

**Save the Children
Nepal Field Office**

**Child Survival 8
Final Evaluation Report**

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Finally, the assistance of the staff of SC in Kathmandu and afield in facilitating this evaluation was much appreciated.

Glossary

AIDS	Acquired Immune Deficiency Syndrome
ALC	Advanced Literacy Class
AMFAR	American Foundation for AIDS Research
ANM	Assistant Nurse Midwife
ARI	Acute Respiratory Infection
BASE	Backward Society Education
BLC	Basic Literacy Class
CDD	Control of Diarrhea ¹ Diseases
CMA	Community Medicine Auxiliary
c s	Child Survival
DDC	District Development Committee
DEO	District Education Officer
DHO	District Health Officer
DIP	Detailed Implementation Plan
ECD	Early Childhood Development
ECE	Early Childhood Education
EPI	Expanded Program on Immunization
FCHV	Female Community Health Volunteer
FP	Family Planning
HIV	Human Immunodeficiency Virus
HMG	His Majesty's Government
HP	Health Post
HPIC	Health Post In-Charge
IEC	Information, Education, Communication
ilaka	Subdivision of a District; based on having a health post
INGO	International Non-Governmental Organization
JHU	Johns Hopkins University
Jeevan Jal	Local brand of Oral Rehydration Salts
KPC	Knowledge, Practice, Coverage
LNGO	Local Non-Government Organization
MCH	Maternal/Child Health
MOH	Ministry of Health
MTE	Midterm Evaluation
NFE	Nonformal Education
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
o s c	Out of School Children
PVO	Private Voluntary Organization
SC	Save the Children
SCF	Save the Children Federation
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
WOREC	Women's Rehabilitation Center

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Executive Summary Save the Children/Nepal CS VIII Project, 1992-1995

From December 5 to 18, 1995, a six person team conducted a final evaluation of the Save the Children Child Survival VIII project in Nuwakot District, Nepal. The evaluation team comprised: Dr. Shishir Kumar Sthapit, an English Professor at Tribhuvan University; Dr. Bikaash Lamichhane, an MOH representative with an MPH degree from JHU; Karen LeBan, SC Health Office Manager; Naramaya Limbu, SC/Nepal Deputy Public Health Coordinator; Mary Linehan, USAID Child Survival Specialist; and Dr. Stephen Bezruchka, the team leader. The team traveled to the site, completed a traverse observing activities, examined project materials, and interviewed staff and villagers as well as the Minister of Health who comes from the project site. The draft evaluation was presented to SC staff in Nepal and comments received.

The project started up in October 1992 in a new area for SC without major difficulties. The site was chosen because of concern about "girl trafficking", reported to be a major economic activity in the eastern aspects. It ran to September 1995, with a budget of \$549,665, with \$412,246 from USAID, matched by \$137,417 from private sources. The beneficiary population of 37,182, although close to rapidly changing Kathmandu, is conservative in contrast. The goal was to improve health by empowering families to address their needs and create an increased demand for improved government services. The major activity was various levels of literacy classes for women, leading to group formation and income generating efforts. Health education was introduced indirectly, through NFE activities. Project objectives included health service provision, improved health knowledge and behaviors, as well as those directly involving literacy acquisition and independent group operation. Health services remained the responsibility of the government infrastructure, with some supplementation by the project in the form of mobile MCH clinics, and immunization catch-up rounds.

Outcomes from the final survey showed significant improvement over the baseline values for almost all indicators, attesting to the strength of acquisition of literacy skills as an intervention. Although most targets were not reached, progress was remarkable, with 10 out of 16 indicators showing substantial positive change. Notable are the numbers of new literates and women's groups. There was indirect evidence of nascent empowerment, but change in provision of government health services was not evident.

The major effect of the project, perhaps under appreciated by the staff, is the widely linked communication network produced by the NFE strategy and resulting group formation. This network is responsive to SC-influenced NFE facilitators, supervisors and class participants.

The major concern is that both coverage with interventions, and community involvement are lowest among the Tamang ethnic group. These people are among the most economically disadvantaged in Nepal, and are the presumed focus of the trafficking activity. Project staff need to make a more serious attempt to understand these peoples and their relative lack of involvement in the NFE activities. Strong use is made of IEC materials in this area that are produced by the project without adequate pretesting. Graphic and written communication in health matters have limited relevance to village information channels. Finally, the FCHV's are a poorly understood work force in the project area. The staff need to spend more time working with FCHV's to help them realize their potential.

Main recommendations center on addressing this inequitable situation related to the Tamang population. The field staff need technical, cultural and linguistic assistance to begin formative study to understand this population, and to begin to work effectively with them. Staff understanding of how behavior change comes about needs to be addressed. Expenditures need to be tracked with project activities to enable decisions to be made based on cost effectiveness and cost benefit. The communication network developed by the project needs to be better understood, nurtured and utilized. Given the community participation model espoused by the project, more effective use of staff time might best be served by their living more closely with the community. Efforts to strengthen FCHV effectiveness should be considered.

SC enjoys earned respect and acknowledgment for its work in the project area, and worldwide. Staff are dedicated, hard working, and enjoy support from the Kathmandu and US based offices. With experience gained by working in Nepal over the last thirteen years, SC can be expected to facilitate major community driven beneficial changes, which the recipient people will perceive doing themselves.

I. Introduction

A. Project finance

Funds for the project came from USAID/BHR/PVC Child Survival competitive grants program. The USAID funding of \$412,250 was matched by \$137,417 from SC/US private funds.

B. Country and project area information

1. Background

- Historical background

Nepal was isolated from the outside world until 1951. Rudimentary health services, begun after that, focused on vertical programs such as malaria control, eradication of smallpox, and family planning activities and were funded by major donors. In the 1970's attempts were made to integrate the vertical programs of the MOH, with partial success. After the Alma Ata declaration of Primary Health Care in 1978, and the response of Selective PHC, the concept of Child Survival was enunciated in the 1980's. USAID committed itself to funding NGO efforts to implement these. Child Survival has come to comprise provision of immunizations, control of diarrhea¹ diseases, treatment of acute lower respiratory infections, continuation of breast feeding, and emphasis on birth spacing. The importance of female literacy as a proximate determinate for child health was recognized in the 1980's. The important effect of socioeconomic status on health and the relevance of factors outside the biomedical model as they apply to populations has been termed the health transition. This multi-factorial process and a secular trend has resulted in the improvement of health status indicators, but Nepal still ranks near the bottom of nations in health indicators.

SC USA/Nepal began community based development efforts in 1982, and was awarded the CS VIII grant for the provision of CS interventions in Nuwakot District.

- Nuwakot District

This district, comprising 1121 square km, lies in the Central Development Region, northwest of Kathmandu. The population was estimated to be 245,260 in 1991, with a growth rate of 1.7% a year. It is organized into 61 Village Development Committees (VDC), and one municipality. Each VDC has an elected chairman. The smallest administrative division is the ward, (there are 9 in a VDC), each with an elected member. The district is transected by a road, linking Kathmandu with the district headquarters at Trisuli. There are now feeder roads off this main thoroughfare linking some nearby villages, but many villages in the district lie several days walk from the road. Nuwakot District lies in the hills of Nepal, with predominant representation from the Tamang, and Hill Hindu Castes. Although Nepali, an Indo-European language is the lingua franca, it is not the native tongue for many people in the district, and some do not speak it at all. The religion of the hills, based on animism and shamanism predominates, is termed Hinduism by many, with Buddhism finding expression amongst Sherpa and Tamang. Most homes are accessible only by foot trail, and have no electricity nor running water. Mini-hydel electricity is supplied to some towns along the road. Kerosene is a fuel source near the road, while most people harvest local forest resources for heat energy for cooking. Communication facilities such as a postal system are limited, there are no phones in the project area, with the exception of one in Samudratar. The economy is based on subsistence agriculture. Most landholdings are small, the extended family is the basic stakeholder. Imports are a few consumer goods, while exports are some agricultural products.

Health services exist in many forms in addition to the *dhami* or *jhankri* (traditional healers). Those supported by His Majesty's Government (HMG) begin with a Female Community Health Volunteer (FCHV), based in each ward. A Village Health Worker (VHW) in each VDC coordinates her activities and runs immunization services. Current health plans call for a Sub Health Post staffed by auxiliaries, including a local MCH worker, to exist in every

VDC, a Health Post staffed by a Health Assistant in each *ilaka* or geographical group of 4 to 5 VDC's, and a Primary Health Center staffed by a doctor and having 4 beds in each of the 205 electoral constituencies in the country. Each district is to have a hospital staffed by three doctors to act as a referral center for the above mentioned facilities. There are some 11 health posts in Nuwakot district, 20 sub health posts for the 61 VDC's, a district hospital in Trisuli with one doctor present and no PH Centers. Many of the health posts and sub health posts are staffed (names are posted to the position) but not manned (staff absent) (Aitken, 1994). Currently, each electoral constituency's elected representative is a minister in the national government, holding portfolios of health, foreign affairs and finance with the health minister coming from the Project area.

For people of Tamang ethnicity, the predominant ethnic group in the project area, health outcomes, including infant mortality, have generally been among the worst in the country (Ali 1991). Available statistics for the district suggest that over 50% of men are literate, but less than 18% of women. Furthermore, 71% have no toilet facilities, and 75% rely on a spring or river as a water source. Some 87% of women deliver without antenatal care, and over 97% have no professional assistance with delivery. Coverage for BCG was reported to be 97%, for measles 75% some 2 years ago. (Atlas of Population Distribution and Health Facilities). However, 68% of women state that they didn't know their VHW, and 66% do not know their FCHV. (NFHS, 1991). Other data shown in the table below vary considerably, and portray the difficulties in obtaining accurate information on health services.

- Health Indicators for Nuwakot District (Summary of Programme Performance for the year 2051152 (1994195)

Indicator	Result	Indicator	Result
Measles Vaccine Coverage	77%	Percentage of malnourished children among under-5 visits	12%
BCG Coverage	75%	Percentage of severe pneumonia among under-5 visits	10%
DPT-3 Coverage	65%	Percentage of severe dehydration among under-5 visits	10%
Polio-3 Coverage	65%	Delivery by trained person as % of expected pregnancies	1%
Contraceptive Prevalence Rate	16%	First ANC visit as % of expected pregnancies	7%

2. Map of Nuwakot, see Appendix 1.

II. Project Background

A. Project Goal

1. sustained reduction in infant, child and maternal mortality and morbidity by empowering families to address their health, educational and developmental needs and by creating an increased demand for improved government services.
2. focus on sustainability through strengthening women's groups, and integration of child survival initiatives (EPI, CDD, maternal health, AIDS prevention, ARI and vitamin A), with broad range of NFE, esp. literacy and early childhood education and nutrition

B. Methods

1. focused on training of health workers to strengthen health care service, and literacy classes used as a vehicle for dissemination of knowledge on child survival messages which is expected to promote behavior change
2. support for mobile health clinics

C. DIP Summary

1. Planned Inputs:
 - Management, technical, and trainers/communication skills training for DPHO/HP staff
 - Technical and communication skills training for FCHV and TBAs;
 - Communication skills training for NFE supervisors and facilitators, school teachers, Child Care Cooperative leaders and women's group leaders.
 - Child survival messages will be widely disseminated by the above mentioned groups during a variety of person contacts: community presentations, meetings, classes, exhibitions, mass campaigns, and personal contacts.
 - Developing relationships with MOH at the central level in order to tap available resources (and demand them).
 - The linkages with the central government will be formed.
 - A minimal health information system serving target groups will be developed with sample surveys reporting on outcome indicators.
 - IEC methods/materials developed and used.
2. Planned outputs:
 - Group formation of Mothers, Parenting, ECE, Child Care, Women's Savings, Self-Help, management committees
 - MCH clinics, STD camps, Vit A camps, EPI camps (TT), and annual health exhibitions
 - Literacy classes (basic, advance and out-of-school classes)

D. Surveys

1. Four surveys were done, a baseline, midterm and final, as well as an AIDS/STD's KPC survey. Results for the final surveys are in the appendices. These followed the standard 30 cluster KPC survey method refined for the US AID Child Survival Projects. The clusters were randomly chosen based on 1991 census records for the region, and were weighted proportionate to the estimated population in the required age range. Seven respondents were chosen in each of the 30 clusters. A standardized Nepali questionnaire was administered to the specified population. Sometimes the population was mothers aged 15 to 44, with children under two, other times, it comprised other categories. The results of this sampling technique have a statistical precision of $\pm 10\%$ using this method, but the non-sample bias can be much more significant (Campbell et. al. 1979).

III. Evaluation Methods

The evaluation team comprised six individuals with diverse backgrounds, including: Dr. Shishir Kumar Sthapit, a Nepali educator who received part of his post graduate training in the US; Bikaash Lamichhane, a Nepali doctor who had just completed an MPH degree in the US and represented the Ministry of Health; Karen LeBan, a Save the Children US official directing health programs in many countries where SC works, Naramaya Limbu, a SC US Nepali who directed the public health aspects of its operations in country; Mary Linehan, a USAID Child Survival Specialist with considerable experience in Nepal; and Stephen Bezruchka, the team leader whose experience in Nepal spanned clinical and public health aspects beginning 26 years ago. These multisectoral and multicultural compound eyes worked as a complex organism and helped stimulate wide ranging discussions resulting in this report.

The group split into teams and toured the project area, with one couple making a north to south transect interacting with villagers along the major thoroughfare, while the others observed activities and had discussions with project staff at the western and southern aspects of the intervention site. Project documents and survey results were reviewed, and gaps in survey data were completed. Details on the itinerary and persons interviewed are in the appendices. Notes on observations and interviews were shared amongst all evaluators, a draft report was circulated amongst project staff, and extensive discussions with SC staff were held in Kathmandu before the team departed.

