

Plan Nepal
Rautahat/Bara Program
Child Survival XIII
Cost Extension Project
NEPAL



FIRST ANNUAL REPORT
(OCTOBER 2001 – SEPTEMBER, 2002)

IMPLEMENTING AGENCY

Plan Nepal Country Office
in partnership with
HMG/N Ministry of Health

LOCATION

Bara District, Nepal
October 2002

Beginning Date:
Ending Date:

30 September 2001
29 September 2006

ACRONYMS

ACHO	-	Assistant Community Health Officer
AHW	-	Auxiliary Health Worker (HP, Sub-HP)
ANM	-	Auxiliary Nurse Midwife (HP, Sub-HP)
ARI	-	Acute Respiratory Infection
BCC	-	Behavioral Change Communication
CBO	-	Community Based Organization
CDD	-	Control of Diarrheal Disease
CHO	-	Community Health Officer
CDP	-	Community Drug Program
CS	-	Child Survival
CWS	-	Child Welfare Society (Nepali NGO)
DHO	-	District Health Office
DR	-	Drug Retailer
EPI	-	Expanded Program of Immunization
FCHV	-	Female Community Health Volunteers
FP/MNC	-	Family Planning/Maternal and Newborn care
GTOT	-	General Training of Trainers
GWP	-	General Welfare Pratisthan (Nepali NGO)
HA	-	Health Assistants (HP, SHP)
HF	-	Health Facility
HMIS	-	Health Management Information System
HP	-	Health Post
IHFA	-	Integrated Health Facility Assessment
IMCI	-	Integrated Management of Childhood Illness
KPC	-	Knowledge Practice and Coverage
LQAS	-	Lot Quality Assurance Sampling
MCHW	-	Maternal and Child Health Worker (SHP)
MOH	-	Ministry of Health, HMG/Nepal
MTOT	-	Master Training of Trainers
NEPAS	-	Nepal Pediatric Society
NFE	-	Non-Formal Education
NFHP	-	Nepal Family Health Project
NID	-	National Immunization Day
NTAG	-	National Technical Assistance Group (Nepal NGO)
PHC	-	Primary Health Care Center
PU	-	Program Unit
SC/US	-	Save the Children Fund US
SHP	-	Sub Health Post
TBA	-	Traditional Birth Attendants
TFH	-	Transformation for Health
TH	-	Traditional Healer
USNO	-	US National Office (Plan International)
VDC	-	Village Development Committee
VHW	-	Village Health Worker (SHP)

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1.0 PLAN NEPAL CHILD SURVIVAL COST EXTENSION PROJECT AT A GLANCE

Project duration	30 September 2001 – September 29, 2006
Project area	98 VDCs in Bara district of the central Terai plain
Total population in the project Area:	525,799
Target beneficiaries	266,313
MOH health facilities and staff, volunteers in project area	1 hospital, 3 PHC center, 11 HP, 84 SHP and 2 AA
Social and economic profile of population in the project area	Various ethnic groups with a strong caste system are living in the project area/district. Percentage distribution of some of the major caste in the district include: Yadav 20 %, occupational castes 20%, Muslims 17%, untouchables 10%, Malaha 9%, Kurmi and others 5%. Target group is below the subsistence level working mostly as tenant farmers. As the project area lies in the bordering area of India there are a large number of group of migrants residing there. The literacy rate in females aged above 5 yrs. in the district is 14 % while it is 42 % in males. Most of the project population lives without proper sanitation (a few latrines) and safe drinking water.
Overall Goal	To assist the MOH to improve the health status of children under five and women of reproductive age (15-49 years) in Bara district.
Project interventions	<ul style="list-style-type: none"> - Diarrhea Case Management (DCM) - Pneumonia Case Management (PCM) - Maternal and New Born Care (MNC) - Child Spacing (FP)
Strategies	<ul style="list-style-type: none"> - Improved training - Improved supervision and follow-up training to MOH health workers and volunteers - Support and non-financial incentives for community health volunteers. - Strengthened community partnership and cost recovery - Development and support to community drug program - Promotion of project's objectives through innovative BCC strategies - Integration of CS activities with Plan's other domains - Collaboration with other local partners and NGOs.
End objectives	<p>1. Behavioral: Women of reproductive age and mothers of children under-five years practicing healthy behaviors and seeking medical care trained providers;</p> <p>Increased access to services: Communities and families have increased access to health education and quality care and essential medicines</p> <p>Quality of care: MOH personnel, community health volunteers and other service providers practicing appropriate integrated management of sick children particularly for pneumonia and diarrhea case management. Practitioners and volunteers delivering quality family planning, and maternal and newborn preventive care</p> <p>4. Institutional strengthening: Community based organizations, local NGO and district MOH facilities developed and strengthened to support and implement activities that enhance child survival</p>

