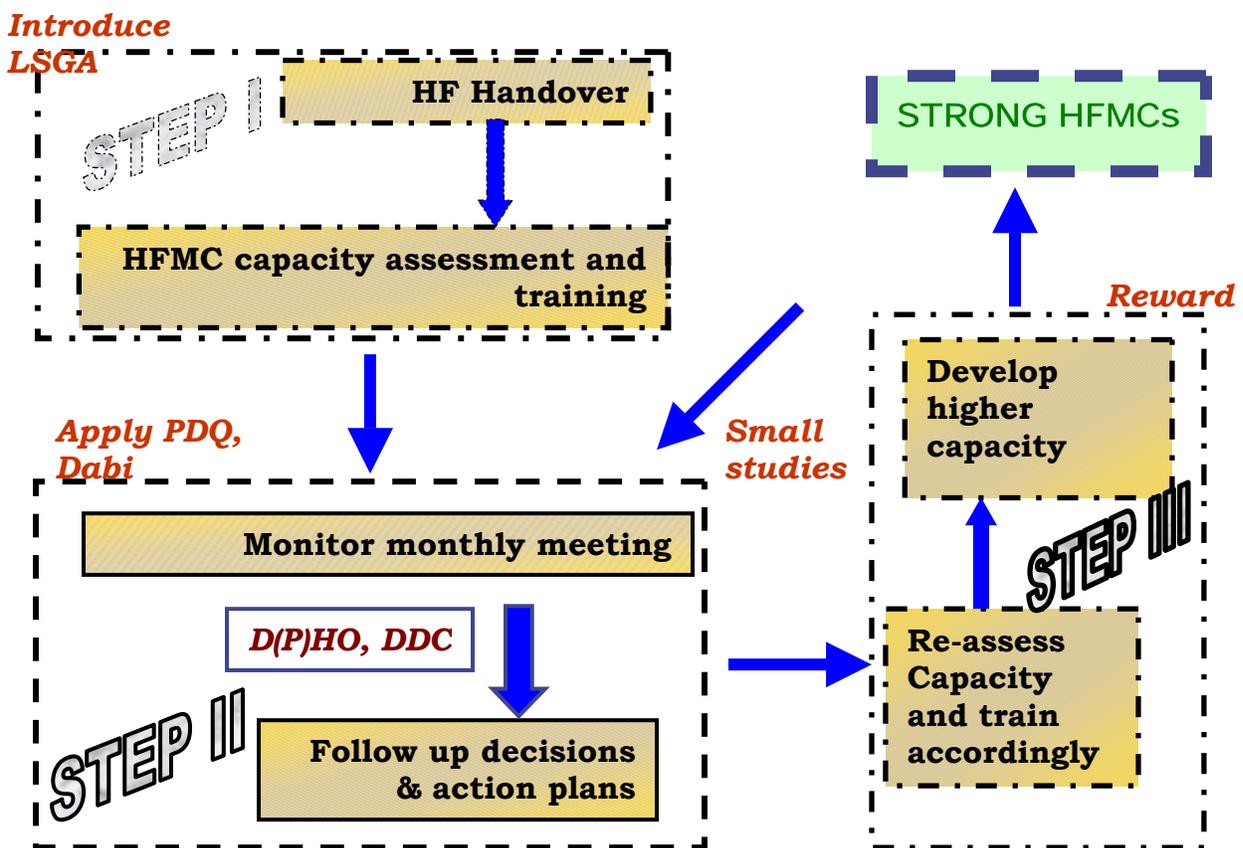
b. Project Inputs

The CS project- Nepal has contributed GON for the effective implementation of decentralized health system; strengthening local capacity to ensure people's meaningful participation in governance and resource mobilization focusing poor and excluded group in its project districts. The project has contributed facilitating HFs hand-over process followed by on-site orientation of HFOMC Operational Guidelines for committee

members to enhance their knowledge and skill to make them able to perform their role effectively.

The project took initiation to re-activate HFOMC fulfilling all vacant position and replacing passive members who usually do absent in regular meeting and were not performing their role effectively. This reformation was done in the leadership of DPHO with adequate consultation with community people.

In addition, CARE–Nepal in collaboration with MOH has developed and implement a five days training guideline on HFOMC’s Capacity Assessment and Programming in all health program being implemented in different district. This package has covered four pillar capacities of HFOMC: a) organization, b) management, c) resource mobilization and, d) planning, implementation, monitoring and evaluation. Overall facilitation framework is given below box.



The project first provided a TOT to DPHO and HF’s trainers on the guideline and LSGA, and then the trained resources person were mobilized to train HFOMC committee members. The HFOMCs have been linked with ongoing right-based initiatives of the districts such as Dabi, PDQ (partner’s defined quality) for critical engagement of community, particularly of excluded group, which contributed to re-activate HFOMC to be more accountable to their responsibility, so on to increase service quality and reach to disadvantage group. Periodical review, reflection and appropriate assistance based on the finding were done to further enhance program quality.

c. Results and changes observed

All vacant positions of HFOMC of CS project districts have been fulfilled with relatively of active representation of women, dalit and ethnic community. Members are now well educated on their roles and are motivated to demonstrate a quality service in their respective areas. HFOMC meeting is being carried out regularly. The project has observed that committee members started to conduct regular interaction with community people and HFs staffs both at formal session and informally “too” to find out possible way to overcome existing constraints and potentialities of local resource mobilization.

With intensive coach, women and dalit members started to put their voice and to influence in decision process, the same as chairperson and teachers used to do at prior. CDP is being implement effectively in the project intervene districts. HFOMC started to look alternative ways to keep sufficient stock of essential drugs both at HFs and FCHV level and started dialogue with local government and support organization to start revolving cotrim scheme where CDP is yet to start.

The training guideline provided a complement support to MOH to implement its' health system decentralization policy, enabling local government and HFOMC to perform their role effectively, moreover to improve accountability towards the civil society.

14.3 Contribution to Scaling Up

The CS project Nepal has piloted different initiatives (Dabi, FCHV-CC, Strengthening HFOMC) in Kanchanpur district during the first phase of CSP. The project piloted CHILD to child program and Local Resource Mobilization in Doti district. The learning of these initiatives are found very effective to make the community sensitive towards various socio-cultural issues that have negative impact in health care, making the community realize the importance of health care needs, preventive measures, and quality of services from their local health facilities. Moreover the communities have also learned about the available local resources and service provisions that have direct benefits to their daily livelihoods. These piloting exercises have also helped to put pressure on service providers to cater quality services making them accountable to their job and responsible towards the communities they are assigned to serve.

These initiations have contributed to achieve overall project objectives of increasing access of quality services and local capacity building through community empowerment. The “Dabi” helped to assess health issues from different dimensions and sustainable behavioral change of service providers and care takers in the communities project has served.

These techniques have been the means to replicate good practices into other three districts. Though the ultimate aim of such replication is to scale up beyond project

districts. If the working environment remains like the present, it will not be difficult to advocate for wider replication of several promising practices generated through by the project. The efforts are now on sharing those practices to all relevant stakeholders including the local mission and the CHD.

14.4 Increase governance capacity in local institution

The CSP works with different partners (e.g. local NGO, FCHV-CC, DPHO, LGs, HFOMC, district line agencies) at local level, but varies the scope and types of partnership. Under 4th objective (i.e. capacities building of CSP), the project has assisted improving the management capacity for local partners through training, exposure visit and on-site coaching assistance. The project has assisted local partner to enhance their inclusive programming capacities to incorporate right-based approach in their work. The project reviewed existing training guidelines and service delivery system and incorporated appropriate contents/inputs to make these packages effective to increase governance of local institution and groups.

Increase representation of different segment of community, social audit and appropriate modification of operational policies to make it more inclusive and accountable towards community with focus to marginalized are some of examples, the CS project Nepal has achieved in the process of enhancing governance and building local capacities.

14.5 Equity

The project has a target to cover at least 30 % of project participants/ beneficiaries from Dalit and excluded group. CARE-Nepal recently developed a health strategy also clearly guide this approach.

Staff orientation on Gender Equity, social inclusions are done already. The community based groups and forums (MGs, FCHV CC, HFOMC) are already sensitized on the issues of inequity, and social exclusions. In some districts such as Kanchanpur, mobile MG meeting is an example of the actions by the community-based groups. Appointing the replacement of dropped out FCHVs by Dalit FCHVs, and in HFOMCs, expansion of MGs with Dalit mothers are some affirmative actions taken up by local government and the community groups. Similarly, the women from project areas have now joined in movements against caste based discrimination, and anti domestic violence and alcoholism movements, same wages, are through DABI centers are few examples we can quote from the in project districts.