IV. Evaluation Findings

A. Table of Achievements regarding Objectives, Baseline and Final Evaluation Surveys

OBJECTIVES (REVISED)	BASELINE%	FINAL %
IMMUNIZATIONS		
40% of children 12-23 months will be fully immunized against BCG, DT, polio and measles	2	29
25% of women between 15 and 45 years will be immunized against tetanus by MOH norms	7	20
CONTROL OF DIARRHEAL DISEASE		
50% of mothers with under-5 children will prepare ORS correctly	not measured	not measured
25% of children with diarrhea in the last two weeks will be treated with ORT (jeevan jal)	12	32
STD and AIDS		
50% of men and women aged 10-45 will be knowledgeable about three main modes of HIV/AIDS transmission and three protective behaviors	not measured	transmission (3 methods) 11% prevention (3 methods) 21%
ACUTE RESPIRATORY INFECTIONS		
25% of mothers will know the danger signs of ARI	18	45 ¹ (rapid and difficult breathing only)
25% of mothers will seek treatment for their children with severe ARI	19	33 ¹ (to hospital, health post or other such clinic)
VITAMIN A		
40% of children between 6 and 60 months will receive Vitamin A supplementation every 6 months (revised acc. to MOH policy)		77 (project records)
FEMALE LITERACY		
Female literacy rate increased to 30% of 15-45 year population	4 ¹	23 ¹ 30/(project records)
NUTRITION		
70% of mothers will know to give supplementary food at 4 to 6 months	39	27
60% of mothers with children under 5 will introduce supplementary weaning foods to their infants between the age of 4 to 6 months	not measured	not measured
MATERNAL HEALTH		
40% of mothers will know the three clean birth principles	2	16
20% of mothers who will have delivered in the last year will have attended at least one prenatal care session	0	13
FAMILY PLANNING		
15% of eligible couples will use any method of contraception	8	17
CHILD DEVELOPMENT		
20% of families will be trained in health and stimulating child care practices	0	20 (project training records)
SUSTAINABILITY		
30% of community groups formed will be operating independently	not available	58% (project staff analysis)

¹mothers with children under 2 years

B. Evaluation Findings

Project activities are described in some detail, in an attempt to clarify this complex project.

PROJECT GOAUGENERAL ASPECTS

Goal and Methods

The Project attempted to produce a sustained reduction in infant, child and maternal mortality and morbidity by empowering families to address their health, educational and developmental needs and by creating an increased demand for improved government services. It was to focus on sustainability through strengthening women's groups, and integration of child survival interventions (EPI, CDD, maternal health, HIV/AIDS prevention, ARI and vitamin A), with a broad range of Non-Formal Education (NFE), especially literacy, early childhood education and nutrition. The major activities to accomplish this were through literacy classes, group formation, and the production of IEC materials. Such programs have been found to be the most effective way to improve child survival in poor countries. (Caldwell 1981, 1985, Cochrane 1980). There was no effort to provide health services directly, but to attempt to stimulate demand for services, and to help improve HMG services indirectly. Project objectives included those directly concerned with health service provision, as well as knowledge and behavior. In response to a meeting with the Minister of Health of His Majesty's Government of Nepal by the evaluation team, a section of this report is devoted to looking at the health care delivery system as it affects Nuwakot.

Major Findings

. Start Up

The Project has done a remarkable job starting up without encountering major difficulties that they could not overcome. The project was directed from the Kathmandu SC US office and from the field.

. General Observations

One evaluator first visited nearby areas to the project site 25 years ago, and reported little change in spite of the proximity to Kathmandu, in contrast to other areas that are more distant geographically. For example, radios were almost never heard, there were few shops, and almost no consumer goods in *ilaka* 13. One of the Nepali non-development focused evaluators felt that the communities in the area were better off than people in Kathmandu: "They are happy."

On a different note, many of the project activities center around training of various categories of people. This follows the almost epidemic pattern of training in Nepal. People are assembled in groups, allowances are paid, much training is top down, with participation limited to chanting in unison. Project staff seem to feel this is the key factor in behavior change. Evidence is lacking. There is no attempt to assess the effects of all this training.

. NFE

As noted above, NFE is a very appropriate strategy to impact health knowledge and hopefully behavior for this area. The NFE classes may be the first opportunity many women have ever had to discuss their health and social situation with each other and to learn from each other. The NFE classes are successful in part because they are totally facilitated by local community people. A most impressive example of empowerment of women was demonstrated by NFE facilitators who were able to provide instruction to their social superiors (women to their mothers-in-law and to older men), everyone sitting respectfully,, and listening attentively. The groups stay together after the literacy classes. These groups and classes have afforded women the opportunity of sitting amongst themselves to discuss social, health and political issues that they never discussed before. "Before we were like monkeys roaming around the jungle collecting firewood" said one NFE participant. It was observed that all women's group members wanted increased income generating skills. Other social changes

observed included women who before would never had said their husband's names in public, and now, after NFE classes, did not feel averse to doing so. Some felt more empowered to move around more freely now, after feeling dominated by males before.

It should be noted that there is little evidence that behavior change results from dissemination of information alone, at least in public health studies in other settings. There has been no study on this mode of behavior change in Nepal, yet information provision remains the cornerstone of public health behavior change efforts throughout the country.

- Regional differences

The three project *ilaka* vary considerably in ethnicity, with *ilaka* 13 being over 80% Tamang, while the other two are closer to 50% Tamang, with the remainder being predominantly the Hindu castes (Brahmins, Chhetri, and the scheduled castes). The project mobilizing efforts seem to be faring better in the less Tamang populated areas, and what follows should be considered with this in mind.

- Community relations and mobilization

The CS VIII project was very popular, and well known in the community. People interviewed spoke highly of SC/US as an institution and of its contribution to local development. "SC/US is the topmost INGO working in our district," reported the Chairman, DDC, Nuwakot. Many adjacent VDCs have requested SC/US to implement this project or similar projects in their areas. The project impact is palpable; communities have been mobilized. Some club leaders felt there was increased community spirit since group formation as a project activity occurred. The community people have realized the importance of community living, doing things in groups, and have learned that organizing themselves makes them more powerful. The community groups have functioned as change agents in their own communities and nearby vicinities, thus facilitating attitudinal and behavioral changes. They have been helpful in doing away with some deep-rooted social evils and inhibitions, according to one Nepali evaluator. The project expectations have helped, rather inadvertently, in the democratization process of the country with formation of community groups, and through their management and executive committees via democratic / electoral processes. Attempts to generate a sense of ownership have been made not only by making the community people participate in decision making processes but also by making them contribute in establishing and managing classes, reading centers, revolving funds and other matters of infrastructure development. In addition, cost recovery activities initiated by the project have been well received by the community, generating greater income than was expected.

The SC staff and community relationship appeared to be cordial and appreciative of one another. However, there was concern among some team members perceiving a sense of distrust or uneasiness noted by communities where the field offices were located. To an evaluator familiar with development projects elsewhere in Nepal, the staff perception that they were doing grass-roots participatory development did not seem entirely accurate. Villagers perceive the SC project as doing top down development (*bikaas*), in the sense of outsiders doing service for the villagers, (as described by Stone, 1989).

- Social marketing, IEC materials and behavior change

The sales agent training failed to provide marketing skills, but focused on knowledge about a product (such as Jeevan Jal, or the safe birth kit), which helped individuals to use it, but didn't help the sales agents to sell it. Staff appeared to have little understanding of the concept of social marketing (as enunciated by Manoff 1985). There was little comprehension of the IEC materials when viewed by non-literates, and probably not much more understanding by NFE graduates either. These materials depicted images outside the range of experience of villagers, and depended on reading messages stated in Sanskritized Nepali. Staff seem to be focused on provision of information as the critical factor in behavior change.

- Child to Child program
The Child to Child program was an excellent opportunity to conduct mother and child development activities, a very popular interactive activity organized around flip charts. "Mothers are sending their younger children because they see it as an additional educational opportunity."
- The District and National Government
There was general distrust in government services especially at the health post level. The one health post worker present during the evaluation stated that from the people's perspective, all he had to offer were loose white pills that looked the same, in contrast to individually foil wrapped impressive medicaments available at medical halls at a significant price. It is interesting that the Health Minister's constituency is in the project area. The District Development Committee Chairman wished all project activities in the future would be channeled through his office and the Chief District Officer felt that his office should be informed about SC's programs, and approval should come through him. He reported that he had been offended by project condom day activities in which condoms were blown up as balloons and otherwise displayed, He denied that there were complaints from the public however. The District Health Officer was very supportive of the activities.
- Furthering the goal of empowerment
There was no direct evidence that the public had been empowered to create an increased demand for government health services, nor that the project actually directly attempted to get citizens of the project area to demand improved services. SC's efforts to lobby the MOH to provide minimal services received little response at either the district or national level.

Constrain&/Unintended Benefits

The project made no effort to measure any child or maternal morbidity or mortality in the service area to determine whether there was any reduction as a result of their efforts. The targeted population is diverse and remarkably conservative, resisting cultural change in spite of its proximity to Kathmandu. Major changes in the economy appear to result from supplemental income from the young women heading to work in brothels in Bombay, in the northern areas, in contrast to men migrating to Kathmandu to work in the southern areas. It is reported that the women who return from Bombay with considerable money are seen to spend it on lavish funeral celebrations.

The most significant unappreciated benefit of the project is the widely linked communication network produced by the NFE strategy and resulting group formation, all in response to the project efforts.

FEMALE LITERACY

Systematic Sector-wise Programs

- Basic Literacy
The Basic Literacy program seeks to help develop knowledge and skills in 3 Rs, i.e. to make the learners able to read and write and perform mathematical operations involving simple addition, subtraction, multiplication, and division, and to make them able to apply them to their day-to-day activities. These classes and others below are coordinated with the DEO, commencing with a ward level meeting, the formation of a management committee that is briefed about the formation of the participants' group and about the criteria for the selection of a NFE facilitator. The selection of participants and nomination of a facilitator is done by the committee with the selection of NFE facilitators and supervisors by the SC US board. Training of the basic literacy class facilitators takes 10 days, with a further 5 day refresher over two sessions, Supervisors participate in facilitator's training and then receive a separate 6 day training on supervision of all sectorwise classes. The classes last 6 months, and are held in the evening. The MOE package of materials is used for the basic classes, while

SC/US has developed packages for advanced literacy classes and vocational education. Besides SC/US, other INGOs/NGOs are using these packages, SC conducts the mid-term and final examinations.

- **Advanced Literacy**
The Advanced Literacy classes last 6 months, work on improving basic literacy graduates' linguistic competence (mainly reading and writing) and mathematical competence, as well as covering matters of cleanliness, sanitation, maternal and child care, forestry and environment, and basic ideas for income generating activities. Women's savings groups are formed from NFE graduates
- **Vocational Education**
Vocational Education classes last 3 months and help students who are advanced literacy graduates that have formed a women's group develop writing skills in applicable aspects, e.g. writing reports, letters, applications and proposals, They also help develop their knowledge and skills in carrying out income generating activities (mainly agriculture-based) on a vocational basis.
- **Out of School Children Education (OSC)**
Out of School Children Education programs work to help such children learn the basics so they can join the mainstream of formal education. Classes are held in the mornings before the day's work begins and last 9 months.
- **Family Based Literacy**
Finally Family Based Literacy classes, lasting 6 months, help graduates of the first four programs disseminate their knowledge and skills among other members of their respective families.

Major Findings (NFE)

The female literacy rate showed a remarkable improvement over baseline. The desire for adult literacy is popular in Nepal, in seeming contrast to the situation 20 years ago, when adults reportedly would not attend classes. Is this popularity a fad or will be it sustained? People in general and women in particular were found to be highly motivated in NFE activities. The success rate of NFE Basic and Advanced classes is outstanding (basic level : 85% pass , advance level 87% pass). The dropout rate of Basic and Advanced classes is substantial (basic 25%, advanced : 27%). Formal school enrollments have increased, most probably due to the following two factors: 326 OSC graduates joined the mainstream of formal education, and following their graduation from NFE classes, the parents encourage their children to join schools, A significant and favorable change has been noticed in the male attitude towards female education. Female literacy in the project area has increased significantly. (See attainment of objectives table). The gender breakdown of class attendance showed that in Likhu and Samudratar, about 95% were women, while in Gaungharka less than 50% were women. This may reflect the lower literacy rates among Tamang men in general. Social discrimination between touchable and untouchables is reported to have decreased considerably in NFE classes. NFE centers served as a major forum for disseminating the key health messages regarding EPI, nutrition / Vitamin A, family planning, CDD, ARI, maternal health-reproductive health, (ANC / Natal / PNC, HIV / AIDS / STDs, FP). As a result, a remarkable change has been observed in community peoples' knowledge, attitude and reported practice regarding improving good health behaviors.

WOREC, a LINGO, has been implementing 15 basic literacy classes in 5 VDCs in collaboration with SC/US. Nava Chandika Youth Club, another LINGO is running six basic literacy classes in collaboration with SC/US. Post-advanced literacy class centers (neo-literate reading centers), a MTE recommendation, have been established for retention of literacy skills. They began in 1995, have completed over 20 classes so far, with each class run for 3 months. Initiation of cost recovery mechanisms by charging a fee of Rs. 21 (basic), Rs. 11 (advanced.) for NFE

participants has begun. NFE graduates have become NFE facilitators in some areas like Gaunkharka, indicative of a move towards sustainability.