2.0 ACCOMPLISHMENT OF YEAR ONE

In the first year, Plan Nepal's Child Survival (CS) Cost Extension Project in Bara district conducted surveys and field assessments, recruited staff, convened project start-up workshop, prepared project's Detailed Implementation Plan (DIP), and procured training materials, equipment, drugs and other supplies based on the findings of Integrated Health Facility Assessment (IHFA) Survey of January 2002, and suggestion provided by DHO. The project also assisted in reactivating and reforming mothers' group at ward level (community level), conducted baseline KPC survey using LQAS method, developed and produced Behavior Change Communication (BCC) materials for the use of health workers and volunteers to deliver health messages. Forty-five pictorial billboards with key Child Survival messages were developed and positioned at public places in the project areas. Likewise, supervisory forms being used by health workers and project staff were improved and HMIS forms were also developed and produced. At the end of the first year project staff and partners were trained on "Transformation of Health" aiming at improving facilitation skills to mobilize the community in identifying their problems and determining solution with their active participation. Besides, the project staff was also trained on LQAS, Integrated Health Facility Assessment (IHFA), Integrated Management of Childhood Illness (IMCI) and General Training of Trainers (GTOT). Training of local health facility staff, Female Community Health Volunteers (FCHV) and trained TBAs on IMCI, Maternal and Newborn Care and spacing were completed. Local health facility staff prior to the beginning of GTOT training was trained on facilitation skills.

Main accomplishment of Year 1 include an excellent staff team in the field, good relations with the HMG/N's Ministry of Health at both the national and district level, frequent technical backstopping and support from Plan. Besides, support received from USNO Washington, as well as USAID and from Plan Nepal's District Project Coordinator and country office has further helped to peruse the activities successfully.

Year 1 accomplishment and activities include:

- Baseline LQAS survey in November 2002 based on interviews with 133 women of 15-49 years in the project area
- Integrated Health Facility Assessment of Bara District was conducted during the month of January 2002. The assessment was carried out in 25 sampled health facilities centers.
- Conducted project start-up workshop held in February with all key stakeholders in attendance of 37 participants in all including representatives from MOH national and district offices, Plan Country Field and CS Staff.
- Conducted 6 batch General Training of Trainers (GTOT) (February- May 2002) (*Detail Annex A*)
- Conducted FP/MNC Training to HA (March 2002) (*Detail Annex. A*)
- Newly hired CS staff that was not fluent in local dialects was provided weeklong language training in March 2002.
- Community Based Maternity Home (CBMH) started in March 1999 in rental premises currently has been functioning in its own building since June 2002. (*Detail Annex B*)
- Conducted IMCI Training to 7 batches (April – July, 2002) (*Detail Annex A*)
- Conducted FP/MNC Training to 5 batches of AHW/ANM (April– June 2002) (*Detail Annex A*)
- Conducted FP/MNC Training to 9 batches of TBA (May– June, 2002) (*Detail Annex A*)
- Conducted FP/MNC Training to 20 batches FCHVs (May– June, 2002) (*Detail Annex A*)
- Distributed essential equipment, materials and medicines to 75 local health facilities
- Detailed Implementation Plan (DIP) was prepared in consultation with USAID and Plan Nepal staff including meeting in Washington and response to DIP reviewers (Oct.- June 2002)
- Distributed equipment and materials to 81 health posts (August 2002)
- Conducted LQAS Training to the Save the Children (SC) team in the month of November 2002
- Conducted CS orientation training by the CS Staff at new field area about the CS Cost Extension project (Dec. 2001, Oct. 2002)
- Conducted Workshop on Transformation for Health for the project staff, partners and health coordinators of other program units (Oct. 2002)