In the process, a study was carried out in Bajhang district to implement Dalit focus program as a special initiation for Bajhang as planned in DIP. Based on the finding, a concept note is developed for Bajhang district, which is being adopted into other districts, but due to budgetary constraints, the project is not able to apply the concept in full-fledged manner.

...Bhagi's dream was stabbed with the event that led Chandra to verge of death. When I tried to talk with Chandra in sign language about her expired child she looked at me with distress as if I scratched something very excruciating from her memories. Her husband tried to forget that nightmare and told stammeringly that it is the event that tried to take his innocent wife from him due to social injustice. I was traumatized. A question to all: why do all poor, vulnerable and marginalized people have to compromise life and health with their fate? Isn't health their basic right? This shows that poverty is the denial of right to live with dignity.

[Extracted from a case study of Doti: poor, dalit and disable family.](#)

Out of seven NGO partner of CSP, four are dalit member-based NGOs. The project has been working with these NGOs to ensure complementary benefits to dalit and marginalized. The has supported formation of dalit pressure group and networking dalit activist organization/groups to pressurize district planning process for equitable resource and priority allocation, and priority setting by the GON district development plan and program.

The table given below explains the increased representation of dalit community in the project district.

Table 12: Coverage of Dalit communities

Approx. dalit population in the district		# of dalit FCHVs		# of dalit member in HFMC		# of dalit in advocacy centers	
District	Total population	Dalit	Total FCHV	Dalit	Total	Dalit	Total Participants
Doti	46700	63	619	60	350	70	98
Dadeldhura	23428	32	462	35	242	0	0
Bajhang	34000	41	423	100	576	180	180
Kanchanpur	56600	56	834	22	147	169	602
Total	160728	192	2338	217	1315	419	880
Percentage		8%		17%		48%	

Dalit representation has been significantly increased in advocacy centers (Dabi), which is initiated by the CSP. But comparatively is low in FCHV and HFMC. Dalit representation in HFOMC and FCHV is guided by government policy, in which the project has limit scope for improvement. However, the project has made attempt with DPHO to replace drop out FCHV with the dalit women and in choosing active dalits and women in HFOMC especially while doing the reformation where needed. In addition, the project has also contributed to enhance the leadership capability of those dalits and

women candidates were selected. The specific percentage of dalit women inclusion in FCHV replacement and HFOMC reformation needs to be assessed as a part of final evaluation.

Dharma proudly says,*If I hadn't met my friend of child club, I would have just ended my future as one of the many orphans who born and die but do nothing. Sometime, I do scare with my past and want to forget it but in the same time it gives me a power of confidence to live with struggle. I got a dramatic happening in my life because of CARE. I am thankful to CARE... and would like to request to search for the unfortunates like me and to care them. I like to advice all orphans, please do always dare to dream, I too... it leads us toward the dawn...abstracted from a case study of working for child right.*

With an aim to increase health service utilization especially by dalit group, FCHV are enrolling more *dalit* mothers in MG meeting and also conducting mobile MG meeting in *dalit* clusters, as well. Based on the observation till date, project has experienced significant increase in health service utilization by *dalits*. To confirm this perception, project has planned to conduct a comparative study to assess service utilization status among *dalit* and other groups using qualitative-quantitative mix techniques.

15. Work Plan

Work Plan (Kanchanpur)

**Bal Bachau in Far West
October 06 – September 07**

SN	Activities	Unit	Target	Timeline												Responsibility	Support Needed
				Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
A	District Level Program																
1	DHO support in supervisors quarterly meetings	Eve	3													DHC	AICBO/HS
2	DHO regular reivew meeting (PHCI, HPI & SHPI)	Eve	3													DHC	AICBO/HS
3	PD/Hearth (Kpur)																
	Monitoring of PD/Hearth session	eve	27													HS	AICBO/DH C
	Sharing of PD/Hearth progress	W/S														DHC	AICBO/HS/ RMDS
4	DABI (REFLECT) program	Center	25													AICBO	HS/DHC/P AS
5	LQAS survey	Eve	2													HS/DHC/AIC BO	RMDS
6	Coordination and Linkage (PAC meeting)	Meetin g	3													DHC	AICBO/PAS/PM
7	Advocacy activities in coordination committee; RHCC, DACC etc.	meetin g	3													DHC/AICBO	PAS/PM
8	Participate in DDCC council meeting	Eve	1													DHC	AICBO/PAS
B	Community Level Program																
9	Review meeting (CDP)	Eve	1													DHC/AICBO	HS/TS
10	HFMC - Re/Capacity assessment	HFMC	23													AICBO/HS	DHC/PAS
	HFMC training																
11	Joint supervision & monitoring	Events	36													DHC/AICBO	HS/RO/CO
C	Municipality support program																
12	Municipality clinic management	Events	7													AICBO/HS	DHC

SN	Activities	Unit	Target	Timeline												Responsibility	Support Needed		
				Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep				
	committee interaction W/S																		
13	Municipality basic child health orientation to MG	Events	174															HS/AICBO/DHC	TS
14	VDC Level Phase out W/S	Events	8															HS/AICBO	DHC
15	Joint monitoring visit of community level health outreach program (ORC/ Imm.CLINIC & MG meeting, one clinic per month)	Clinics	76															HS/AICBO/DHC	RMDS/PM/TS
D	FCHV Program																		
16	Reveiw meeting	Events	60															HS	AICBO/DHC
17	Partnership with FCHVCC	FCHVCC	21															AICBO/HS	DHC/PM
18	Reward to best performer FCHV	No	60															HS/AICBO	DHC/RO
19	FCHV Day celebration	Events	1															HS	AICBO/DHC
E	Others (MG and S/L programs)																		
20	Capacity assessment of FCHVCC	FCHVCC	8															AICBO/HS	DHC/PAS
21	Mother group strengthening program																	HS/AICBO	DHC
22	Monitoring of Mother Behavior																	HS/DHC	RMDS

Work Plan (District), Bajhang

Bal Bachau in Far West

October 05 – September 06

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
1	General					
B	Program Management					
1.10	Regional management visits (quarterly)				PM	
1.11	Technical support visit (as an when needed)				Specialist	
1.12	Regional level regular program review meeting (quarterly)				PM	
1.13	All staff meeting of all CSP staffs (biannually)				PM	
1.14	National level management visit (twice a year in every districts)				HSC	
2	Sharing progress with District Level Forums (i.e. Project Advisory Team, District Council Meeting, Technical Monitoring Committee)					
2.2	Regular meeting of advisory committee				DHC	PRP
2.3	District Council (Jilla Parishad) Meeting			I	DHC	PRP
2.4	Infromal/formal coordination with technical monitoring committee of DAO (District Administration Office)				DHC	PRP
3	Development of District Profile					
3.4	Update of district profile in yearly basis					
4	Integration with exisiting project					
4.1	Develop coordination strategy with POWER and PRP				NS/Jay	
4.2	Provide nutrition training to strengthening kitchen garden activites in 14 VDCs of PRP					