- literacy of CHV/s and TBA's

Area	Volunteers	Total No.	Literates includ. NFE graduates	NFE graduates
Samudratar	FCHVs	45	30	15
	TBAs	14	14	5
Likhu	FCHVs	45	35	10
	TBAs	15	15	5
Gaunkharka	FCHVs	36	8	7
	TBAs	12	1	1
Total		167	103	43

- The table shows again that the situation for literacy is much more favorable in the less heavily Tamang populated ilaka.
- There is a much higher percentage of literates and NFE graduates in Samudratar and Likhu than in Gaunkharka. This poses the question as to whether the population generally reached are the high Hindu Castes, rather than the Tamang.

Constraints (NFE)

Constraints include the unavailability of educated manpower for handling NFE classes, especially in ilaka No. 13, and especially female manpower (only 13% of facilitators are women) As well there is substantial reduction (approx. 30%) in the number of NFE participants due to seasonal migration to the areas of higher altitude (above 5,200 ft) in all three *ilakas*.

GROUP FORMATION

Major Findings

- Below are tabulated the various groups, or LNGO's in the project area. One project objective is that 30% of groups formed will be working independently. Attainment of this objective is explored in the following section. Clubs are local organizations, which SC has played a role in forming or assisting. The women's groups are formed by NFE graduates, who form a bond of comradeship a reason they appear to be successful. WOREC is a LNGO, and numbers for WOREC affiliated groups are not available. Mother's groups are those formed by FCHVs and not facilitated by HMG. Once again, in *ilaka* 13, predominantly Tamang, there are fewer groups, for unexplained reasons.

. GROUPS FORMED IN PROJECT AREA TABLE

Numbers of Groups by Ilaka

Name/type of Group		Ilaka Number		Totals
	1	12	13	
Women's Groups	18'	18'	10*	
MCH Clinic Mgmt. Committees	12	11	10	
Women's Group Mgmt. Cmte.	2'	-		
Nava Chandika Youth Club		1*		
Dupche Youth Club		1*		
Sundara Youth Club		1*		
Ralukadevi Youth Club		1'		
Raluka Srinkhala Pariwar		1*		
Yuva Sangam Yuva Club		1*		
Salpadevi Yuva Club	1*			
Shivapuri Yuva Club	1*			
Ghyangphedi Yuva Club			1*	
Jan Sudhar Samiti			1*	
Mothers Group	N/A	N/A	10	
WOREC				
TOTAL	33	35	32	100
*Working Independently	22	24	12	58
% Working Independently	66%	68%	38%	58%

- Basis for saying "Working Independently" in the above table:

For women's groups, they are considered independent if they collect membership fees, monthly dues, and carry out group work, such as providing loans to members, or doing community social work such as sanitation programs, toilet construction, doing small construction, doing income generating projects, community plantation, micro-enterprise operation, or nursery establishment. Other activities include conducting home based child care cooperatives, pre-primary schools. They report to the Women's Group Management Committee of SC. This latter entity collects and manages funds from the groups, and compiles monthly reports from the women's groups. They coordinate meetings with other women's groups and link with other agencies.

The MCH Management Committee members are chosen by the community, comprising the FCHV, TBA, perhaps a dhama, or the ward chairman, and they meet after the clinics are held. Their tasks include: collecting funds from the clinic clients, keeping records, providing loans to community members, and providing logistic support to the clinics. Again, in *ilaka* 13, meetings are difficult to hold because the population is scattered, and it is hard to get people together to meet, so there have been no meetings there for the last 2-4 months.

Local Clubs have conducted eye camps, rabbit raising programs, promotional programs (celebrating health day, AIDS day, condom day, education day and literacy day), as well as carrying out street drama and cultural programs.

- SC's efforts to foster independence:
SC's efforts to make these groups function independently includes: leadership and management training, proposal writing training, skill development and micro-enterprise training (knitting, nursery, mushroom cultivation), cross visitation with other similar groups, providing seed money, as well as monitoring and supervision.

Findings

It is reported by project staff that Sherpa women's groups are more advanced because of contact with foreigners along the eastern boundary of the project area, accessed by trekkers (Bezruchka 1991). There is a high demand for SC's integrated development program services from non-project areas of Nuwakot district to assist in formation of women's groups. SC gives allowances to women's groups, NFE facilitators, and FCHV's when they attend training. WOREC has asked SC to stop this practice as they carry out training without this allowance. There has been no change in practice by SC to date but they are considering the problem.

Constraints:

Constraints SC faces in this endeavor include geographical limitations (it takes a minimum of two days walk to cross the project area, no roads are present, and there is no telephone communication network). There are traditional or cultural barriers to people of differing ethnic backgrounds associating, as well as transhumant (migratory) agro-pastoralism that limits opportunities for get togethers. Political parties, outlawed until 1990, may also present factional barriers.

EARLY CHILDHOOD DEVELOPMENT

Activities:

Community Based Child Care Centers comprised 5 groups of 7-8 mothers/group who were trained on basic health and child development messages. Each mother would then provide child care in her home or another designated place. As well, family based child care centers were formed. These consisted of 7 groups of 25 families/group who were trained in early childhood stimulation methods and toy construction with the intention that they would better take care of their own children in their own home. Parenting education classes were held for 78 groups of 20 mothers and fathers/group. They were trained in child care, basic health, and child rearing. Later in the project NFE graduates could apply for and receive an additional fifteen days training in appropriate child care. Finally, Child to Child Classes comprising 45 mixed gender groups of 10-20 participants/group between the ages of 8 and 14 years were given training for 15 days. Classes were conducted by SC staff on basic health and sanitation messages appropriate to children.

Major Findings:

According to project records, the objective of 20% of families having been trained in health and stimulating child care practices has been met.

The home based child care center concept was not readily accepted by the community at the beginning of the project. However, 5 centers are still functioning, one of which has proved to be very popular and has been formed into the first pre-primary school in the district. None of these are in *ilaka* 13. The family based child care program has been more effective and successful than the community based child care program particularly in remote areas. This has been attributed to superstitious beliefs regarding child care between different family groups. The parenting education program is still in a formative stage and has not yet been evaluated. Project staff have many examples of anecdotal evidence that many children who attended child to child classes improved their basic hygiene, cleanliness habits, personal appearance and social skills during and after these classes. In *ilaka* 13, the evaluation team observed one sessions. There were no participatory activities, the children answered questions in unison, and there was no water or other props to help demonstrate sanitation issues. Project staff report that parents realize the importance of the child to child classes and have encouraged younger siblings

between the ages of 5 and 8 years to attend classes, often raising class participation levels to around 40 trainees/class. Mothers also sit around and watch the classes. They feel the early childhood development program has facilitated social integration between children of different caste groups. Ethnographic research is needed to confirm all these staff observations, however. Seasonal migration alluded to earlier, and ethnic divisions in the Tamang community, unknown to the staff, may be significant factors in the limited acceptance of these activities among the Tamang.

IMMUNIZATIONS (EPI)

Activities

SC did not directly provide clinical services, a responsibility of the MOH. However, as project objectives were framed in terms of immunization coverage, EPI "catch up" rounds began in January 1995, and were carried out monthly for 3 months, and then after a hiatus of 3 months, continued monthly. Each *ilaka* health post maintained a register on children in their catchment area, which was kept by the VHW. Sites for the rounds were focused where VHWs were not present or where coverage was thought to be low. The staff of the SC project informed FCHV's to get children to come to be immunized. Approximately 30-40 children were reached in each catch up round. Vaccinations were administered by VHW's, who were often paid a travel allowance and daily allowance to come from neighboring areas for this activity. The project also attempted to organize VHWs to improve service provision. As well, SC lobbied for the kerosene fueled refrigerator required to maintain the cold chain. It was provided by DHO, placed in the Samudratar health post as per HMG guidelines, and SC arranged for portering of the refrigerator and provided support for the DHO staff to instruct in its maintenance. Motivation for EPI services was carried out through clubs, NFE, and the school health program. SC health staff visited high schools quarterly, and primary schools on a less regular basis, carrying out health education classes. In the high schools, student health societies were organized by project staff. The project also produced posters, wall paintings and durable lettered metal plates for motivation to get children immunized.

Findings

While the project objectives were not reached, substantial and significant progress over baseline levels was made.

For the MOH EPI activities, the DHO reported that the three project *ilaka* have better coverage than other areas in the district. The FCHV's know the EPI schedule, and saw EPI motivation as part of their role. The HP staff and VHW participation in EPI activities was not regular, and SC appeared to have little impact on this problem. There was good attendance at MCH mobile clinics, but sometimes the VHWs were not there. SC does not provide vaccinations at the mobile clinics if VHWs are not present. The seasonal migration to high pastures during monsoon mentioned earlier, affects accessibility.

The public perception appears to be that children are healthier since SC has been present, and mothers appreciate that immunizations are important for a child's health, though the depth of knowledge is limited. NFE graduates seemed to know more about EPI than the general public, and student to student recall about EPI in a class appeared to be an effective dissemination method.

The catch up rounds were a good temporizing measure, but they were not held during the monsoon, as project staff perceived that people would not be available in lowland sites, because of seasonal activities.

Verifying immunization status is problematic as people lose immunization cards. The survey suggested that only 48% of mothers could show EPI cards, 19% had lost them and 33% report never having EPI cards. When VHWs come to give immunizations, and if people lose their record cards, there is difficulty in determining which immunizations are due, since the VHW

keeps a register of children but not the numbers of immunizations given to a child. There is probably multiplicity of vaccinations, since the rates of vaccination imputed by UNFPA are higher than the survey results.

Problem areas include the lack of morbidity/mortality surveillance at the health posts, and no monitoring process exists for verifying cold chain temperatures. IEC activities for EPI are limited to murals at health posts and SCF offices, metal plates with text on EPI that is inaccessible to non-literates and many neo-literates, as well as posters on EPI that demanded literacy for comprehension. These materials were not visible on major trails, and only at a few houses.

DIARRHEAL DISEASES (CDD)

Activities

Training in NFE classes, and clubs on ORS preparation was carried out, including demonstrations in basic and advanced NFE classes, with class participants themselves demonstrating how to prepare it in advanced classes. Women's groups and management committees were trained in ORT by SC, and ORT corners were set up during mobile MCH clinics, providing free ORS, after clients paid the registration fee. Training of TBA and FCHV's by health post staff on CDD, was given priority by DHO, so that district staff would be sent to do training if health post staff were absent. SC did not provide training independently to DHO staff, but added additional training to supplement HMG's. Basic training for TBA's was conducted by SC, utilizing a resource person from DHO. FCHV's were given Jeevan Jal packets instead of a training allowance, so they could sell it in their villages. Finally traditional healers were given training on ORT, CDD, ARI, to supplement their traditional treatment.

To improve availability of ORS, a stock of Jeevan Jal was provided to shop keepers in sales agent training instead of training allowance (about 30 packages each). They could sell it at Rs 3.50 a package. Qualitative studies were carried out by the project including a focus group discussion. on the belief that simplicity of preparation and that it is free makes Jeevan Jal less valued. In addition a Staff Nurse ran a focus group on Jeevan Jal with mothers by herself. Posters on Jeevan Jal were displayed.

Major Findings

The knowledge observation objective for this problem was not measured in either survey, and the behavioral objective was met in the final survey.

There are almost no latrines in the area; promiscuous defecation is the norm. Piped water sources have questionable protection, with pipelines cut by villagers for access, with the potential for contamination at cross connections. The use of open water sources, probably contaminated, is common, there is sporadic availability and use of soap, and cold temperatures during the winter limit bathing.

The public perception as reported to the evaluators was that the incidence of serious diarrhea has declined in the community. However, from information on SC's sponsorship of 1166 children last year in *ilaka* 13, there were 6 deaths, 1 from a fall, the remainder from diarrhea. In *ilaka* 1 with sponsorship of 1409 children, there were no deaths, while in *ilaka* 12 with 948 children sponsored, there was 1 diarrhea 1 death. This suggests a significant problem in *ilaka* 13, where there is a high proportion of Tamang. Notably, the final survey showed a high incidence (49%) of reported diarrhea in children, even though it was carried out during a low prevalence period.

Regarding the availability and marketing of Jeevan Jal, there appeared to be a reluctance to sell Jeevan Jal in local shops because of low profit. Many people knew their FCHV's, but reported they didn't have any Jeevan Jal. Some FCHV's in women's groups expressed reluctance to sell Jeevan Jal; they were given instead of a training allowance, but were encouraged to do so by

other group members. It is stated that FCHV's don't want to sell Jeevan Jal, because if someone goes to the HP, they will get it free of cost and villagers feel the FCHV obtained the packet for free, so they don't want to pay her for it. The reluctance in community to pay for Jeevan Jal, was perceived by staff to be a result of a low level of awareness. At the one mobile clinic observed, there was no ORT corner. The knowledge of preparation of Jeevan Jal was consistently good among all FCHV's interviewed.

Some clubs and many women's groups disseminate information on CDD. One presumed effect of the training activities was the increased referral of patients to HP after the training of traditional healers. The high drop out rate in literacy classes in ilaka 13 (41% in 1st year, 24% in 2nd, 21% in 3rd year) limits penetration of CDD messages in that important area. As well, targeting FCHV's to attend literacy classes was apparently not done in ilaka 13.

The qualitative studies, including one focus group done in the first year, by Charles Pradhan, suggested that availability was the most important aspect of using Jeevan Jal. The other focus group done by a staff nurse showed a need to target information on Jeevan Jal to Tamangs.