Project Milestones

- The project has already prepared, developed and positioned 45 billboards with pictorial messages. In addition classification card by FCHVs, TBAs and Community Health Workers (CHWs) to deliver the key CS messages has already been improved and reproduced.
- Project HMIS supervisory forms for health posts and sub-health posts have already been developed for use by project staff to compliment and support HMG/N HMIS database. HMIS pictorial classification cards have also been developed for the supervision of community based health service delivery to be used jointly by project staff and community based FCHV and TBA volunteers.
- The project is considering to pilot application of Transformation for Health (TFH) – a method developed by Paulo Freire, in seven VDC of the project area. In this connection, the project has recently completed a 5 days training on Transformation for Health to the CS Staff, partners and other health coordinators working in Plan's different program units. Skills developed out of Paulo Freire's pedagogy over a 15-year period in East Africa into a process called training for transformation. Salley Timmel and Ann Hope were instrumental in adopting this method to train women local communities in Africa. The training adapted in Plan's local context intends to make this methodology available to people working in the community throughout Plan's Child Survival Project. The approach aims at providing community leaders with skills to empower their community to identify needs and work in a participatory process to meet those needs.

3.0 REQUIREMENT OF TECHNICAL ASSISTANCE

Selected CS Project staff needs to be trained to run recent up-dated version of EPI Info. The CS project has limited knowledge in this area so far. The Health Advisor, CS Project Coordinator, HMIS and Training Coordinators are potential staff that will benefit from this training.

Project and partner staff that had initial basic training on transformation for health approach requires follow-up training. For this the project requires technical support to organize the follow-up workshop. In addition, the project also needs technical backstopping to implement the TFH approach at community level while piloting it in selected communities of the project area.

CS Project staff has realized the need of frequent technical support from USNO based admin/finance personnel to clarify some grant related issues.

Since the project is heavily involved in managing a variety of training courses to meet the project goal, having short-term training on training course management should capacitate Training Coordinator. Project has also felt need of training the HMIS Coordinator in the area of database and office management computer updated courses like: Oracle, C++, MS Project, MS Windows, and MS Office. This will enable the project to utilize advance data analysis.

4.0 PROJECT CONSTRAINTS AND ALLEVIATING STRATEGIES

CONSTRAINTS	ALLEVIATING STRATEGIES
MOH Staff turnover: MOH HF turnover in the project area has been observed during the last quarter of year one.	Project focus on TBAs and FCHVs who stay in the communities. Project will arise this issue during regular coordinating meetings at district and central level.
Many TBAs and some FCHVs are from the untouchable castes and thus usually cannot directly assist birth in some families/communities and may have trouble interacting with some women in community.	Review meeting will develop confidence among TBAs and CS staff in the communities will stress FCHVs, importance and skill of TBAs and FCHVs; organizing TBA/FCHV quiz contest in front of communities has been considered by the project. Non-Formal Education (NFE) materials and discussion session with mother-in-laws and husbands will also emphasize the important role of TBA and FCHV. Project may also train some FCHVs in TBA work. In first year FCHVs upon completion of FP/MNC training started to attain the deliveries. In year two, the project will be encouraged to attain the deliveries where untouchable issues exist. Further, alternatives to address the issue will also be explored and tested in year two.
Very low literacy among female beneficiaries population and among TBAs and FCHVs.	Plan Nepal is running literacy classes in many of the project's old VDCs; as an incentives project FCHVs will be encouraged to join Plan's literacy classes and micro credit. Besides, the project will coordinate with all financial institutions and NGOs who have been involved in literacy classes. The project coordinate to use the forum even for enhancing the level of literacy among the women which also include TBAs and FCHVs.
Supplies of drugs in MOH health facilities using about 4-5 months in the project area.	Revolving drug scheme to be set up in all health facilities on a cost recovery basis (with some subsidies in the beginning). Community based TBAs and FCHVs will also stock a regular monthly supply of medicine in cost recovery basis. In the first year CS Project has already supported all local health facilities equipment, materials needed to operate the CDP program. Likewise TBAs and FCHVs were provided FCHV and TBA kit box along with BCC materials to deliver and execute the volunteer work they are trained for.
Beneficiary population speaks a variety of local dialects (Bhojpuri is the main dialect in the project area). Although, Nepali is widely spoken most of women, beneficiaries and FCHVs and TBAs speak only Bhojpuri.	Project has given priority to hiring local staff. However, in March 2002, weeklong intensive language training on local dialect (Bhojpuri) was organized for the staff to elevate their difficulties in communicating in the local language.
Project beneficiary population sometimes has a negative attitude on recent development workers. Development Projects and Funds in the past have disrupted traditional, well-functioning community participation systems. The caste system and the large gap between rich landlords and poor tenant farmers in the Terai, particularly bad in project area, have created great social and economic inequalities.	Time spent in the communities by project staff is critical to build trust and mutual knowledge. CS Staff spends 80% of their time in the communities with two days a month at CSP field office for coordination meetings. Staff ability to speak local language is essential to adopt a long-term framework for project planning is an essential part of Plan's development philosophy.
Extreme poverty in project area. Most of the project area has no electricity and latrines. It is estimated that half of all newborns under weight.	The CS Project has been implementing credit/income generation activities in several VDCs of the project area. FCHVs and TBAs working with CS Project area also encouraged being involved in such credit center to disseminate health message. CS Project has already developed BCC materials with key CS messages to use the forum by micro-finance institutions in previous project cycle. The same approach and BCC materials are being adopted in current project.
Distance to emergency obstetric care (up to an 8 hour journey to district hospital)	In addressing this issue FCHVs and TBAs are encouraged to establish local fund and emergency obstetrics evacuation scheme at the