4.1.1	Develop training curriculum				TS	
4.1.2	Implement the training				TS	
4.3	Empowerment training fro Saving and Credit group (27 families)					
4.4	Incorporate FCHVs in IGAs				AICBO	
4.5	Link 27 savings and loan group with FCHV in their area and provide special priority to them for training and other CS oppurtunities				HS	
4.6	Link and prioritize FCHV families (Dalit boys and grils and non girls) for scholar scheme				AICBO	
	POWER Project					
4.7	Analyze the POWER training package and incorporate health message into it (access and behavior)				DP	
4.8	Develop a integrated 3 days good governance, gender and leadership training				DP	
4.9	Provide integrated training to HFMC members				TS	
5	Strengthening of Health System					
5.1	<i>CB-IMCI training</i>					
5.1.5	FHCV level second phase training 2 days				TS	
5.1.6	Traditional healer orientation 1 day				TS	
5.1.7	Yearly one days review/refresher training of all level health workers				TS	
5.2	<i>CDP Training</i>					
5.2.6	Community program				TS	
5.2.7	Implementation of program				TS	
5.2.8	Supervision and monitoring					
6	FCHV Program strengthening Program					
6.1	Discussion with DPHO office on strength & weakness of existing FCHV program district based on BSL and HMIS				DHC	

	reports					
6.2	Development of activity plan of FCHV program strengthening				DHC/AICBO	
6.4	Implementation of technical intervention of FCHV strengthening program				HS	
6.6	Supervision program for FCHV				HS	
7	Working with Local NGOs					
7.1	Develop potential role of NGOs partners in Child Survival					
7.3	In-depth capacity assessment of selected partners				AICBO	A&PS
7.4	Develop partners strengthening program for individual partners				AICBO	A&PS
7.5	Implementation of partners strengthening program (yearly review)				AICBO	A&PS
7.6	Linkage partners with MoH and National/International level donors				A&PS	DHC
8	Activities with DHO					
8.1	Facilitate/participate in every quarter of DHO focal persons meeting	Times	12		DHC	AICBO
8.2	Technical support in CDP review meeting	Eve			DHC	AICBO
8.3	Integrated joint monitoring visit	Times	Ongoing		DHC	AICBO
9	Activities with DDC					
9.1	Participate and present CSP progress and plan in DDC council	Times	3		DHC	AICBO
9.2	Technical support in health coordination activities at district level	Times	Ongoing		DHC	AICBO
10	Activities with VDC					
10.1	Get an agreement from VDC to establish FCHV	VDC			HS	AICBO, DHC

	endowment fund					
10.2	Attend regular meeting of VDC (quarterly)	Eve			HS	DHC, AICBO VDC
10.3	Attend VDC council meeting	Eve			HS	DHC, AICBO, VDC
10.4	Joint monitoring visit of community level health outreach program (ORC/Imm. Clinic & MG meeting) one clinic/month	Clinic			HS	HFMC, FCHVCC
11	Prepare Phase out plan				DHC/AICBO/HS	Region
12	Human Resource Development Activities					

Work Plan (Doti)
Bal Bachau in Far West
October 06 – September 07

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
1	General					
1.1	Regular mail runner to site office		Ongoing		DHC	AICBO
1.2	District staff meeting (conditional; monthly)	Event	5			
2	Monitoring of project through district level forums (i.e. Project Advisory, District council meeting)					
2.1	Conduct/Facilitate meeting of District Advisory Committee	Times	Biannully		DHC	AICBO
2.2	Support RHCC meeting	Times	Bimonthly		DHC	AICBO
2.3	Briefing CSP program, progress and future plan in District Council (Jilla Parishad) Meeting	Times	Yearly		DHC	AICBO
3	Working with existing health networks					
3.1	Workshop on intersectoral collaboration in Health with DLA	Event	Yearly		AICBO	DHC, P&AS
3.2	Develop integrated action plan	Event	Yearly		AICBO	DHC, P&AS
3.3	Joint progress review	Event	Quarterly		AICBO	DHC, P&AS
4	Strengthening Health System					
4.1	CB-IMCI training					
4.1.1	Newly transferred in Health Facility level workers training (both clinical and management)	Pers	20		DHC	TS
4.1.2	FHCV level second phase training 2 days	Pers			HS	
4.1.3	Traditional healer orientation 1 day	Pers			HS	DHC, AICBO
4.1.4	Yearly one days review/refresher training of all level health workers (including community health workers)	Pers	1		HS	DHC, AICBO

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
4.2	<i>Ilaka level review meeting including PHCI, HPI, SHPI (semi-annually) 2 days</i>	Pers	93		HS	DHC, AICBO
4.3	Supervision and Monitoring					
4.3.1	Support to conduct integrated monitoring and supervision		1		M&DS	DHC, AICBO, PM
4.3.2	Lot Quality Assurance Sampling Survey				M&DS	DHC, AICBO, PM
5	FCHV Strengthening Program					
5.1	Identify the number of drop out FCHVs and plan/conduct training for them. (priority to Dalit on replacement)	Pers.				
5.2	Quarterly review meeting of FCHV (alternate with DHO quarterly review meeting) (Content; Health message/orientation development)	Times			HS (Shanti and Durga)	AICBO, DHC, DHO
5.3	Reward for best FCHVs at VDC level	Times	3		HS	AICBO, DHC, DHO
5.4	Celebration of FCHV day			1	HS	AICBO, DHC, DHO
5.5	POWER Training Package for FCHV (add comm. Mobilization beyond mothers group)				HS	DHC, AICBO, TS
5.6	Support FCHVs to develop network cell FCHVCC as per demand				HS	DHC, AICBO
5.7	FCHVCC training on organizational management & development				HS	DHC, AICBO
6	MG Strengthening program					
6.1	Ilaka level workshop for MG strengthening					
6.2	Reward to VHW/MCHW for demonstrating model MG					
7	Behavioral Change Program					

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
7.1	Interaction workshop between healthy baby and malnourished baby mothers	Eve			TS	DHC, AICBO
7.2	<i>School health program</i>				TS	DHC, AICBO
7.3	Review of program progress, problems etc with DDC, DEO, DHO		Ongoing			
8	Working with local partner					
8.1	Capacity assessment of selected partners	Part.	2		AICBO	DHC, P&AS
8.2	Develop organizational work plan				AICBO	DHC, P&AS
8.3	Review meeting with partner organization	Times	6	I, III	AICBO	DHC, P&AS
8.4	Linkage/coordination with other INGOs/NGOs/GOs	Eve	1	III	AICBO	DHC, P&AS
8.5	Health Facility Management Committee strengthening					
8.5.1	Formation and activation of HFMC with DHO collaboration					
8.5.2	Training to health facility management committee	Eve	50		AICBO	DHC, TS
8.5.3	Joint Monitoring (DDC, DHO) visit to HFMC (half Yearly)		Ongoing		DHC	AICBO
8.5.4	Prepare monitoring plan					
9	Coordination with DHO					
9.1	Facilitate/ensure every quarter of DHO focal persons meeting	Times	12		DHC	AICBO
9.2	Facilitate /ensure in CDP review meeting	Eve			DHC	AICBO
9.3	Support in National Health Programs					
9.4	Integrated joint monitoring visit by regional and central level	Times	Ongoing		DHC	AICBO
10	Coordination with DDC					
10.1	Share CSP progress and plan in DDC council	Times	3		DHC	AICBO

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
10.2	Facilitation in health coordination activities at district level	Times	Ongoing		DHC	AICBO
11	Coordination with VDC					
11.1	Get an agreement from VDC to establish FCHV endowment fund					
11.2	Update meeting's decision with VDC and it's council	VDC			HS	AICBO, DHC
11.3	Joint monitoring visit of community level health outreach program (ORC/Imm. Clinic & MG meeting) one clinic/month	Clinic			HS	HFMC, FCHVCC
12	Maternal and Neonatal Health					
12.1	Support ORC clinic (Supplies, Technical Support)		Ongoing		HS	AICBO, DHC
12.2	Mobilize HFMC to strength ORC				HS	AICBO, DHC
12.3	Awareness creation on ANC Coverage, behaviour change against misbeliefs, malpractices (pregnancy care and safe delivery practices through LRP		Ongoing		HS	AICBO, DHC
13	Integration with existing project					
13.1	Develop coordination strategy with POWER, ASHA and PRP				HSC/PC	
13.2	Provide nutrition training to strengthening kitchen garden activities in the working VDCs of PRP, ASHA and POWER					
13.3	Link and prioritize FCHV families (Dalit boys and girls and non girls) for scholar scheme of POWER,PRP and ASHA Project				AICBO	
13.4	Analyze the POWER, ASHA and PRP training package and incorporate health message into it (access and behavior)				DP	

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
14	Prepare Phase out plan				DHC/AICBO/HS	Region

Work Plan (Dadeldhura)
Bal Bachau in Far West
October 06 – September 07

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
2	Management					
2.1	District level Meeting bi-monthly	times	6		DHC	HS/AICBO/Region
2.2	Provision/Movement of Messenger (Monthly)	times	12		DHC/TS	AICBO/HS
	Program				''	''
3	Monitoring of project through district level forums (I.e. Project Advisory, District council meeting)					
3.2	Regular meeting of advisory committee	Times	Biannully		DHC	AICBO
3.3	Support RHCC regular meeting	Times	Bimonthly		DHC	AICBO
3.4	Present CSP program, progress and future plan in District Council (Jilla Parishad) Meeting	Times	Yearly		DHC	AICBO
4	Working with existing health networks					
4.1	Workshop on intersectoral collaboration in Health with DLA	Event	Yearly		AICBO	DHC, P&AS
4.2	Develop integrated action plan	Event	Yearly		AICBO	DHC, P&AS
4.3	Joint monitoring review of progress				AICBO	DHC, P&AS
5	CB-IMCI				HS	AICBO/DHC
5.2	Newly transferred-in HF level worker training (clinical training)	Per	51		''	''
5.5	FCHV level follow-up training (2 days)	Per	462		''	''
5.6	Traditional Healers training (1 or 2 days)	Per	100		''	''
5.7	Supervision and Monitoring				''	''