The building of latrines, not a focus of the project, is not a culturally acceptable solution to sanitation problems in this area. Apparently 13 households built latrines in Khelanda (ilaka 13) as a result of an NFE class and MCH management committee activity. Usage is unknown. According to project staff, a latrine building program in Pangar sponsored by UNICEF has resulted in 50% being in use. The sophisticated latrine at Rautbesi HP was filled in with dirt and the latrine at Samudratar HP was locked. The only others seen by evaluators were in project staff quarters.

ACUTE RESPIRATORY INFECTIONS (ARI)

Activities

Like other disease oriented aspects of this project, ARI activities were focused on training of various groups, and production of IEC materials. Training in ARI was carried out to HP staff, FCHV's, TBA's, literacy classes, other groups including traditional healers (see appendix 4 for details). It focused on recognition of the serious signs of respiratory distress in children ((rapid breathing, and chest indrawing)

Major Findings

The project objectives were met in this activity.

Evidence suggests that community based distribution of antibiotics to children with severe ARI can be lifesaving, but such timely services were not available in the project area. HMG/MOH is field testing two models of service, one being FCHV treatment of cases, the other being referral, but Nuwakot is not one of the target districts for the ARI program intervention.

VHWs appear to know little about ARI, while some FCHV's trained in ARI by SC are very knowledgeable but have no place to refer cases. Project staff appear to be less well informed about ARI compared to other CS problems. Project staff reporting monitoring rapid breathing by watches a difficult task for the untrained, and were unaware of the use of timers in other areas of Nepal.

Approximately one third of women report breast feeding within the first hour of birth, providing passive transfer of antibodies which can be beneficial in reducing the incidence of ARI in infancy. As with other subjects, flip charts, posters, wall paintings and street drama were developed and used to disseminate information, but visual materials are not accessible to non-literates, and written messages are very complex as well. These materials are not found on well traveled routes.

For ARI treatment at the mobile clinics, the project uses co-trimoxazole suspension and there are no pediatric tablets (cheaper form) of co-trimoxazole available at the pharmacies. The antibiotic supply for HP's lasts less than 6 months. Antibiotics were provided by SC only to mobile clinics (verified in the one mobile clinic observed). Inappropriate polypharmacy was observed in a medical hall treatment for ARI in Apra, without use of an antibiotic. Smoky interiors with open fires used for cooking, with little ventilation in houses, especially in the winter is the norm. Many houses in one village (most of the men worked in Kathmandu in that village) in *ilaka* 1 had smokeless *chulos* (the result of an SC effort), but they were not used in the cold winter in order for the inhabitants to keep warm.

NUTRITION/VITAMIN A

Activities

The project strategy, supported the DHO. It was to establish a Vitamin A supplementation program administered by project staff, using FCHV's and TBA's trained in vitamin A requirements of children, appropriate food sources, and the promotion of kitchen gardens. Vitamin A capsules were distributed by FCHV's and MCH workers, and mothers given small paper records of the treatment. Nutrition education and demonstration was carried out in women's groups, mothers groups MCH clinics and NFE classes to teach mothers about appropriate weaning foods and their timing. Women's groups were to produce packets of weaning food (ready-to-eat) and to sell them at mobile clinics.

Major Findings

According to project records, the objective of vitamin A distribution was met by the project while those for nutrition behavior were either not actually measured by the survey or showed no change.

Malnutrition among infants and children does not appear to be a major problem in the project area. No cases of malnutrition were seen by the evaluators, and almost none were considered to exist by project staff. As well, it was suspected there was little xerophthalmia although 2 cases of night blindness were reported in the last year in Likhu project area. Tamang appear to have a low prevalence of xerophthalmia in children (Brilliant 1988). The distribution of vitamin A was carried out by FCHV's, and many mothers lost the vitamin A capsule distribution records used to verify vitamin A administration for the surveys. Project records were used to assess coverage. (see table below). Each FCHV in the vitamin A program, has a register of every child in her area, which she maintains once or twice a year, so that every child under 6 is recorded. The registers were observed in the SC staff offices, but usually no staff person was aware of this resource. Typically the FCHV has to ask someone to write for her, so another person learns about the program, and in assisting her, the FCHV's status in the community may be elevated. Keeping the register also keep her informed about the community. Breast feeding in the area is almost universal, and weaning foods are introduced at four to six months. No one bought the weaning food initially produced by the women's groups, so that program stopped. The DHO received no training in case management of diarrhea and ARI with Vitamin A. Almost no radios were heard in a field visit across the project area by the evaluations, so it can be assumed that dissemination of national radio messages on vitamin A is minimal in the project area.

• Vitamin A coverage Table

Area	Total Children (6-60 mos.)	Vitamin A Doses Provided**	% Coverage
Likhu	1898	1602	84
Samundratar	1897	1658	87
Gaunkharka	1761	1040	59
Total	5556	4300	77

*Estimated figure based on 1991 census.

**One dose only; there has only been time for one six month period to elapse.

MATERNAL HEALTH AND FAMILY PLANNING

Activities

Training was carried out for the SC Nuwakot team, FCHV's, and TBA's, and an emergency obstetric care workshop **was** conducted for the health post worker in Samudratar as well as for VDC and club representatives. Collaboration with the DHO resulted in maternal health/FP refresher training to health post staff.

Promotion of Safe Birth Kits was done through women's groups, mother's groups and FCHVs and TBAs, with SC selling them after demonstration to sales agents. MCH mobile clinics were set up and carried out, by SC staff with a site chosen based on discussions with VDC officials. Iron/folate supplementation was provided at these mobile MCH mobile clinics to pregnant women attending an antenatal visit. There were plans to establish MCH rooms in health posts in project area with one completed before the end of CS VIII.

Condom boxes were set up at SCF offices. Birth spacing promotion was conducted through mother's groups, parenting groups, child care cooperatives, women's savings groups and school health classes. Technical training and logistical support of contraceptive availability was provided to the VHWs and HP staff through COFP course, also to the medical hall shopkeeper in Samudratar.

Major Findings

Survey results on attainment of project objectives demonstrated significant improvements over baseline for this category.

The HMG goal is to coordinate all NGO's doing TBA training and have it standardized. SCF has been helpful in developing IEC materials, flip charts, safe birth kits, etc. TBA training was carried out in Samudratar and Likhu, with refresher training in all areas as well. It appeared that as soon as SC trains and starts working actively with TBA's, they are perceived by people as government employees who shouldn't be paid. In some cultures in Nepal it is felt inappropriate to pay TBA's, because those who do might be indebted in future lives. It is unknown if this operates in the project area. In *ilaka* 12, there were 19 active TBA's, with 7 trained 7 years ago, 1 trained 2 years ago, and 8 trained in the last year. SC tried encouraging TBA's to attend NFE classes, with varying success.

Obstetric deaths were reported to the evaluators, including some in transit to Kathmandu, and appear to be due to obstructed labor and hemorrhage. SC doesn't track maternal deaths, but in 1993, 4 women died in pregnancy in Bolgaun; they tried to transport one woman to Kathmandu, but she died on the way. Another woman with a breech presentation at a Mobile MCH clinic was advised to go to Kathmandu. She followed through and had a successful delivery.

Prenatal care may not be acceptable to some women in the community, especially Tamangs. As well, many village women have no interest in TBA's, often deliver alone, or sometimes with the husband or mother in law attending. This seemed to vary from location to location, without a general pattern and project staff were unaware of the husband being present at delivery, so did not target any information to him. There is no traditional role for TBA's in much of the project area. The main referral center for obstetrical problems is Kathmandu, not Trisuli, and never a health post, since no one is assumed to ever be there. The minimum cost for any clinical encounter in Kathmandu is thought to be at least 1000 to 2000 rupees. SC staff (ANM, staff nurse) used to become involved in clinical obstetrical care in the community, but the practice was stopped because of fatigue. One club official wanted to get a stretcher and torches posted somewhere near Samudratar to carry seriously ill patients to Kathmandu or Trisuli. The terrain is difficult for transport of critically ill patients, and several days and considerable expense would be necessary to reach Kathmandu. If a seriously ill mother gets to Kathmandu, it is likely that her transport party may not know what to do or where to go for assistance. Many people interviewed had never been to the road or Kathmandu.

While many TBA's and FCHV's could recite the three clean birth principles, the perception of the Safe Birth Kit is that it is expensive especially for a piece of plastic. Discussions with FCHV's and TBA's suggested there was an over-emphasis on clean plastic in the birthing kit being necessary for a safe birth. In ilaka 12, there was distribution of 194 safe birth kits, in ilaka 13, 130 and the usage rate estimated to be 30%. One lady shopkeeper in *ilaka 12* has sold 4 over the last 6 months. IEC materials produced by SC showed a woman in labor in the lithotomy position, which the staff said was the usual practice, but no woman delivering away from medical facilities uses this position, The materials were unintelligible to most villagers.

There is considerable interest among villagers in family planning, with a desire to use both temporary and permanent methods. Only 1 VHW distributes temporary FP materials and little family planning is done in mobile clinics, because staff say they are overworked. Condom boxes are locked up inside health posts, while those in SC office sites had a few condoms, written materials about AIDS, but these were placed where they are inaccessible to most people. Apparently approximately 10,000 condoms have been distributed through condom boxes in SCF offices. Injectable depot contraception is available. An unexpectedly high number of men had been vasectomized, presumably because there had been some family planning camps in the project area.

SEXUALLY TRANSMITTED DISEASES

Activities

Training was again a major activity using SC AIDS curriculum materials, and was provided to most people in the communication network mentioned above (see Table in Appendix 4). Street Drama done by local NGO's was reported to be popular with 100+ people attending. It was carried out more often in *ilaka 12*, where more clubs were active, than in *ilaka 1* and *13*, a result, according to SC staff, of the higher level of education in *ilaka 12*. SC trained some club members on STD's, ARI, EPI, and CDD street drama presentations and pre-drama and post-drama questions were asked to the audience. A school health program in the 5 high schools covered family life education and established a school health society in each high school. There in quarterly meetings SC attempted to provide training in HIV. SC produced AIDS, and ARI booklets, as well as an AIDS novel that was originally produced for a radio program. As well, STD Camps were held in 4 spots the first time, 3 the 2nd, and the 3rd time an LNGO, WOREC organized the camp. They were staffed by doctors from Kathmandu and Trisuli. Finally, hotline boxes, where questions on STD's and AIDS from the villagers were solicited, were placed at SC offices and at markets at Gulubhanjyang, as well as at all high schools, Answers to questions were then posted on nearby bulletin boards.

Major Findings

Progress was made towards achieving the objectives for this intervention area

The staff seemed to feel that the issues of girl trafficking is the major reason for the project activities. There are no specific data pertaining to this question, nor on the prevalence of HIV or STD's in the area. Public perceptions from discussions with the evaluation team suggest that most people met along the way report there is no AIDS here, except some reporting that some sick women had returned from far away, and were suspected of having the disease, with one death presumed to be of AIDS. There is a decline in girls going to Bombay, because of a fear of AIDS and what is being said in the NFE classes, according to some informants. There is not much talk of STD's in the community, with little knowledge about them, but most people recognized the word AIDS, and discussions suggested it was indirectly associated with girl trafficking. Literacy graduates have greater knowledge on STD's compared to non-literates, but no one approached by the evaluators could read the AIDS poster with the woman dangling condoms, and no one could read the blue metal sign about AIDS. Another poster with women of different ethnic dress all holding raised hands together was incomprehensible to those questioned.

It appeared to the evaluators that income generation from sexual activities in Bombay appeared to be more common in the north, while closer to Kathmandu, men went and worked there to enable the households to feed themselves, since crop production lasts only 6 to 9 months of the year. Income from the women working in Bombay is spent on lavish funeral ceremonies for grandparents, according to some informants.

The response to the hotline boxes is mixed. They are not used much in *ilaka* 13, but questions are increasing in *ilaka* 1 and decreasing in *ilaka* 12.

Finally, talk of sexual activity continues to be a taboo topic to outsiders, Nepali or foreigner, unless living in the community for a long time. One project staff person had managed to talk to villagers at length about the issues.

DISTRICT HEALTH SERVICES

Major Findings

The Ministry of Health suffers from severe budget limitations, as the result of structural adjustment, and the bureaucracy is mired in difficulties that go back to the days of the Rana Prime Ministership. At the district level, most of the observations of Aiken (1994) pertain, Nuwakot is considered remote by health workers, but because of its proximity to Kathmandu, and the presence of a road bisecting the district, no remote area allowance is given to workers there. At the district hospital level, the same problems with manpower exist, the reorganization of the Ministry of Health carried out in 1993 has resulted in the District Public Health Officer's role being subsumed under that of the District Medical Officer who is now termed the District Health Officer. Nuwakot has been designated a Safe Motherhood Implementation district, meaning among other factors, that emergency obstetrical services are to be available in the district hospital

Doctors in rural areas are loathe to intervene in any manner other than writing prescriptions, fearing reprisals from the family or community if they were to carry out some procedure with an adverse outcome. In Nuwakot, the current DHO office holder has experience in both public health and clinical medicine, and reports he is trained to do Cesarean sections. When a scenario was presented to him requiring intervention for obstructed labor, he stated he would refer such a person to Kathmandu, or do a destructive operation, evacuating uterine contents. The reason given was lack of support. This DHO has his own computer and is facile with Epi

Info software. Japan International Cooperation Association (JICA) has built a PHC in the district, and he describes it as MOH's not JICA's and he has to staff it.