CONSTRAINTS	ALLEVIATING STRATEGIES
	community level. Further women of reproductive age, families and community will be oriented for early identification of the danger signs during pregnancy, delivery and post natal period through mothers group meeting by FCHVs and TBAs. Similarly, relevant forums available in the project area will also be utilized. Gender incorporation for the safer-motherhood package targeting to mother-in-laws, father-in-laws and husbands of pregnant and lactating mothers implemented in previous cycle will be also replicated to address this issue even in current project.
Community's reliance on Traditional Healers for medical problems.	At present the project has no plan to train Traditional Healers. However, in previous cycle a majority of key traditional healers were oriented on CDD and ARI. Therefore project staff will try to encourage FCHVs, TBAs and local health facility staff to get help from them in CS activities.
Lack of follow-up to government run health posts once referrals given by FCHVs	For referrals, project is hoping that improved HF services and ample drug supplies will attract communities for treatment and referrals.
Transition process in Plan from an assistance/charity organization to a development organization.	Plan Nepal staffing and program are undergoing changes in Nepal as well as at headquarters as Plan switches over to a more centralized development organization. Staff is adapting to the new framework and working closely with technical back stoppers regionally and in headquarters.
Monsoon rains (four months from June-September) flood in most of the project area effect on the transporting systems between field office and community.	Field based CS staff has been providing needed support during flood to mitigate the adverse effects.
Working with partners in network sounds good but time consuming	Exploring other ways to communicate with partners', which is strategically and economically viable. It helps on making the project more sustainable.
Meeting of the working group to support the CS Project could not take place as planned date, as there were some political disturbances when meeting was scheduled.	The issue has been raised due to frequent and long duration nation wide strike called by Maoist and dissolving of local political bodies of government during the fourth quarter period. However, the project is trying to convene this long awaited meeting in near future. In this connection, the preparatory task for the meeting has already been completed.
Insufficient institutional support to initiate and run Community Drug Program due to dissolving of local elected bodies.	The project has been trying to maintain the program by increasing the staff visit and trying to get support from the community. This problem has been expected to be solved after the election of the local bodies as the government has already announced for the election of local bodies.
The project has made lots of adjustments in timing the activities despite the unprecedented political disturbances observed during third and forth quarter of year one.	

5.0 CHANGE IN PROJECT DESIGN

No significant change has been made in project design and implementation.

6.0 PROJECT RESPONSE TO DIP REVIEWER'S SUGGESTIONS

- **Revisit the Rapid CATCH indicators that were submitted for this DIP regarding comparability of baseline questions (i.e., for certain indicators, children 0-11 months were the basis of 0-23 months), contacts CSTS further discussion and clarification.**

Adjustment will be made in future surveys to comply with Rapid CATCH indicators and age group.