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
6	CDP program					
6.1	Explore possibilities of collaboration with UNICEF person to integrate CDP and CB-IMCI					
7	FCHV strengthening program					
7.2	FCHV review meeting (one day) quarterly plan with DHO as per gvt. protocol including HMIS	times	3		HS	DHC/AICBO
7.3	Develop FCHV network cell i.e. FCHVCC	CC	5		„	DHC/AICBO/PAS
7.4	POWER training (governance, leadership, gender & cast)	Per	462		„	TS/DHC/DHO
7.8	MG Strengthening				HS	AICBO
7.9	Prepare joint action plan to reactivate MGs with HF staff				DHC/AICBO	
7.10	Reward to best FCHV (VDC wise)	per	3		DHC/AICBO	DHO
7.11	Celebration of FCHV Day					
7.13	Develop linkage with VDC to establish Endowment fund of FCHV for Blue Cup, Cotrim and ORS				HS	AICBO/DHC
8	Behavioral communication change					
8.1	BCC Sstrategy for project and DHO staff	per	20		Region TS	CO/HSC
8.2	Develop/ implemnt BCC Action plan with DHO				DHC	TS, AICBO
8.3	Intraction between healthy babys mothers and unhealthy baby mothers					
8.4	School health program (Secondary 29, Lower Secondary 28)	per	57			
8.4.2	Training to school teachers (lower Secondary)	event	2		DHC	
8.4.3	Prepare Action plan on health education dissemination	event	1		DHC	AICBO/TS
8.4.4	Joint Monitoring Visit (DEO, DHO,BBFW				DHC	AICBO/TS
8.4.5	Review meeting with school teachers (Semi-annually)				DHC	AICBO/TS

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
9	Capacity Building of Local Partners					
9.1	FCHVCC					
9.1.2	Organizational deve/mgmt training for FCHVCC				AICBO	HS/DHC
9.1.3	Capacity assessment of FCHVCC				AICBO	HS/DHC
9.1.4	Work in partnership with FCHVCC				AICBO	HS/DHC
9.1.5	Explore/strength DDC/ VDC counsil for effective coordination between multi sectoral agencies to complemtnt child survival					
9.2	Local NGO's					
9.2.3	Organizational capacity assessment of partners				AICBO	HS/DHC/PAS
9.2.4	Preparation organizational development and implementation plan				AICBO	HS/DHC/PAS
9.2.5	Annual review and extension of Agreement				AICBO	HS/DHC
9.3	Health Facility Management Committee					
9.3.1	Reorganize HFM Committee with DHO/DDC/GTZ/UNICEF/CECI				AICBO/DHC	M&DS
9.3.2	HFMC ToT for DHO					
9.3.3	HFMC training (4 days) Maagement and operational	Event	25		DHC	AICBO/M&DS
9.3.5	Joint Monitoring and supervision (DDC, DHO)					
10	VDC level Health Review meeting (VDC,VDCLA, FCHV, HFMC, Community and HF staff) once in a year :				HS/AICBO	DHC
11.3	Prepare / Update District Profile (yearly basis)				DHC	AICBO/HS
12	Coordination with DHO					

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
12.1	Facilitate/ensure every quarter of DHO focal persons meeting	Times	12		DHC	AICBO
12.3	Integrated joint monitoring visit by regional and central level	Times	Ongoing		DHC	AICBO
13	Coordination with DDC					
13.1	Share CSP progress and plan in DDC council	Times	3		DHC	AICBO
13.2	Facilitation in health coordination activities at district level	Times	Ongoing		DHC	AICBO
14	Coordination with VDC					
14.1	Get an agreement from VDC to establish FCHV endowment fund					
14.2	Update meeting's decision with VDC and it's council	VDC			HS	AICBO, DHC
14.3	Attend regular meeting of VDC (quarterly)	Eve			HS	DHC, AICBO VDC
14.4	Attend VDC council meeting	Eve			HS	DHC, AICBO, VDC
14.5	Joint monitoring visit of community level health outreach program (ORC/Imm. Clinic & MG meeting) one clinic/month	Clinic			HS	HFMC, FCHVCC
17	Nutrition (Micro nutrient)					
17.1	Support National Vita A Program			I III	DHC	AICBO/HS
18	Quality of care					
18.1	Introduce/Implement PDQ in Health Facility	HF	5		HS	AICBO
19	Integration with existing project					
19.1	Develop coordination strategy with ASHA Project				HSC/PC	
19.2	Provide nutrition training to strengthening kitchen garden activities in the working VDCs of ASHA					
19.4	Implement the training				TS	

SN	Activities	Unit	Target	Yr.4	Responsibility	Support Needed
19.9	Link savings and loan group with FCHV in their area and provide special priority to them for training and other CS oppurtunities				HS	
19.1	Link and prioritize FCHV families (Dalit boys and grils and non girls) for scholar scheme of ASHA Project				AICBO	
19.11	Analyze the ASHA training package and incorporate health message into it (access and behavior)				DP	
20	Prepare Phase out Plan					

Bal Bachau in Far West
Regional Workplan
October 2003 - September 2007
FW Regional

SN	Activities	Unit	Target	Time Frame								Responsibility		Support Needed
				May	June	July	Aug	Sep	Yr.2	Yr.3	Yr.4			
1	General													
1.1	<i>Startup and staffing</i>													
1.1.1	Selection/recruitment of Training Specialist and logistic assistant	Pers	1										HSC	
1.1.2	Finalization of Job Description												PM	
1.1.3	Procurement of computers	Pcs	9										LA	PM
1.1.4	Procurement of motorbikes and furniture and fixtures	Pcs	9										LA	PM
1.2	<i>Staff Development</i>													
1.2.1	Staff training need assessment												TS	
1.2.2	Consolidated yearly staff training plan for all CSP staffs									III	III	III	TS	
1.2.3	Implement and monitoring of training plan												TS	PM
2	Program Management													
2.1	Development Regional AIP (Coordination mechanism with stakes)	Times	4							IV	IV	IV	PM	Specialist
2.2	Develop individual operating plan (PM, Specialist and DHC)	Pers	8							III	III	III	PM	Specialist
2.3	Regional Program review meeting (CO, DHC, AICBO; quarterly)	Times	13										PM	Specialist

SN	Activities	Unit	Target	Time Frame							Responsibility			Support Needed
				May	June	July	Aug	Sep	Yr.2	Yr.3	Yr.4			
2.4	Regional management visit to district	Times	Ongoing										PM	Specialist
3	Regional Advisory committee													
3.1	Formation of regional advisory committee (DHO of all districts, INGO/NGO rep. Regional directorate rep, CO rep, PM, 2 civil society repre, and ivitee)	Comm	1										PM	Specialists
3.2	Meeting with regional advisory committee	Times	13						IV	IV	IV		PM	Specialists
3.3	Attend District Advisory committee meeting	Times	Ongoing										PM	Specialists
4	Integration with with other existing projects													
4.1	Strategy Development												HSC,PC	PM, CHS
4.2	Development of components for Integration												PM	HSC,CHS, RT
4.3	Review of the documents and necessary amendments												PM	HSC,CHS, RT,PC
5	Coordination with health stakeholders													
5.1	Regional level													
5.1.1	Regional quarterly review meeting with RHD	Times	13										PM	Specialist
5.1.2	Joint field visit with RHD (two times per year)	Times	Ongoing						II, IV	II, IV	II, IV		PM	Specialist
5.1.3	Explore possibilities of housing regional office in premise of RHD												PM	Specialist
5.2	Central Level													
5.2.1	Participation in National level MoH committee viz. CDP, Nutrition, IMCI and FCHV		Ongoing										HSC	CHS