Doctors almost never have any time or inclination to carry out field supervision of their staff, The interiors of most health posts and other such facilities are kept in a state of disarray, with supplies scattered, and hygiene limited. The latrine built at the Rautbesi health post, with a modern porcelain floor piece, was filled in with dirt for example. Staff are often (most villagers would say usually) absent from the health posts and sub health posts, staff are posted, but often do not take up their posts, although they are thought to continue to collect their salaries, Health post management committees are not active because they were formed after the health posts had already been established. Supervision of staff actually in the field is almost non-existent, and if carried out, may result in a great financial burden on the supervised worker, as he has to wine and dine the supervisor. The only health post worker active in the district at the time of the evaluation reported that not only had he never been supervised in the field, but in fact had never been supervised. Clinical care, when given, is limited to diagnoses based on a brief interview, almost no examination, writing prescriptions and dispensing a few medicines, almost no surgical intervention or hands on care is ever done. The register of one health post visited, that was not currently active showed most patients came with worms, scabies and boils, and no surgical intervention was done for the latter. When interventions are mandatory (wound or burn), they are delegated to the piun (locally hired sweeper and water carrier), who learns over the years to dispense medicines, and is the backbone of the functional health care system (Justice 1983). Inspection of health post registers shows 2-6 visits per day at most, yet the project has placed more of its educational materials in this rarely visited site, in contrast to places such as Mane Bhanjyang, a major trade route, where more than 100 people a day pass through. FCHV's in project area do not have identifying plaques to place on houses; apparently they have not moved since arriving at the health posts some time ago.

STAFFING AND MANAGEMENT ISSUES

Major Findings

The staff interaction is marked by cordiality, cooperation and team spirit. SC field offices display posters and testimonials to a grass-roots approach. However, many of the staff tend to have a top down attitude, and some appear to see the people they serve as backward. Their job: "we have to tell them about our philosophy" we're here to teach the community things they don't know, the community will remember after we leave, for all the good things we did for them." Their tone of speech in interactions with locals reflects this. The attitude is exemplified by terming people the "poorest of the poor." After discussions with staff on this issue, they said they did not use this term, instead saying they were called 'self-help' groups, but it was the first label applied to the program during opening discussion, and the identifying acronym, POP is present on all the documents. The perceived sentiment expressed by the staff regarding the girl trafficking issue was highly moralistic. The staff are commended for not openly discussing these issues in the project area, thereby risking alienation from the community.

When asked questions about lessons learned from working in the project the staff offered few remarks. When asked what would they do differently if they were to begin the same project again, knowing what they know now, they reported they would make no changes, or they would scale the objectives down. Yet some staff report: "we should live like the community, we need to listen to them and design programs around their needs, not ours."

The administrative and management systems appeared to be quite efficient but the organized office system was of varying quality in the different sites. The management information system generates considerable data which is compiled into reports, but these data are often not meaningful, and not relevant for decision making. Many data are collected and not analyzed at the field level, nor at the central level as well. Data, and charts on the wall, giving numbers of

visits and diagnoses at mobile clinics, suggests worms are the most common problem, based on a clinical diagnosis of large abdomen, and appearing pale. This is drawn as a pie chart and the stated purpose is for "purchasing supplies". When asked what the response is to having worms be the commonest problem in the MCH mobile clinics, their response was to have people build latrines, Other graphics, such as seasonal ARI bar graphs are very time consuming to produce, and display many artifacts when interpretation with the staff by the evaluators was attempted. Staff did not appear to understand the idea of following up on the data they collect. The key staff did not understand the concept of incidence (though it was portrayed in their material), nor the use of estimated (imputed) denominators, though in their quarterly reporting forms, there are places to put these estimated denominators, which they don't do. They do collect useful data, but appear not to know how to use it effectively. Significantly, the staff do not understand the limitations of survey research, especially how questions asked may be misunderstood by Nepalis in rural areas (Campbell 1979).

Field logistics are problematic, with the staff spending a great deal of time walking to a work area, and then returning, rather than staying at the site. Some staff feel they might have a better impact if they lived out in the project area. There is not much staff transfer out of the project area suggesting they like working here. The project is having an effect on the local economy as SC pays porters more than local shopkeepers, who report having a harder time finding porters to work for the usual rates.

The field *offices* in *ilaka* 1 and 13 are insulated from the rest of the community, symbolically facing away from the people, resulting in little casual staff-village interaction. Few staff speak the local language (only one externally hired non-Tamang or non-local inhabitant speaks Tamang).

The staff report they do not receive adequate technical field based supervision. There are no continuing education resources for staff development, with no library present in field staff offices. With many volumes published on the local culture, this could be a major resource providing insight into community processes.

CSVIII funds were used to support international and regional training opportunities to upgrade staff capabilities. A list of these trainings and the final training reports can be found in Appendix 4.

Finally, it was problematic to the evaluators that project staff were scheduled to be absent and not available to the team during parts of the evaluation.

C. Final Evaluation Survey

1. KPC Survey Report, see Appendix 11

- Executive Summary of Final KPC Survey

Save the Children/US, Nepal Field Office (NFO) has been implementing a three year CS VIII Project in Ilaka 1, 12 and 13 of Nuwakot District from October 1992 to September 30, 1995. NFO had completed the project in close coordination with Ministry of Health (MOH), District Health Office (DHO) with a support from Home Office in Westport, Connecticut SC/US. NFO received **US\$ 412,248** from USAID through the Bureau for Humanitarian Response/ Office of Private and Voluntary Cooperation to implement the project, SC/US matched with US\$ 137,417 totaling **US\$ 549,665**.

A final survey was planned from November 5-21, 1995 on the completion of the project to ascertain the project's ability to reach stated objectives and recommend for project design, management, monitoring and evaluation. The survey questionnaire used was initially drafted at the PVO Child Survival Support Program (PVO CSSP), The Johns Hopkins University, School

of Hygiene and Public Health. It was based on a standardized format which USAID requires of all PVO CS VIII projects. The questionnaire was further refined in coordination with PVO CSSP. It was further refined in field tests in country. The final survey was conducted by SC/US staff who had received a training in 30 cluster sample survey.

The major findings are : 23.3% of mothers are literate. 41.9% of mothers were doing same kind of income generating activities. 72.2% of mothers introduce supplementary food to their 4-6 months old children. The complete immunization coverage is 28.7%. 49.2% of children had diarrhea in the last two weeks. Jeevan Jal (ORS) use rate is 31.9%. ORT usage rate was found to be 36.2%. 50.8% of mothers who reported that their child had ARI sought treatment from hospital/health post/mobile MCH clinics. 25.1 % of the children between 6-23 months received first or more doses of Vitamin A. 13.1% of mothers with cards had at least one antenatal visit. 15.7% of mothers correctly reported correctly three birth principles. 29.7% of mothers received at least one dose of TT. 39% of mothers identified three danger signs of pregnancy. Three danger signs of labor and three danger signs of delivery were identified by 2 and 12 mothers respectively. 17.1% of mothers were using family planning. 19 mothers identified main three modes of HIV/AIDS transmission. 10 mothers reported three methods of prevention. The condom use rate was found to be 3.8%

The major recommendations developed by the project staff include : continue to organize EPI catch up rounds; coordinate and collaborate with MOH and JSI to initiate ARI treatment/ service at community level; develop promotional activities on Jeevan Jal (ORS) and importance of giving fluids and foods during diarrhea; increase accessibility of ORS through various outlets like sales agents/THs; develop key messages regarding dangers signs of pregnancy, labor and postnatal period, and provision of MCH services through both MCH Rooms of health-posts and MCH Mobile clinics.

Save the Children
Child Survival 8
Key Child Survival Indicators*
Knowledge, Practice and Coverage Survey

Indicator	Baseline (11/92)			Final (11/95)		
	Numerator	Denominator	%	Numerator	Denominator	%
Appropriate Infant Feeding Practices						
Initiation of Breastfeeding within 1 hour			NA	77	236	33
Initiation of Breastfeeding within 8 hours			NA	175	236	74
Exclusive Breastfeeding < 4 months			NA	27	47	57
Introduction of Foods 6-10 months			NA	28	28	100
Introduction of Foods 4-6 months			NA	26	36	72
Persistence of Breastfeeding 20-24 months			NA	21	25	84
Management of Diarrheal Diseases						
Child given same or more breastmilk	78	89	88	100	115	87
Child given same or more fluids	25	63	40	63	86	73
Child given same or more food ²	4	63	38	40	81	49
Child treated with ORT	16	92	17	57	116	49
Pneumonia Control						
(others who sought treatment)	11	89	12	112	95	34
Immunization Coverage (by Card)						
EPI Access (DPT1)			NA	52	108	48
EPI Coverage (OPV3)		82	21	38	108	35
Measles Coverage	9	82	11	40	108	37
Drop out Rate			NA	13	52	25
Maternal Care						
Maternal Card Coverage (Card)	15	210	7	45	236	19
1+ Antenatal Visits (Card)	0	210	0	31	236	13
1+ Antenatal Visits (Self Report)			NA	63	236	27
Modern Contraceptive Usage	14	172	8	33	196	17
Recommended Indicators						
Mother's Literacy	8	210	4	55	236	23
EPI Knowledge: Timeliness of Measles	47	210	22	110	236	47
EPI Knowledge: TT Protection			NA	87	236	37
Mat. Care Knowledge: Timeliness of Ante-Natal Care			NA	98	236	42

* from Johns Hopkins University Child Survival Support Program indicator definitions (version March 1995)
Source: Save the Children/Nepal CS8 KPC Survey Reports -- Baseline and Final

2. AIDS/STD Survey, see Appendix 12

- Executive Summary of Final AIDS/STDs Survey

Save the Children/US, Nepal Field Office (NFO) has been implementing a three year CS VIII Project in Ilaka 1, 12 and 13 of Nuwakot District from October 1992 to September 30, 1995. NFO had completed the project in close coordination with Ministry of Health (MOH), District Health Office (DHO) with a support from Home Office in Westport, Connecticut SC/US. NFO received US\$ 412,248 from USAID through the Bureau for Humanitarian Response/ Office of Private and Voluntary Cooperation to implement the project, and SC/US matched with US\$ 137,417 totaling US\$ 549,665.

A final survey was planned from November 5-21, 1995 on the completion of the project to ascertain the projects ability to reach stated objectives and recommend for project design, management, monitoring and evaluation. This survey also serves as the baseline information for the extended USAID funded CS-XI project in the same working area. The survey **was** conducted using the WHO recommended 30 cluster survey methodology.

Major survey findings include a female literacy rate of 30%. Of the total respondents, 67.6% had heard about STD with males higher (77.39%) than females (57.82%). Sores in the penis (57.8%) itching (48.2%) and discharge (24.7%) have been frequently known signs and symptoms of STD. Respondents heard about AIDS is higher (80.86%) compared to STD. More males (87.39%) have heard about AIDS compared to females (74.3%). Sexual intercourse is commonly (83.3%) referred modes of AIDS transmission followed by blood (48.1%) and use of unsterilised instruments (39.2%). Use of condom was widely known (67.7%) methods for preventing AIDS/HIV followed by treating STDs (30.3%) and use of sterilized instruments (25.2%). One fourth of the respondents said that the purpose of condom usage was to space children, prevent STD and prevent HIV/AIDS. Condom usage rate among respondent during their last intercourse was found to be 8.2%.

Some recommendations made by the project staff are:

- Introduce/promote reproductive health message in the project area.
- Incorporate STD message in NFE
- Develop key message on STD including signs and symptoms and prevention
- Train HP staff on syndromic management of STD illiterates and neo-literates
- Initiate counseling services for HIV/AIDS in HPs.
- Initiate condom social marketing.

STD/AIDS Survey Key Findings

Question Component	Baseline (%)	Final (%)
Women's Literacy	7	30
STD Awareness (heard of them)	15	68
STD Prevention		
- avoid multipartner sex	16	60
- use condoms	16	59
- treat both partners	0*	23
AIDS Awareness (heard)	24	81
AID Transmission		
- sexual	79*	83
- blood	50*	48
- unsterilized instruments	38*	39
- perinatal	22*	10
AIDS Prevention		
- use condoms	75	68
- treat STDs	4	30
- use sterilized syringes	16	25
- use HIV-free blood	14	18
Purpose of Condom Use		
- prevent AIDS	47*	77
- birth spacing	89*	70
- prevent STDs	27*	32
- all	15*	25
Condom Use	4	8

. data are all from mid-term survey, because of lack of comparable data in baseline

V. Project Expenditures

A. Pipeline analysis of project expenditures

1. Please refer to Annex for a copy of the pipeline analysis of actual field project expenditures by project year and life of grant.