SN	Activities	Unit	Target	Time Frame								Responsibility		Support Needed
				May	June	July	Aug	Sep	Yr.2	Yr.3	Yr.4			
10.1	FCHVCC													
10.1.1	Support Kanchanpur district office to prepare strategic prospective plan of FCHVCC												A&PS	PM, Specialist, DT
10.1.2	Support Kanchanpur district office to register FCHVCC as CB-NGO and work in partnership												A&PS	PM, Specialist, DT
10.1.3	Advocate FCHVCC and its effectiveness in District, Region and National forums		Ongoing										A&PS	PM, Specialist, DT
10.1.4	Document and Dessimination		Ongoing										M&DS	PM, Specialist, DT
10.2	Health Facility Management Committee													
10.2.1	Finalize the HFMC curriculum												M&DS, TS	PM, Specialist
10.2.2	Coordinate and support districts to implement HFMC committee trainings												M&DS, TS	PM, Specialist
10.2.3	Joint monitoring with RHD and D/PHO												TS	PM, Specialist
10.2.4	Documentation and Dessimination		Ongoing										M&DS, TS	PM, Specialist
11	Health System Strengthening													
11.1	CB-IMCI Training													
11.1.1	Coordinating meeting with RHD and D/PHO of CSP districts	Eve	2										PM	Specialist, DT
11.1.2	Coordination meeting with NEPAS and NTAG	Eve	2										PM	Specialist, DT
11.1.3	Review the progress of training (Monthly)	Times	Ongoing										PM	Specialist, DT
11.1.4	Joint monitoring with CHD and RHD persons		Ongoing										PM	Specialist, DT

SN	Activities	Unit	Target	Time Frame							Responsibility		Support Needed	
				May	June	July	Aug	Sep	Yr.2	Yr.3	Yr.4			
11.2	Community Drug Program													
11.2.1	Facilitate/coordinate meeting with RHD, D/PHO, UNICEF and GTZ for CDP implementation in collaboration	Eve	2+										PM	Specialist
11.2.2	Support district office to coordinate and implement CDP program with LMD CDP section		Ongoing										Specialist	PM, DT
11.2.3	Joint Monitoring visit with LMD and RHD		Ongoing										Specialist	PM, DT
11.3	HMIS/LMIS strengthening Program													
11.3.1	Coordinate and support review meeting of HMIS/LMIS in regional level (Semiannually)	Eve	6										M&DS	PM, Specialist, DT
11.3.2	Support in development of Regional Health Annual Report	Pcs	3										M&DS	PM, Specialist, DT
12	FCHV Strengthening Program													
12.1	District, Regional and National level evidence based advocacy		Ongoing										M&DS	PM, SPecialist, DT
12.2	Coordinate and implement with RHD/DHO to add short health review session (CDD or PCM or etc) in review meeting of FCHV	Eve	2										TS	PM, SPecialist, DT
12.3	Documentation and dessimination		Ongoing										M&DS	PM, SPecialist, DT
13	Behavioral Communication Change													
13.1	Coordinate with AED for BCC strategy ToT training for RHD, DHO and project staffs												TS	PM, Specialist, DT
13.2	Identify point person for BCC at region and district	Pers	5										PM	Specialist, DT
13.3	Documentation and Dessimination		Ongoing										M&DS	PM, Specialist, DT

Assessment of the Project based on CARE International Program Principles Year 2006

Principle: Promote Empowerment

Current Position	Why?	Proposed Position	How?
Considerable	<ul style="list-style-type: none"> • The project works in partnership with FCHVCC and mothers groups.? • Evidence based advocacy is the one of the core strategy of the project.? • The project had been advocating its promising lessons to influence FCHV strategic document viz. selection criteria, concept of coordination committee, and endowment fund etc.? • Collaborates with FCHV coordination committee and provides a significant proportion of its resources to implement community initiative. 	Strong	<ul style="list-style-type: none"> • Join different level of alliances and networks that are based on rights movements. • Encourage women and <i>Dalits</i> to take lead role in change process • We support FCHV to actively participate in decision-making process.

Principle: Work with Partners

Current Position	Why?	Proposed Position	How?
Considerable	<ul style="list-style-type: none"> The project works with 19 FCHVCC and four local NGOs (among them two are from <i>Dalits</i>) Multisectoral collaboration is the principle of project to improve health status along with economic and social status.? Mission partnership strategy paper has considerably conceptualized and followed in partnership program.? The project jointly assesses partner's institutional capacity and support in institutional development.? The voice of partners is not so strong as project activities are fixed during the design process. 	Strong	<ul style="list-style-type: none"> Develop partnership with different organizations based on demonstrated action and results. Involved partners from project designing phase till completion.? Review and updates CARE-Nepal policies based on partnership strategy.

Principle: Ensure Accountability and Promote Responsibilities Principle: Address Discrimination

Current Position	Why?	Proposed Position	How?
Basic	<ul style="list-style-type: none"> Project promoted women empowerment and strengthen the role of women representatives at the local government more accountable and responsive towards the issues of women.? One of the major outcomes is to make service providers more accountable and responsive to the need of women and children.? We share our program and budget to concerns stakes.? Project has prepared entry point and implementation strategy for different districts. 	Considerable	<ul style="list-style-type: none"> We work with women and <i>Dalits</i> to make claims on duty bearers. We work for pro poor policies and try to get our message across who prefer not to hear the message. Create forums at different levels where right holders and duty bearers have an opportunity to interact each other. Ensure involvement of Dalit women and poor in project design process.

Principle: Address Discrimination

Current Position	Why?	Proposed Position	How?
Basic	<ul style="list-style-type: none"> The project works with women groups to address marginalization. The project goals and objectives clearly address discrimination and denial of rights.? Gender and diversity strategy of CARE-Nepal is guiding documents for CSP II 	Strong	<ul style="list-style-type: none"> The project will challenge the power structures that are discriminatory. We will find out where discrimination is rooted (policy, norms, structure etc.) and proactively work to confront these factors.? Promote public auditing and hearings.

Principle: Non-Violent Resolution of Conflict Principle: Seeking Sustainable Results

Current Position	Why?	Proposed Position	How?
Basic	<ul style="list-style-type: none"> The project and partners staffs are oriented in DO No Harm.? Project has developed strategies to work in conflicting situation.? Community level orientations trainings are targeted to rights holder and duty bearers to understand their roles and responsibilities to minimize conflict We conducted start up workshop to ensure our activities will not create or contribute conflict 	Considerable	<ul style="list-style-type: none"> Promote gender and diversity strategy in staff development and hiring process. Develop alliances with Human Rights organizations.? Promote public auditing and hearings.

Principle: Seeking Sustainable Results

Current Position	Why?	Proposed Position	How?
Basic	<ul style="list-style-type: none"> • Project assist project participant to enhance their skill and knowledge through capacity building trainings. • Project attempts to empower partner organizations to take lead in the project implementation. • Project influenced policy makers in favor of women children and <i>Dalits</i>. • We have plans to handover the project promising activities to partners 	Considerable	<ul style="list-style-type: none"> • Conduct social analysis during design phase of project. • Develop strong policy analysis and feedback mechanism.? • Orient project participants on RBA?



CHILD SURVIVAL SUSTAINABILITY ASSESSMENT (CSSA)
Child Survival Project, Kanchanpur
CARE Nepal

Concept

Sustainability is an intangible concept and a term without common definition. Different people define sustainability in different ways. The Oxford dictionary defined sustainability as 'cause to continue or be prolonged for an extended period or without interruption'.

In simpler term, in context of child survival project, sustainability can be defined as positive health outcomes in maternal and child health situation, even after project input cease or decrease. Positive health outcomes can have no real impact on children's health, development and well being unless they are maintained over time; even if and when external assistance is reduced. In summary, sustainability can be understood as:

- institutionalization of project efforts
- population level impact through project efforts
- community ownership on project efforts
- multi-sectoral system level impact of project efforts

These other definitions have included—

- *Institutionalization* of strategies and practices in local organizations, often MOH structures or local NGOs;
- *Financial support* for the continuation of activities, through cost-recovery and business development strategies;
- *Empowering communities*, for instance to implement essential health activities or manage and oversee health committees;
- *Improving the supply and demand cycle* for care services, by combining quality improvement efforts with cost-recovery schemes;
- *Development* that meets the needs of the present without compromising the ability of future generations to meet their needs (i.e., "*ecologically sustainable development*").¹

The concept of Sustainability covers following issues in context of Child Survival Project

¹ World Commission on Environment and Development ("Brundtland Commission"), United Nations, 1987.