B. Comparison of DIP budget vs. actual project expenditures.

1. During the life of the project, budget figures were adjusted according to project need. Adjustments were recommended by the Kathmandu Office and approved by the Operational Support Office at Save the Children HQ in the USA. All adjustments were in accordance with grant regulations which allowed for budget flexibility.
2. Comparison of Detailed Implementation Plan Budget and Actual Field Expenses

Category	DIP Budget	Actual Expenses	Difference	% Expensed
Evaluation	\$ 19,816	\$ 10,430	\$ 9,386	53%
Personnel	\$ 142,244	\$ 161,839	(\$19,595)	114%
Travel	\$ 39,091	\$ 37,891	\$ 1,200	97%
Communications	\$ 22,682	\$ 17,827	\$ 4,855	79%
Facilities	\$ 8,800	\$ 13,016	(\$ 4,216)	148%
Other Direct	\$ 35,985	\$ 25,729	\$10,256	71%
Procurement	\$ 74,067	\$ 78,106	\$ 4,039	105%
Total	\$ 342,685	\$ 344,838	(\$ 2,153)	

3. Expenses were changed during the life of the project to account for savings in evaluation costs, communications, and other direct costs. Costs of the final evaluation were absorbed by SC private funds instead of being charged against the grant due to the approved postponement of the final evaluation after the grant had ended. Other Direct Costs decreased as SC charged NFE expenses against SC private funds. Personnel costs were increased based on recommendations of the midterm evaluation team. Facilities costs increased with increases in staff housing needs in the three *ilaka*.
4. Budget issues brought out in the midterm evaluation report have been addressed by project staff. In the third year of the project, expenses were tracked by each of the three *ilaka*, allowing for improved planning of project activities and monitoring of expenses at the *ilaka* level. During the final project year, the project budget was divided between the three areas, with the District Office in Samudratar (*ilaka* 12) receiving 42% of funds, *ilaka* 1 receiving 31% and *ilaka* 13 receiving 27%. Three accountants have been hired, one for each *ilaka*, for the CSI 1 extension project to further improve budgeting and office administration. The *ilaka* offices are now receiving timely expenditure information on purchases made for the project by the Kathmandu Office.
5. The district office has written guidelines on cost center definitions for the CSI 1 grant; an idea appreciated by each *ilaka* office. However, some confusion still exists between the three accountants as to the definition of cost centers in the CSI 1 grant, and the best way to track ledgers.

VI. Sustainability Issues

Many of the questions in these guidelines pertain to sustainability, which is taken to mean whether activities undertaken by this Project can be supported by the people to whom the services are provided, and by in country organizations supported by Nepalis. Nepalis will sustain health care activities of their own choosing in their own fashion and in their time. It is laudable to have services provided by external agencies such as USAID and SCF, especially those in this Project that strengthen the HMG health services delivery system. Nepal's per capita GNP, however, and its per capita consumption of global resources is a minuscule fraction of that of the donor countries. It is unrealistic to expect the people of this country to bear the economic burden of the interventions designed and provided by external agencies, but it is reasonable to ask local communities and institutions to begin to consider supporting those activities they consider valuable. It is with this perspective, and the knowledge that follow-on project funding has been given, that answers to the following are provided.

A. Community Participation

1. The resources contributed by the community to date that will continue that will encourage continuation of project activities after donor funding ends include the following:
 - MCH management committee time
 - TBA and FCHV time (as volunteers)
 - Women's groups' time
 - Local Clubs' time
 - NFE centers construction costs
 - Cost recovery information
 - VDC participation

B. Ability and Willingness of Counterpart Institutions to Sustain Activities

The current ability of the MOH or MOE to provide the necessary financial resources to sustain effective project activities once CS funding ends is that MOH will continue to staff and supply health posts and sub health posts, and support VHWs and run **all the health campaigns, at the current minimal level.** The MOE will run NFE on a minimal level. Regarding human resources to sustain effective project activities once CS funding ends, clearly many filled posts in the health care system will remain unmanned because the area is not considered remote enough to qualify for an increased allowance. For material resources to sustain effective project activities once CS funding ends, all the DOH infrastructure exists.

The current ability of other relevant local institutions to provide the necessary financial human and material resources to sustain effective project activities once CS funding ends is minimal. There would be some activities through WOREC and other local NGO's.

C. Sustainability Plan, Objectives, Steps Taken, and Outcomes

1. The steps the project has undertaken to promote sustainability of child survival activities once the project funds end table with sustainability objectives and outcomes are outlined in the following table:

Goal	End-of-Project Objectives	Steps taken to Date	Outcomes
SC aims to improve the knowledge and practice of health protective behaviors at the household level	See project objectives	See interventions	- See survey results - Perception that health has improved
Leadership training at the community level, to better participate in the local development process and demand provision of latent public health services	- 30% of community groups formed will be operating independently - groups advocate for better services	100 groups formed - 2 women's groups requested service - 3 groups requested funds from under Build Your Village Yourself program	58 groups functioning (58%) - increased demand for more mobile clinics and for extension of services beyond MCH - increase in number of visits to private medical hall in Samundratar
AIDS awareness and prevention methods and materials benefit national programs	AIDS IEC materials used by other organizations	SC provided technical assistance to AMFAR LINGO's and others	WOREC uses STD camp methods in and out of project area, replacing SC's effort
Multisectoral model for MOH/MOE service delivery systems (combining literacy and health education)	Other organizations use model for improving health knowledge & practices	- Collaboration with DOE/DOH - Organizations received training in multisectoral model	- SC belongs to District MOE Coordination Committee disseminating model - 3 LINGOs in Nuwakot currently using the model and one nationally (BASE)
Identify some ways to recover health and education costs	Methods for cost recovery identified	- registration fees for NFE, mobile clinics - Jeevan Jal & Safe Birthing kits sold - Women's Groups savings funds	- Rs 19,720 collected by mobile clinics - NFE=Rs21/Class participant - Rs 391,000 has been saved

VII. Lessons Learned:

A disturbing finding is the lack of much soul searching or introspection on the part of the staff regarding lessons learned. From the evaluators' perspective, the following are lessons learned.

There is a considerable acceptance of NFE in the communities which produces a stimulus for group formation. This results in new social linkages that has produced a major communication network in the area.

Training local facilitators for NFE is practical and sustainable.

The proximity of the project area to Kathmandu is not related to diffusion of "modern ideas" such as a desire for consumer goods. One can't assume that proximity to Kathmandu is an indicator of receptivity to modern ideas and values.

Ethnic differences within small geographical divisions in this district are factors producing major differences in program outcomes.

Trying to influence empowerment for improved health services from the government in the short run by stimulating non-formal education in a community may be ineffective. Strong, motivated individuals in the government health system should be the focal point of trying to improve services.

Working with social and economic situations resulting in girl trafficking is difficult in that the behaviors and patterns are problematic to assess and monitor, and project interventions are not closely linked with the practice.

Giving women jobs empowers them in the community's eyes, at least among the Hindu caste groups.

Prenatal care may not be acceptable to many people in the area, the birthing kit does not make economic sense to many people and there is not a significant demand for TBA services, at least among the Tamang.

IEC materials are not effective behavioral change agents, especially among non-literate populations. Geographical economics may be a major factor in STD epidemiology in the region.

Finally, and perhaps most importantly, formative qualitative study should guide program development.

VIII. Recommendations for CS XI Extension Project

The scope of work for this evaluation includes producing recommendations for the follow-on project whose goal is to reduce infant, child and maternal morbidity and mortality by: (1) increasing family level health protective behaviors; (2) establishing private sector health commodity distribution and marketing systems at the community level; (3) promoting community level health care management; and (4) increasing women's literacy.

The key interventions of CS 11 place primary emphasis on reducing the child morbidity and mortality associated with diarrhea disease (CDD), acute respiratory infections (ARI), the promotion of maternal and child health (MCH) through pre-and post natal examinations, family planning (FP) services and distribution of Vitamin A capsules. Immunization will be addressed through health education and promotion of available services. The growing problem of HIV/STD transmission will be addressed

through expanded family planning services and related to women's trafficking prevention education and counseling. Nonformal education (NFE) will continue as a foundation of CS11 to provide health education and women's empowerment in ways which impact positively on family health status. SC will also focus on empowerment of women and families to embrace a broader community focus. CS11 will continue the awareness-raising, skills-building and women's group formation and mobilize communities to assume greater responsibility for the costs and care and delivery of vital services and commodities. There will be a planned transfer of skills through training, creation of infrastructure for the distribution of selected commodities and community awareness-raising through the addition of mass media campaigns. The campaigns will complement and reinforce the currently existing health promotion activities initiated through women's groups, parents groups, mothers groups, TBAs and NFE centers.

Some Key objectives: 55% of children under 2 with diarrhea will be treated with ORS; 70% of mothers will seek and obtain appropriate ARI treatment (including antibiotics) from CHVs, TBAs or other health professionals, for children under 2 with cough and rapid or difficult breathing; 75% of women will attend at least one ante-natal clinic; 45% of women will attend at least one post natal clinic after delivery at the MCH mobile clinic; a 30% increase above the baseline survey in knowledge of women and family members about at least five appropriate actions to take during pregnancy, labor/delivery and postpartum period when danger signs occur; 25% of couples 15-49 will use a modern family planning method; condom use among men above 15 years old will be increased by 100% above the baseline survey; 70% of children below 60 months will receive a Vitamin A supplement every six months; 20% of women will receive one dose of Vitamin A at or within one month of delivery, according to MOH guidelines.

Many recommendations follow. Any recommendation below should be considered on a trial basis, with monitoring to assess effects and then modification based on lessons learned.

Recommendations in General

1. Progress towards the goal

There are no data from the project area on child and maternal morbidity or mortality, this needs to be addressed. Some district data are available from the 1991 Nepal Fertility, Family Planning and Health Survey. The project should try to improve the FCHV monitoring of child mortality. SC's sponsored children mortality is another source, using verbal autopsy methods.

Efforts need to be made on monitoring an increased demand for and resulting improved government services, for without some improvement in these services, access to biomedical health care will remain minimal for years.

2. Key intervention

Continue to focus on literacy, and post basic literacy and women's group strengthening. This is the key intervention of CS VIII that may have an impact on health outcomes. Continue to reinforce cost recovery mechanisms and women's savings groups as a key strategy for attaining greater sustainability. With all the training taking place in this project, there is a need to assess the training in operational **ways**.

3. Information Gathering

Strive to determine the major determinants of the differences in impact between the more Tamang populated *ilaka* 13, and the less Tamang area of *ilakas* 1 and 12, and modify programs to increase coverage among the Tamang. It is common for health development programs, to reach those for whom the problem is significantly less serious, and this appears to be the case here. Do seasonal analysis of diarrhea¹ incidence, other prominent diseases, so the project can tailor messages to the population to coincide with the incidence of problems. Do seasonal analysis of work patterns in a community, at the local level, so the project can provide services when people have spare time (e.g. EPI, NFE classes). Do seasonality analysis of sales of socially marketed products so one can determine demand and make sure ample stock is available. Investigate PRA mapping to

generate census information. Do formative research on communications channels in rural Nuwakot, ethnic groups. Carry out focus groups on why the HP are so underused. Do PRA on body mapping, diseases, seasonality with a view to modifying programs (Welbourne 1992). Choose appropriate indicators, and follow national and Nepal mission indicators, in addition to Washington indicators.

4. FCHV's

Where there is no FCHV, the project should strive to get one in place, using existing mothers groups, etc. to identify an appropriate individual and have her receive training. Get the FCHV's to generate local information by PRA mapping methods, and also do seasonality methods by PRA, having a school child as a recorder. Get FCHV's working together as a group. SC should consider cross-visitation with Siraha (where there are active FCHV's), Surkhet, Doti, or Achham, to brainstorm ways of getting the FCHV's more actively involved. The project should conduct focus groups in the community to see how FCHV status and performance could be elevated. Consider doing a positive deviance examination of FCHV's in this area. Do publicity/promotion of FCHV activity in wards where she is eager and effective. Methods could include posting a photo at the health post, or on a community bulletin board, or in a newsletter for the literacy classes. Get the FCHV badges distributed to the homes to make them identifiable. Every time project staff go into every village, they should ask for the FCHV and she should be a part of every activity they do, she should be in every NFE class, and should be the only person exempted from a registration fee. Consider villager recognition of their FCHV as an indicator of progress in strengthening government service.

5. DHO

The DHO should continue to be included in the planning process, and in periodic feedback meetings. He/she should come to see the SC programs as MOH programs. Support local analysis of data, at the HP level and at the district level. It should not be computer based, unless the individual already has a computer. The DHO is to be involved in all decisions, and since there is a trunk call line to Trisuli from Samudratar, there could be good phone contact between the DHO and the project. Involve the current DHO in analyzing data, since he has a computer and knows EPI info. Finally, carry out focus groups on why the health posts are so underused, and develop an action plan to remedy this.

6. Future Evaluations

Future midterm and final evaluations should include the DHO and future evaluators should walk the project sites from north to south to gain a balanced perspective, rather than just visit the sites closest to the road. It would be useful to have someone from the MTE included in the final evaluation. The local SC office should plan to have the project staff available to the evaluators during the entire incountry evaluation.

7. IEC Materials

A total reorientation with regard to IEC materials is required, with serious consideration of their value and effectiveness in a mostly non-literate and minimally literate population. Begin by looking at past experiences in this matter in Nepal (Fussel, 1976). Work with community members to develop logos for key messages, and see if this can be an effective way to developing recognition of concepts. There needs to be some objective way of evaluating this communication channel. Consider having a local "minstrel" or educator in each *ilaka* going from village to village, and casually talking about health matters, and suggesting communities lobby for better health services. Any visual IEC materials should be generated through local formative studies in the way HIV/AIDS messages are in the US.

8. Communication networks

Use communication networks created by the project to disseminate information through people identified by villagers as social change agents. Employ geographical distribution points such as

Apra, Mane Bhanjyang and Kutumsang and possible Kathmandu entry/exit sites, for communication in addition to the network developed by the project.

9. Increasing Linkages

Share NFE materials that are effective with ministries, other NGO's (World Education, others).

Recommendations on EPI

Work to increase community advocacy for EPI services, and to strengthen VHW reporting. Consider a registration fee for the immunization card as an attempt to improve retention. Strengthen FCHV reporting on mortality, with follow up SC verbal autopsy to estimate mortality due to vaccine-preventable diseases in the region. Philosophically, this helps determine the extent to which EPI diseases are a problem here: if not they should not be a major focus of project efforts. Place IEC wall paintings on major trails where they will be seen after careful pretesting. Finally, use the SC generated community network links to notify other groups when EPI doesn't happen, and when the health post worker is in his post. Report this information to the district in the hopes of realizing better services.