- Improved health outcomes is what we seek to sustain (programs, activities, and institutions are merely means to accomplish that goal in a changing and complex environment).
- Who owns tomorrow? Think *in* the local system, and work with others to complement, not compete.
- Plan for sustainability *now* (ideally at the beginning of a project)!
- Be accountable. Define contextually realistic objectives with your partners.
- Assess in order to know where you start, and evaluate to show how far you have gone. Monitor progress along the way.
- Find synergies between areas of intervention.
- Balance process and results.

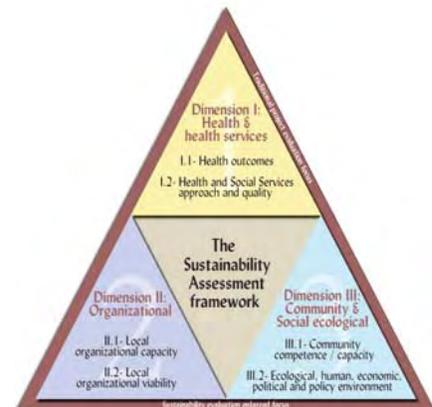
Project Overview

CARE Nepal implemented Child Survival project in Kanchanpur district since October 1999. The first phase of the project (CS XV, Oct 99 - Sept 03) was focused on intensive implementation of the project activities based on the framework of community based integrated management of childhood illness. The progress of the first phase of the project was remarkable and thus the second phase of the project (CS XIX, Oct 03 – Sept 07) was awarded to CARE Nepal for extending program impact to additional three districts of far west Nepal. Currently, CARE Nepal in close collaboration and coordination with District Public Health Office, Kanchanpur is implementing activities with an aim of sustained health impact in health, development and wellbeing of children in Kanchanpur, that was gained during the first phase of the Child Survival project.

Dimensions of sustainability

Sustainability in Child Survival projects is a contribution to the development of conditions enabling individuals, communities, and local organizations to express their potential, improve local functionality, develop mutual relationships of support and accountability, decrease dependency on insecure resources (financial, human, technical, informational), in order for local stakeholders to negotiate their respective roles in the pursuit of health, development and wellbeing, even beyond a project intervention.

Every project operates in the local system comprising the individuals, groups, communities, local organizations and the environment on which they operate. These elements of local system are coordinated and linked through social actions and interactions and affecting the health of individual and community at large, either positively or negatively. Thus, there are three distinct dimensions of sustainability in context of Child Survival Project,



namely i) health outcomes, ii) organizational capacity, and iii) enabling environment.

Measurement of sustainability remained a big question in the development arena since a long time. In fact, measurement of sustainability is problematic, as this is an intangible concept. Sustainability is not only difficult to measure, but is quite unpredictable most of the times. The complexity of models, the multi-factoral nature of sustainability, and the practical difficulty of measuring post-intervention outcomes on various dimensions have constrained measurement of sustainability of development efforts.

Though sustainability is difficult to measure, the Child Survival Collaboration and Resource (CORE) Group, Child Survival Health and Grants Program (CSHGP) and Child Survival Technical Support project (CSTS) have worked collaboratively to develop a system to measure sustainability of child survival project being implemented through various Private Voluntary Organizations (PVO). The framework, named as Child Survival Sustainability Assessment (CSSA) framework, has been used in various Child Survival projects being implemented through different PVOs and found fruitful in monitoring progress towards sustainability and to take appropriate actions on timely manner to drive the project towards sustainability.

Methodology

With the support of CSTS, encouragement from the local USAID mission and technical assistance of New Era, CARE Nepal decided to apply the CSSA framework in Kanchanpur district. Thus a list of possible indicators were selected in consultation with the project team and shared with CSTS and other PVOs during the CSSA orientation workshop in Kathmandu. Based on the feedback and suggestion from them, a final list of indicators was prepared.

During the month of May 2006, CARE Nepal, Child Survival Project Organized two days workshop at Mahendranagar, Kanchanpur in presence of local stakeholders (CS project, District Public Health Office, District Development Committee, Mahendranagar Municipality, Female Community Health Volunteers, local NGO partners, and media).

The Objectives of the CSSA Workshop in Kanchanpur was:

- To orient district level Child Survival stakeholders on the concept of program sustainability in context of Child Survival Projects
- To review project progress in context of program sustainability based on Child Survival Sustainability Framework
- To build common understanding on improving program sustainability in context of Child Survival Project in Kanchanpur

The workshop participants had interactive discussion on the short listed indicators and indicator value. The some of the indicators were modified, added and discarded as suggested by the workshop participants. Then, based on the final list of indicators, indicator value was score value was calculated in presence of all stakeholders. Data for such indicator value was obtained from different data source already available (e.g. LQAS, HMIS, LMIS etc). For some of the qualitative indicators, data value and score value was calculated through interactive discussions with participants. Finally, the score was plotted on the sustainability dashboard and presented in the plenary. The plenary analyzed the dashboard and conclusion was drawn.

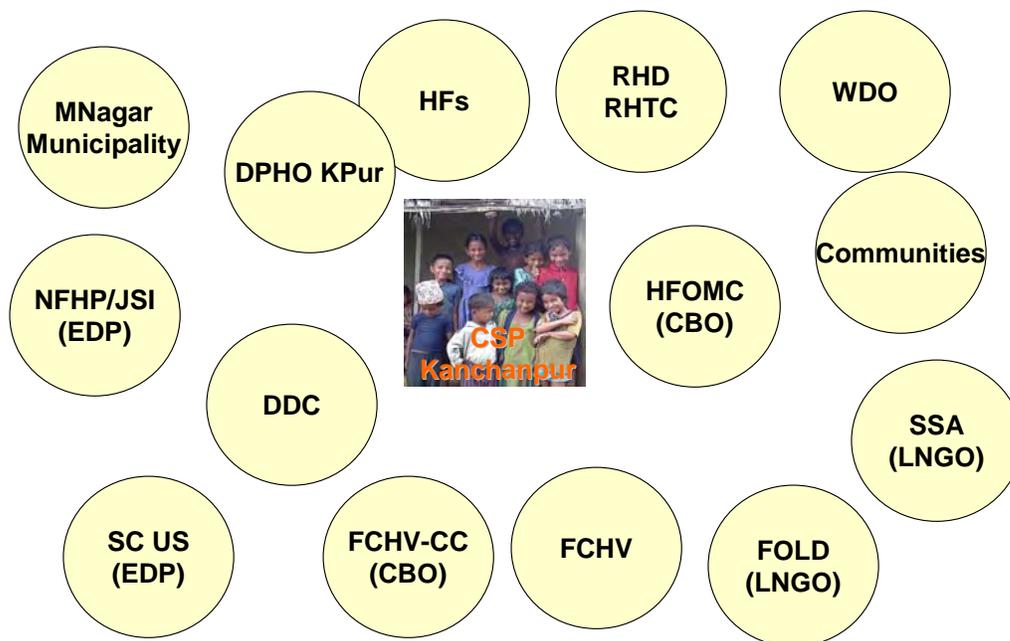
At the end, role of different stakeholder for sustaining the project impact was discussed. All participants expressed their commitment to support and act in line with sustainability based on the exercise.

How the Child Survival project, Kanchanpur is moving towards sustainability?

Local system:

Participatory exercise was carried out to identify local context in context of Child Survival Project. The stakeholders were identified in relation to their role and influence in the overall goal of the project.

Local system



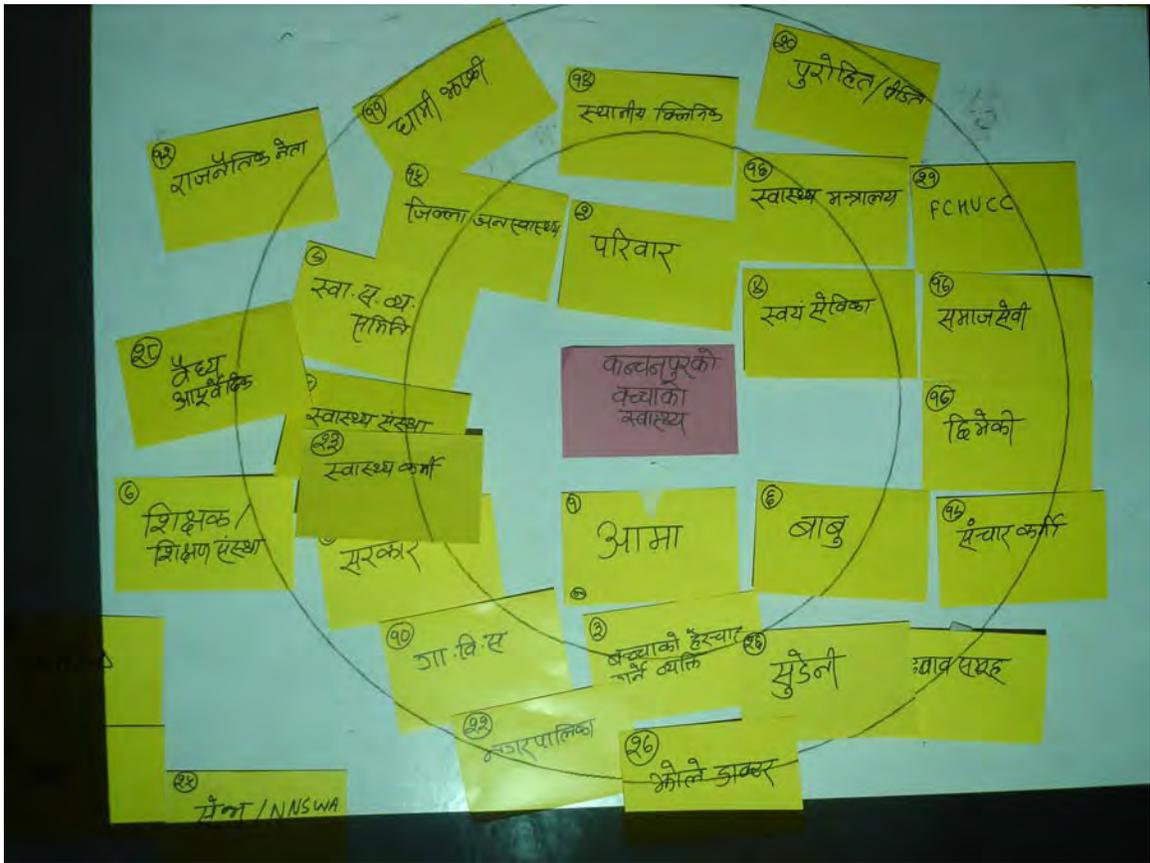


Fig: Mapping the local system of Child Survival Project, Kanchanpur

Vision:

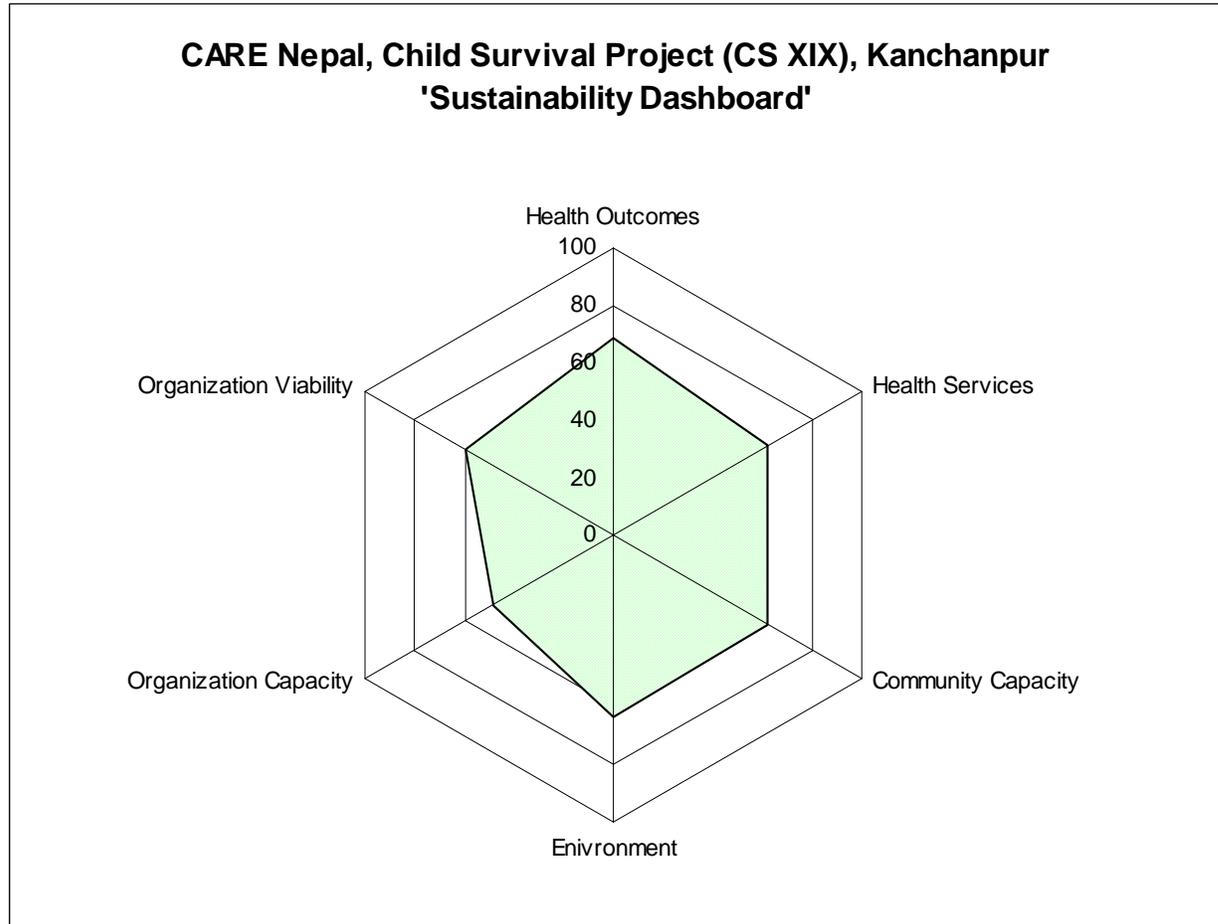
“All women and children in Kanchanpur will be healthy and prosper and will survive with wellbeing and dignity”

Indicators:

Components	Dimension/Elements	Source	Measured value	Score value	Remarks
Health and Health Services	Health Outcomes				
	Percentage of births attended by skilled personnel	LQAS	31	41	
	Percentage of under six months children exclusively breastfed	LQAS	70	73.3	
	Percentage of sick children receiving increased fluid and continued feeding during illness	LQAS	89	89	
	Percentage of underweight children (based on weight for age)	Nutrition survey	20	70	
	Health Services				
	Health facilities with separate place for ANC and PNC maintaining privacy	Discussion	60	60	
	Health facilities having adequate stock of Cotrim	NFHP TSV Data	98	98	
	Percentage of health workers treating pneumonia with Cotrim	HWS	56	56	
	Percentage of health workers able to correctly diagnose pneumonia case based on respiratory rate	HWS	33.8	34	
	Percentage of FCHVs having four key commodities (ORS, Cotrim, Condom, Pills) available	NFHP TSV Data	63	63	
	Organizational	Organizational capacity			
Percentage of health workers received CB-IMCI training		Training	90	80	
Health facilities having functional community drug program (updated register, income-expenditure, transparency, decision making etc)		Discussion	4	80	
Percentage of health facilities having Supervision and Monitoring Plan		Discussion	30	20	
Percentage of health facilities having annual plan of action		Discussion	20	13.3	
Organizational viability					
Extent to which HFOMC meetings are regular and decisions are implemented		Discussion	3	40	
HFOMCs receiving cash or in-kind support from external agencies		Qualitative survey	4	80	
Health facilities having own plan of action and implemented activities with their own initiation		Qualitative survey	2	40	
FCHVs facilitating regular meeting of mother groups to discuss on maternal and child health issues		Qualitative survey	4	80	
Community and Environment	Community Capacity				
	Percentage of mothers group meeting regularly to discuss on health issues	Qualitative survey	4	80	
	Capacity of HFOMC to analyze local context, issues, need and capacity	Discussion	1.5	30	
	Capacity of FCHV Coordination committee to implement local level health awareness activities	Discussion	2.5	50	
	Capacity of local groups to discuss, analyze local issues on equity and social justice	Discussion	4	80	
	Extent of cooperation, cohesiveness and social harmony in community groups	Discussion	3.5	70	
	Enabling Environment				
	Percentage of health staff positions filled	AR, FWRHD	100	80	
	Extent to which project activities has been disturbed by conflict	Discussion	2.5	50	
Capacity of local NGO partners to carryout child survival activities	Discussion	3	60		

Dash Board:

Fig 1: Sustainability Dashboard of CARE Nepal, Child Survival Project, Kanchanpur



Conclusion

Based on the analysis of the dashboard, following actions are recommended for moving Child Survival project, Kanchanpur more towards sustainability.