Recommendations on CDD

Target training and stock supply of Jeevan Jal to coincide with peak diarrhea1 season, determined locally. Produce pleasant advertising materials for Jeevan Jal, like those for the safe birthing kit. Work to increase the availability of Jeevan Jal and attempt a more visible display of Jeevan Jal in shops especially during peak diarrhea1 seasons. Produce better posters on Jeevan Jal, accessible to non-literates. Have a consistent presence of ORT corners in mobile clinics during the diarrhea1 season. Carry out formative studies with the FCHV on all deaths from diarrhea especially those in sponsored children which SC can track. Investigate having non-literate women running ORT corners on Mane Bhanjyang and other heavily trafficked sites. Tailor ORT messages to Tamang people. Have a competition in the local schools or NFE classes to develop a logo or IEC materials for ORT. Investigate the potential of enlisting VDC members to carry out distribution for Jeevan Jal. Consider a trial of having ORT corners in the schools, and increase health messages on CDD in schools. Focus on dissemination of key messages for CDD, consistent with HMG practice.

Recommendations for ARI

Train all project staff to HMG level of competency in ARI diagnosis and treatment. Switch over to pediatric tablets for co-trimoxazole, which are much cheaper. Focus on dissemination of key messages for ARI, consistent with HMG practice. Stress the importance of breast feeding within the first hour of birth. Meet with MOH/USAID/JSI to determine whether or not SC should pursue an intensive ARI program at this time and to what level. Monitor the results of MOH/AID/JSI ARI program trials in 4 districts to use as a baseline for ARI project strategy. Consider ARI services at the community level, whether FCHV's to diagnose and treat or diagnose and refer. Have SCF do support supervision, using HMG/JSI training materials.

Recommendations on Nutrition/Vitamin A

The timing of vitamin A distribution should be pre-monsoon and pre-harvest. Use the national vitamin A register (available from National Vitamin A Program Technical Assistance Group) to record data and not the little piece of paper given to mothers to record vitamin A distribution. Every district health worker should be trained in treating measles and xerophthalmia, and persistent diarrhea with vitamin A (200,000 units). Investigate having FCHV's and TBA's and family members hand out vitamin A to post partum women.

Recommendations on Maternal Care and Family Planning

Carry out formative studies in an attempt to select emergency treatment protocols. Similarly, use such methods to clarify triage issues upon arrival in Kathmandu for villagers transported for serious obstetrical problems. Study is needed on: getting the community to use TBA's, especially for

Sherpas and Tamangs; educational messages for why it is important to use TBA's; and whether pregnant women attending ANC actually comply with iron/folic acid daily dosing.

Carry out a cross visit with Aide Medical et Sanitaire in Parbat to learn how to improve TBA coverage. Have quarterly meetings with TBA's to find out what they are doing. Consider locally produced sign boards, badges with pictures, T shirts logos, boxes, for TBA's in the community, much like for FCHV's. Investigate sales records of safe birth kits, their usage, and economics of their sale. Include husbands in maternal education, especially in those areas where they are present at the delivery. Place a condom box on Mane Bhanjyang, the major thoroughfare in the area, and keep it full. The project should do everything to increase family planning accessibility and availability regardless of sustainability issues. Mobile clinics should do "reproductive services", and provide depot, condoms, pills and counseling. Consider training a local woman to work in the MCH mobile clinics, and do FP training and motivation. Explore having a private place for family planning activities at the mobile clinic. SCF should facilitate sterilization camps twice a year in the region, consider Mane Bhanjyang as a site. Finally add safe motherhood stories produced for radio to the NFE libraries.

Recommendations on STD's

Carry out formative studies on attitudes towards communication channels for receiving sexual information among different ethnic groups. Consider doing a small syphilis prevalence survey on mothers coming to the ANC/PNC. Work with the DOH to put the condom boxes outside the locked health posts and keep them filled..

Recommendations on Expenditures and Budaet

The ledger system should be able to segregate operational and program activities by cost center, enabling project management to track changes in the administration to program cost ratio over time. This could serve as a tool to facilitate increased project efficiency and decision making.

Since the follow-on project will have three accountants, detailed ledgers should be kept for core program activities to facilitate project budgeting and planning on an activity level. Core activities would include those activities that are considered to be models for sharing with the MOE/MOH and dissemination and training to other local clubs and NGOs, such as NFE classes and MCH clinics. Cost data can be used by SC and institutional partners to compare costs of running and maintaining activities in different areas of the district, to look for ways to enhance efficiency, and to compare with different groups running similar activities in Nepal.

The three ilaka accountants should reformulate guidelines for defining cost centers and establishing a detailed ledger for the CSI 1 grant that is clear to everyone.

Recommendations on Staff and Management Issues

1. Headquarters needs to provide technical assistance to field staff to help them the data they collect and display. This should be with a view towards having them only collect and display data they can analyze in the field and that are meaningful for decision making.
2. Consider having the various trainings conducted outside of the project offices in each *ilaka*
3. Consider consolidating all the offices on or near Mane Bhangyang, or at least having a strong educational focus there, with a locally trained person carrying out educational programs for the large numbers (at least 100 people a day) crossing the pass daily
4. Consider having staff live in the communities, and out from the town where the headquarters is located
5. Address the changes to the local economy of paying high wages for portering, and commodities, to see if there are more sustainable alternatives

6. Technical supervision should be done in the field
7. Offer a month's intensive Peace Corps conversational style Tamang language study to all staff working in the field with local inhabitants
8. Do a workshop on behavioral change models for the staff, in the hopes they learn the role of information provision in behavior change.
9. Place library resources in field staff offices appropriate for the audience, and include Tamang ethnographies
10. Do accounting by activity to be able to generate cost/activity data, and present this to village and district leaders to have discussion on cost benefit and cost-effectiveness

APPENDIX 1

Map of Nuwakot

REGION: CENTRAL

ZONE: BAGMATI

DISTRICT: NUWAKOT

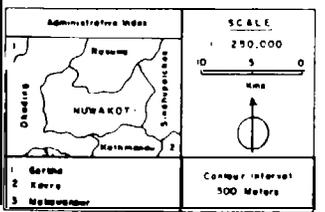
POPULATION DISTRIBUTION & HEALTH FACILITIES



Sl. No.	VDC/ Mpt.	Population	H.P.	U.I.
1.	5	15,161	1	2
2.	5	22,183	1	2
3.	5	28,978	1	1
4.	5	31,047	1	2
5.	4	16,171	1	2
6.	5	18,824	1	2
7.	5	13,488	1	2
8.	4+1	43,203	1	1
9.	5	25,443	1	1
10.	5	20,932	1	2
11.	4	15,058	1	2
12.	5	15,088	2	1
13.	4	13,500	1	3
Total	1+1	279,078	1	0

HEALTH INSTITUTIONS	
HOSPITAL (N.M.C.)	⊕
HOSPITAL (Private)	⊞
HEALTH CENTER	⊕
PHILMAY HEALTH CARE CENTER	⊕
MD CLINICS	⊗
HEALTH POST	⊙
SUB HEALTH POST	⊙
AYURVED AUSHADHALAYA	⊙
FOOD ASST. HEALTH INST. (VFP)	⊙
POPULATION (June, 1994 est.)	⊙
(1 dot = 1000 Persons)	⊙

LEGEND	
INTERNATIONAL BOUNDARY	—•—•—
DISTRICT BOUNDARY	—•—•—
ILAKA BOUNDARY & NUMBER	①
MAIN RIVER & LAKE	—•—•—
ALL WEATHER ROAD	—•—•—
SEASONAL ROAD	—•—•—
TRACK	—•—•—
DISTRICT HQS	⊕
MUNICIPALITY	⊕
V.D.C.	⊕
CONTOUR LINE	—•—•—



Krishna Man Sharma, Cartographic Art, Chitwanpuri, Nepal

N.M.C., Nepal

UNFPA (United Nations Population Fund, Nepal)

APPENDIX 3

Outputs Expected/Actual

Appendix 3 Outputs Expected/Actual

OUTPUT	YEAR 1 TARGET/ ACTUAL	YEAR 2 TARGET/ ACTUAL	YEAR 3 TARGET/ ACTUAL	PROJECT TARGET/ ACTUAL
Mobile clinics	70/ 70	145/ 143	145/ 185	360/ 398
TT camps ¹	3	6	6	15/ ⁵
CDD TRAINING				
DPHO/HP				6/5
VHW'S				24/ ⁵
CHV'S				126/104
TBA'S				126/ ⁵
NFE facilitators				313/134
Mother's groups				130/320
VITAMIN A SUPP camps	14/ 27	28/ 250	28/ 250	70/ 527
MATERNAL CARE				
meet with HP staff, CHV's, TBA's	3/ 4	3/ 4	3/ 4	9/ 12
coodination with DPHO	2/ 2	2/ 2	2/ 2	6/ 6
mothers group training	30/ 50	80/ 100	126	256/ 150
sites of MCH clinics	23/ 27	28/ 27	28/ 32	79/ 86
# clinics held	70/ 70	145/ 143	145/ 185	360/ 398
MCH management committees formed	14/ 27		/ 5	
marketing of safe birth kits		40	60	100/ ~170

LITERACY CLASSES classes/students				
basic classes	104/2080/ 90/2131	75/1400/ 50/1252	60/1100/ 49/1117	239/5308/ 189/4500
advanced literacy		80/1600/ 64/1295	50/980/ 35/719	130/2580/ 99/2014
out-of-school children		50/1000/ 44/1112	25/500/ 29/910	75/1500/ 73/2022
ECD GROUPS/participants				
fathers & mothers ²	36/720/ 36/720	42/840/ 3/60	6/ 39/664	78/1560/ 78/1444
child care coops ³	6/84/ 6/42	12/168/ 6/45	6/ 9/63	18/252/ 21/150
child-to-child groups	3/60/ 7/175	6/60/ 8/192	6/ 30/540	9/120/ 45/907
NFE women's groups	18/360/ 141210	2114201 281420	P 461690	39/780/ 8811320
self-help groups	3/60/ 141210	3/60/ 5/40	P 20/80	6/120/ 251120
pre-primary school ⁴		I 1/22	I 2/40	/ 3/62

1. conducted jointly with mobile clinics and EPI catch up rounds

2. objective revised

3. including Home Based Child Care Cooperatives

4. no initial target in proposal or DIP

5. data unavailable

6. no targets established for this year

APPENDIX 4

Training

Appendix 4 Training

1. Training Conducted to Community / Volunteer / HP Staffs

Training On	Participants	Number of Participants
EPI	NFE Facilitators Parents Group	162 persons 16 groups
Diarrhea / ORT	CHVs NFE Facilitators THs NFE Supervisors	104 134 140 20
ORT Corner / ARI / FP	NFE Facilitator	209
Jeevan Jal Social Marketing	Management (MCH) Committees Saving Groups Shopkeepers	310 persons 2 groups 32 persons
AIDS / STDs	School Teacher CHVs THs Peer Counselors School Students School Teachers TBAs VHWs HP Incharges Club Members AIDS Educators	97 103 82 126 13 19 38 9 2 18 3
ARI	CHVs THs	103 193
Vit A	HP Incharges CHVs / TBAs OSC Facilitators School Teachers	2 160 134 19
Basic Training	TBAs	26
Refresher Training	TBAs CHVs THs	18 49 88
FP / Maternal Health	CHVs VHWs WGs Members	123 10 30
ARI / EPI / SBK	NFE Graduates	39
SBK	TBAs	33
Communication Skills	CHVs	74
Health Service Management Workshop	HP Staffs / CHVS	36
Supervision Training	TBAs	21

2a. International Training/Workshops/Seminars Attended by SC/Nepal Staff with full or partial support from USAID Child Survival 8 funds

Name	Training/Workshop/Seminar/Venue	Date
Jamuna Devi Lama (WDC)	Diploma Program in Social Development, Canada	6/94 - 12/94
Rajendra Kumar Lama (NFE Coordinator)	Education & Development Program, Thailand (Management of Training Centers)	6/95 - 7/95
Ravindra Thapa (DPC)	26th Summer Session on Population, USA & Thailand	6/95 - 7/95
Maya Kumari Gole (Staff Nurse)	Family Planning, Health and Community Development, Thailand	11/7-18, 1995
Bhim Kumari Pun (Staff Nurse)	FP, Health and Community Development, Thailand	11/7-18, 1995
Krishna Bahadur Gurung (FCO)	Regional Leadership Training Course, India	9/1/93-9/30/93
Ranja Khanal (ANM)	Regional Leadership Training Course, India	9/1/93-9/30/93
Chanda Rai (PD)	AIDS Conference, New Delhi	11/6-13, 1992
Ravindra Thapa (DPC)	Community Based AIDS Prevention Strategies, Thailand	12/92

2b. International trip reports not previously submitted in quarterly, annual or midterm evaluation reports are attached.

TRIP REPORT
TWENTY SIXTH SUMMER SEMINAR ON POPULATION
"Multisectoral Response to HIV/AIDS Epidemic"
EAST-WEST CENTER, HONOLULU, HAWAII

DATES: June 1 - July 8, 1995
ATTENDEES: Ravindra Thapa/Health Coordinator, Nepal FO

Background

Ten Countries from Asia and the Pacific were represented at this conference, with 4 participants from Nepal. The first four weeks of the seminar were conducted in the East-West Center, Hawaii, and the remaining one week in Chulalongkron University, Bangkok.