- The progress of the project towards health outcomes, health services and community capacity was found encouraging.
- Efforts should be made to ensure that the progress made on health outcome, health services and community capacity be sustained over the period of time.
- For the remaining period, project should focus on strengthening systems to improve organizational capacity, organizational viability and enabling environment. For this, project should identify actors that have roles on creating enabling environment and to strengthen organizational viability and mobilize them for sustainable health outcomes.

- Project should regularly monitor its progress based on the CSSA framework and take appropriate actions. This system should be institutionalized within district public health system.

References

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Sarriot, E. et. al. Qualitative research to make practical sense of sustainability in primary health care projects implemented by non-governmental organization. Int J Health Plann Mgmt 2004; 19: 3-22.

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CARE Nepal and District Public Health Office Kanchanpur
Child Survival Sustainability Assessment Workshop
28-29 May 2006
Mahendranagar, Kanchanpur

Objectives:

- To orient district level Child Survival stakeholders on the concept of program sustainability in context of Child Survival Projects
 - To review project progress in context of program sustainability based on Child Survival Sustainability Framework
 - To build common understanding on improving program sustainability in context of Child Survival Project in Kanchanpur
-

Agenda:

Day I, Sunday 28 May 2006

<u>Time</u>	<u>Agenda</u>	<u>Responsible</u>
10.00 – 10.15	Introduction, Objectives and Agenda sharing	KPur
10.15 – 11.00	What is Sustainability and Program Sustainability?	R Sharan
11.00 – 1.00	Child Survival Sustainability Assessment Framework <ul style="list-style-type: none">• Framework sharing• Indicator transformation (concept and process)• Experience of other PVOs and other countries• CSSA Frame: “What it is?” and “What it is not?”• Usefulness of applying CSSA Framework• Challenges and constrains	Jagat
1.00 – 2.00	LUNCH BREAK	
2.00 – 2.30	Brief review of Child Survival Project <ul style="list-style-type: none">• Goal and Objectives• Strategic approach	CSP RO
2.00 – 4.30	Applying CSSA in context of CSP Kanchanpur <ul style="list-style-type: none">• Identifying and defining local context• Visioning Exercise for Child Survival in Kanchanpur	Deepak
4.30 – 5.00	Wrap up and Summarization	

Agenda:
Day II, Monday 29 May 2006

<u>Time</u>	<u>Agenda</u>	<u>Responsible</u>
10.00 – 10.15	Review of Day I	Notetaker
10.15 – 11.00	Indicators for measurements <ul style="list-style-type: none">• Indicator sharing and discussion• Group Exercise to finalize indicators• Sharing indicators by groups• Finalization of indicators	R Sharan
11.00 – 1.00	Finalizing indicator values <ul style="list-style-type: none">• Group Exercise to finalize indicator value• Sharing indicator value by groups• Discussion and drawing conclusion	Deepak
1.00 – 2.00	LUNCH BREAK	
2.00 – 3.00	Preparing Sustainability DashBoard <ul style="list-style-type: none">• Dashboard sharing• Discussion, Interpretation and Conclusion drawing	Jagat
3.00 – 4.30	Drawing conclusion and Common Understanding <ul style="list-style-type: none">• Drawing conclusion, based on application of CSSA• Suggestions and Recommendations• Next actions for sustained child survival in Kanchanpur	R Sharan
4.30 – 5.00	Wrap up and Summarization and Closing	

CARE Nepal and District Public Health Office Kanchanpur
Child Survival Sustainability Assessment Workshop
28-29 May 2006
Mahendranagar, Kanchanpur

List of Participants

SN	Name of Participants	Position	Organization
1.	Bhagat Sing BK	Coordinator	Samajik Samanta Abhiyan
2.	Bhanmati Khadayat	FCHV Coordination Committee	FCHV, Daijee VDC
3.	Bhanu Dev Bhatt	Program officer	District Development Committee
4.	Bharati Singh	FCHV Coordination Committee	FCHV, Mahendranagar Municipality
5.	Bijay Bharati	Research Monitoring and Documentation Specialist	CARE, Child Survival Project, Regional Office
6.	Deepak Paudel	Community Health Specialist	CARE Kathmandu
7.	Dharani Bhatt	Reporter	Chhure Times (media)
8.	Ganesh Datt Joshi	Focal person	District Public Health Office, Kanchanpur
9.	Gomati Chandh	FCHV Coordination Committee	Suda
10.	Indra Adhikari	Partnership and Advocacy Specialist	CARE, Child Survival Project, Regional Office
11.	Induka Karki	Health Supervisor	CARE, Child Survival Project, Kanchanpur
12.	Jagat Basnet	Resource Person	New Era
13.	Karan Datta Aawasthi	Secretary	NFPA
14.	Keshav Datt Bhatt	CDPA	Pipladi
15.	Kusum Shahi	Health Supervisor	CARE, Child Survival Project, Kanchanpur
16.	Nandha Raj Bhatt	AHW	Laxmipur SHP
17.	Nava Raj Joshi	AHW	Jimmuwa HP
18.	Ram Sharan Pyakurel	Project Manager	CARE, Child Survival Project, Regional Office
19.	Ratan Singh Bist	AHW	Pitamber HP
20.	Shanti Raut	Health Supervisor	CARE, Child Survival Project, Kanchanpur
21.	Upendra Dhungel	Asst Institutional Capacity Building Officer	CARE, Child Survival Project, Kanchanpur
22.	Yagya Raj Chataut	Program Coordinator	FOLD

Case Study

Change Agent... For the community

Make every mother and child count

"I am proud to say that every mothers and children in my community are counted. The mothers are regularly visiting the out reach and immunization clinics. The community has given importance to the National health programs. I feel my commitment has reflected the lower maternal, infant and neonatal morbidity and mortality. Commitment without escaping the challenges has proved that there is nothing-impossible iff there is genuine efforts. Now there will be no more Firuwa's incident repeated in my community."

"Namaskar... I am Tara Rana." This is the greeting that she expresses to every people and guest of her community. This greeting has confidence and commitment to serve for the community. This confidence pulled me nearer to her.

Tara, 28, Tribhuwanbasti Kanchanpur, is an FCHV from a Tharu community, one of the marginalized communities in Terai of Far West, Nepal. The major occupation of this community is agriculture. The older women are engaged in knitting wrappers, blouse and shawl, which are the common dress of the females of this community. Study is what the community tries to escape from.

The village used to be enveloped in the sheath of early pregnancy, not giving any food to the postpartum mothers for 3 to 5 days, infectious diseases related to child health: diarrhea, measles, pneumonia and fever, seeking the traditional healers for health care. Tara hark back to one incident," the mourning cry at my neighbor Firuwa's house, haul me. Alas! I found dead bodies of a woman and 2 children of the same family lying before." Further, in the same village Tara recalls the death of a pregnant woman due to prolonged labor pain and a neonatal death due to severe pneumonia in the village. Tara was traumatized with these events and she kept these events within her soul so that she would contribute for the health of the community. Tara, with the events stored in her soul and her confidence and commitment, dared to be an FCHV when CARE Nepal and community health worker announced its need in her mothers group.

Tara received various health related training after attending in the basic FCHV training and struggled hard to change the traditional behavior of the community. The trainings continuously helped her to increase her confidence and commitment to serve voluntarily. She recalls," I faced several obstacles and hindrances while trying to change the unhealthy behavior of the community, but my commitment to serve the community and keep them free from illness and harmful traditional practices drove me towards my dream of healthy community."

Tara devoted herself to regularize and facilitate the mothers group meeting. She knew that poverty is the root cause of ill health, thus explored with the mothers group that poverty will not come between the community and their health. As a result she was succeed in getting support from the mothers to establish emergency fund. Tara says," There are several mothers, especially from the marginalized and socially excluded community, are devoid of getting health services and the ill health toils over them. Therefore, I am exercising the

rotational meeting of mothers group in such marginalized community to provide health education. At present I am recognized as the role model of the community and the community has chosen me as a chairperson of FCHV coordination committee and teacher for Child Care Center."

"I am full of pride and I believe being an FCHV is a decision point in my life that has inspired other Taras to get committed and work as a change agent for the dramatic happening in their community and vis-à-vis in their life. Thanks to child survival project of CARE for bringing me in front and helping to address the health issues even in the socially excluded community. My dreams has come true..."