The realization of the fact that AIDS is no longer strictly a health problem has led to the emphasis on other sectors of society beyond the health sector making efforts to prevent and control HIV transmission, dealing with the epidemic's impact and consequences, and giving rise to the concept of a "multisectoral response" to the epidemic.

Objectives

1. To examine the relevance and implementation of multisectoral approaches in specific country settings
2. To identify ways to promote multisectoral efforts to improve national AIDS/HIV responses.

Process

The process followed was lectures, discussions, visits and country group workshops and presentations. The output of these was the development of a country paper on "Multisectoral Response to the HIV/AIDS Epidemic."

Findings

Four major sectors identified for a multisectoral response were GOs, NGOs, Communities (including those living with HIV/AIDS) and Business. These sectors must work together in planning, assigning responsibilities, lobbying for obtaining funds, implementing, monitoring and evaluating, and building each sector's capabilities where necessary. After we examined the country-specific national plans and responses, it was found that most of the participating countries and Asia and the Pacific did not have a true multisectoral approach in practice, since for the most part these were dominated by Ministries of Health. After reviewing these, a paper for each country was prepared examining the weaknesses in current programs and suggesting ways to improve them.

Conclusions

The changed strategy of SC/US Nepal Field Office from direct implementation to working through various NGOs and community groups by enhancing their capabilities has been one potential area where lessons learned from the seminar can be applied. Experience shows that NGOs can play an important role in advocating and lobbying sensitive issues, particularly relating to HIV/AIDS. Also, some NGOs are working directly with people with high risk behavior and people living with HIV/AIDS. This seems to be a concrete step in moving toward a multisectoral approach.

DIPLOMA PROGRAM IN SOCIAL DEVELOPMENT
613195 - 1212195
A Short Report

Prepared by: Jamuna Devi Lama
District Women in Development Coordinator
Save the Children/Nepal

Dr. Moses Coady was one of the outstanding leaders in Adult Education and is best known for his influence on the cooperative movement in Canada. Coady International Institute **was** established after the death of Coady in 1959 as a center for training people of many races and creeds in programs of social development and community education. The institute is located at St. Francis Xavier University in Antigonish town, Nova Scotia Province. The Institute is well-known in Canada as well as many developing countries for its unique technique of organizing training. It provides 6 months training on social development annually to overseas participants, especially those from third world countries.

The 1995 training was held from June 3, 1995 until December 2, 1995. There were 41 participants from 19 different countries. Almost all the participants were from Asian and African countries, and were very rich in knowledge and experience. There were also a few Canadian participants, who attended specific courses only.

Purpose:

The ultimate aim of the program is to promote a more equitable and adequate satisfaction of the basic human needs of disadvantaged groups within the global community through the participation of these people in the development process through institutional organization and human resources.

The program goal is to strengthen organizations engaged in achieving the above aim by providing training for development workers who are directly or indirectly involved in organizing disadvantaged groups.

The objectives of Diploma Program 1995 were:

1. to increase commitment to social transformation based on the philosophical orientation of the Antigonish Movement
2. to increase knowledge of contemporary issues, theories and strategies of development
3. to develop a critical awareness of the dynamics of integral development, including the personal, collective, cultural, structural and ecological dimensions
4. to develop social action and organizing skills through the use of adult education, communication and group process techniques

5. to increase ability to develop ongoing peoples' movements and organizations, with emphasis on cooperative forms of enterprise
6. to develop organizational management skills, including program planning, project management and evaluation

Description of the course content:

The study course was divided into two terms, along with independent study and writing.

Term 1 - 6/4 - 9/18. Term 1 was comprised of the Adult Education and Integral Development Workshop, the mandatory Foundation Course "Participatory Program Planning," and elective courses.

The following elective courses were offered in term 1:

Community Economics
 Issues in Cooperative Development
 Community Health and Development
 Development Communication
 Environment and Development
 Microenterprise Development
 Gender and Development
 Participatory Evaluation Methods
 Savings and Credit
 Managing Development Organizations

Each course had a certain amount of credits. Participants were given the option of selecting elective courses of their own interest, carrying a minimum of two credits and a maximum of four credits.

Term 2 - 9/11-9/25. Term 2 consisted of a two week long workshop entitled "Think Global, Act Local," and the following elective courses:

Managing Development Organization
 Managing People in Organizations
 Rural Development
 Strategies of Social Change
 Training of Trainers
 International Economics

The participants in this term could take any course with a minimum of three credits to a maximum of five credits. The other important part of term 2 was Independent Study, with 2 credits. The whole course carried a minimum of 12 credits and a maximum of 16 credits.

Independent Study:

Each participant was required to complete an independent study project. It as the major project to be written, usually addressing an area of interest related to the participants work situation in his home country. The purpose of Independent Study was to encourage participants to apply

the course learning appropriate to the study. For this, each participant was given an advisor for necessary guidance.

Methodology of the Training:

The training was conducted basically through participatory approach in which each participant was encouraged to participate actively in all activities. Video show, home group discussion, buzz group discussion, role play, drama, case study analysis and presentation, field visits, etc. were used to make participants share their rich knowledge and experience and to reflect critically upon various global issues which affect the people at the grass roots level in third world countries.

Other Activities:

Besides the mandatory course and independent study writing, the participants were given plenty of exposure to the Coady community. There was a g-member student council which had responsibility for organizing various activities like sports day, international day, social day, etc. There were also many committees to look into different activities - education committees, food committees, etc. Participants were invited by people in the community, schools, universities and many organizations to share their experience in community development, their country situations, culture, etc.

My Experience:

I left Katmandu on June 2, 1995 and reached Halifax International Airport on June 3 at 9pm; the representative from the Coady Institute received us and drove us to the Institute. For the next week, the course started with the introductions of the program, the institute, participants, countries, etc., after which Term 1 Integration Workshop began and in July the Independent Study Advisor was assigned. I was lucky to have Mrs. Martha McGinn, a graduate of the Coady School, as my advisor; she had visited Nepal in 1993.

In Term 1, I took 4.5 credits, which included Microenterprise Development, Gender and Development, Issues in Cooperative Development, Participatory Evaluation Methods and Managing Development Organizations. In Term 2, I took only 3 credits so as to be able to give my time to independent study. These courses were Rural Development, Training of Trainers and Managing People in Organizations.

The title of my Independent Study was "Women's Functional Leadership Development, A Training Program for the Women of Samundratar VDC, Nuwakot." In this independent study I attempted to analyze the problems that caused women's low participation in development programs in Nuwakot district, especially in the Samundratar working area, and to suggest solutions to the situation.

I was a member of the Food Committee, served as a guest speaker in a Women's History Month Symposium organized by St. Francis Xavier University and other Women's Organizations, and gave a talk on the status of Nepalese women to the students of the sociology department. On graduation day, I was selected to give a vote of thanks on behalf of all the participants.

The training was very useful for me. It increased my knowledge and skills in participatory program planning, various approaches to community development, organization/project management, monitoring and evaluation, etc. The courses I studied enabled me to complete my independent study project successfully. I am much impressed by the dedication, generosity, and vast knowledge and skills the professors of the Coady Institute have in the area of social development. They have shown keen interest in working with Save the Children/US in Nepal.

Follow-Up:

Mr. Anthony Scoggins, an expert and Cooperatives and Savings/Credit, and other professors of Coady Institute have a tentative schedule to come to Nepal in February 1996 at the request of various organizations. If our organization permits me, I would like to organize a workshop on Cooperatives and Microenterprise development for my colleagues with the help of these Coady professors.

In addition, I have decided to take the following immediate actions to benefit the organization and my colleagues with my learning:

- Share my experiences and learning with my colleagues of Nuwakot District in the forthcoming meeting
- Write a proposal for the Productivity sector, Nuwakot, in a participatory manner to solve budgeting problems and bring sustainability to the program.

TRIP REPORT
MANAGEMENT OF TRAINING CENTERS, BANGKOK, THAILAND

DATES: JUNE 5-JULY 5, 1995
ATTENDEES: MR. RAJENDRA LAMA FROM NEPAL FIELD OFFICE

The aim of this course was primarily to assist present and prospective training managers and training personnel to achieve successful employee development and improved organizational performance through training.

The course focused on

1. Understanding human behavior, at work, individual differences, values, attitudes through perception, motivation, communication, interaction and conflicts in groups/teams, leadership and power delegation.
2. Defining the training function framework of human resource development (HRD) practice, organizational development, defining the scope and structure of the training function, and the roles of the Human Resource practitioner.
3. Planning and linking training to organizational impact: Strategic planning of training centers, creating vision, defining mission, identifying internal and external influences of training, training structure, training needs, methods, techniques, new technology for training and education, developing training plan.
4. Managing of training resources: Strategic planning of human resources, selection competencies required for training centers, financial management of training.
5. Evaluation of training resources: Evaluation process, methods, techniques, developing evaluation strategy, designing evaluation questioners.
6. Case Study: Study visit, program discussion, program analysis, observation training, materials and technology.

Various activities were organized to enrich the experiences of the participants. The management of training centers course was designed to allow participants to participate as much as possible. Various audio-visual aids were used. At the same time, study visits, observation of training materials and technology were also organized.

Active involvement of participants increased the effective and efficient learning and sharing of lessons learned and experiences enriched the participants' experience. Useful materials were received by the participants which will be used in their own working areas.

The course covered the essential topics that were necessary to build capacity of the participants in achieving successful employee development and managing training centers and a comfortable learning environment was recreated for the participants.

The ultimate goal of training is organizational success, resulting in the enhanced performance of employees at all levels of organization. Hence most of the ideas and techniques could be adopted to our organization. The lesson had been shared with all my colleagues, subordinates and supervisors as per required for organizational success.

TRIP REPORT
FAMILY PLANNING HEALTH AND COMMUNITY DEVELOPMENT PARTICIPATION AND
OBSERVATION STUDY TOUR, BANGKOK, THAILAND

DATES: Nov. 7-18, 1994
ATTENDEES: Bhim Kumari Pun - Staff Nurse/Nepal FO
Maya Gole - Staff Nurse/Nepal FO

The main objectives of this training program were to observe family planning health and community development activities implemented by the Government of Thailand and NGOs, in both rural and urban areas, and to share experiences **and** exchange ideas with participants. The training program was sponsored by PDA (Population and Community Development Association).

The training program was combined with an observational study tour. The first two days of the training period the participants received an orientation on community development activities, the rural development administration system and the AIDS situation. Arrangements were made for observation study tours in different government and NGO offices and in PDA's urban and rural programs.

Observations/Lessons Learned:

• Family Planning

Family planning programs are more effective in Thailand. Although the government has been distributing pills and condoms free of cost, the NGOs have been charging a minimal fee for pills and condoms and distributing them through sales agents. It seems that family planning programs run by NGOs are more successful than government programs.

• Income Generating Programs

NGOs have been implementing the various income generating activities in rural and urban areas with the objective of improving the living standards of the population, i.e., integrating farming, mulberry tree planting, vegetable farming, etc.

• Demonstration Farms

PDA has been launching demonstration farms with pig raising, fish production, banana production, etc., and we were able to observe latest techniques in demonstration farming.

In conclusion, such programs would be extremely beneficial in our own impact areas. This type of training program is highly useful and effective for field based staff to gain knowledge and new ideas which may be replicable in Nepal Field Office impact areas.

TRIP REPORT
REGIONAL LEADERSHIP TRAINING, BANGALORE, INDIA

DATES: September 2-30, 1993
ATTENDEES: Krishna Bahadur Gurung
Field Coordinator/Nepal FO

This training was organized by the South Asian Reconstruction Association (SARRA) in order to develop and increase the skills of development workers in management and leadership.

The major topics discussed in the training were structural analysis and community development, community organization, leadership, interpersonal relations, communication, health planning, sustainable and bio-intensive gardening, gender issues, project planning, monitoring and evaluation, organizational lifecycles and integration strategies. A field visit **was** extremely helpful in gaining first hand experience in different aspects of Community Development.

Methods of training included sharing of experience, lectures, group work and field visits.

The training emphasized integrated community development, encompassing every sector of community development, all pertinent to Child Survival. Child Survival 8, which aims to reduce IMR/MMR by empowering families through literacy, income generation and training to address their health and development needs, is essentially a community development endeavor.

Without doubt, skills and knowledge acquired from attending this course will help to fulfill the goals of the Child Survival 8 project.

**TRIP REPORT
SECOND INTERNATIONAL CONGRESS ON AIDS
ASIA AND PACIFIC REGION
DELHI, INDIA**

DATES: November 6-12, 1992
ATTENDEES: Chanda Rai, Health Coordinator/SC Nepal
Dr. Pushpa Bhatta, Medical Officer/Ministry of Health, Nepal

Description:

The inauguration of the Congress was conducted by the Vice President of India; the Health Minister, Mr. Folader, thereupon declared AIDS as a public health problem in India. Dr. Michael Merson, in his keynote address, warned that Asia will be hit hard with the HIV virus and strategies need to be implemented; he noted that HIV is especially difficult to control in the developing world due to ignorance, denial and lack of political commitment.

Scientific sessions were conducted covering twenty different subjects. Trainings we attended included:

- intervention strategies
- . sexually transmitted diseases
- . counseling and care

Lessons Learned:

- intervention is the most important part of global AIDS control program
- . condom promotion for sex workers, migrant laborers, etc. is necessary
- . not much emphasis has been placed on condoms in developing countries; they are seen as male contraceptives only
- . availability, accessibility and quality of condoms are important programming tools

Overall, at this time actual HIV cases are estimated to be 50 times higher than registered cases, and there is an immediate necessity for a sexually transmitted disease control program. Aggressive awareness and intervention programs at community level will be essential.

APPENDIX 5

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