- **Check the estimation of birth (98,000+) in the project area for accuracy.**

A total birth/new born (77,025) is calculated somewhat lower than the previously estimated number (98,241) for the entire project period (5 years). This new figure has been estimated on the basis of national census 2001. Accordingly, the other target beneficiary has also been recalculated as 110,418 for women of reproductive age (15-49 years) and 78,870 for children under five years of age.

- **Discuss sustainability issues in the original project area regarding micro- finance and environmental health and linkages to be made with community health volunteers.**

Selected Female Community Health Volunteers (FCHVs) were trained on facilitating skills in order to deliver the BCC package developed by CS Project through micro-credit centers. The aim of training FCHVs on facilitation skills has presumed the continuation of such a program even after the phase out of the project through the skills and capacity they developed during the project period. The project has been observing effective continuation of similar program in the previous project area. In this connection, active involvement of FCHV in delivering health messages through micro-credit forum by using the pictorial flip chart (BCC) has been experienced effectively by the project staff and FCHVs.

- **Provide a more detailed explanation of the overall BCC strategy timeframe for its development and implementation.**

Detailed explanation of the overall BCC strategy timeframes for its development and implementation:

In order to develop a project wise BCC strategy, messages delivery have been directed to target individuals and groups in the project area through the three channels which includes, one to one BCC session, small group forums and message targeting large group audience. The following table demonstrates some major BCC strategy time frames along with its development and implementation.

BCC Strategy	Time frame			Intervention Covered
	Development/ Production	Implementation	Present Status	
Development of pictorial classification card (modification) and application	Dec. 2001 – Mar. 2002	Apr.-2002- Throughout the project period	Development/ Production and Implementation started Completed as per time frame	CDD, PCM, MNC, Spacing
Positioning of bill boards with key CS messages (pictorial)	Mar.2002- September 2004	Positioning of bill board started from June 2002	Out of 100 billboards being planned to develop, 45 boards have already been developed and positioned as of Aug. 2002. The remaining will be completed in year 2 and year 3.	CDD, PCM, MNC, Spacing, Nutrition, EPI, HIV/AIDS
Staging street/village drama	Oct. 2002- Dec. 2002	Jan. 2003-Jun. 2005	Selection of NGO to undertake the initiatives is under process	CDD, PCM, Spacing, Nutrition, EPI, HIV/AIDS
Staging of puppet shows	Oct. 2002- Dec. 2002	Jan. 2003-Jun. 2005	Selection of NGO to undertake the initiatives is under process	CDD, PCM, Spacing, Nutrition, EPI, HIV/AIDS
Onsite coaching at workplace of FCHVs and local facility staff	Feb. 2002-Sep. 2006	Jan. 2003-Jun. 2005	Onsite coaching of local health facility staff, volunteers, mother's group members and local health facility support committee have been started from Feb. 2001.	CDD, PCM, Spacing, Nutrition, EPI, Community Drug Program (CDP)
Flipchart of Newborn care	April 2003	August 2003	Selection of NGO to undertake the initiatives is under process	Newborn care
Reproduction of calendars to FCHVs/TBAs	Jan. 2003	April 2003	Selection of NGO to undertake the initiatives is under process	CDD/EPI/HIV/AIDS
Launching of Audio Tower program with key CS messages through child club	Jan. 2003-Sep. 2003 (Reactivation of existing child club and formation of new child club)	Oct. 2003-Sep. 2005	Reactivation of existing child club and formation of new club initiated	CDD, PCM, Spacing, Nutrition, EPI, HIV/AIDS, Early child marriage and Child labor.

- ❑ Complete the objective for increased access to service and supplementing (page 39) regarding quantitative indicators.

The objectives for the increased access to service and supplementing and supplies regarding quantitative indicators have been completed as follows:

Objectives	Indicators
<p>Increased access to services and supplies</p> <p>Communities have increased sustainable access to health education, quality care and essential medicines</p>	<p>Control of Diarrheal Disease</p> <p>1. Increase the number of FCHVs from 20 % to 80 % who distribute ORS and have supplies</p> <p>Pneumonia Case Management</p> <p>2. Increase % of communities with access to cotrimoxazole (through FCHVs and CDP) by 50%</p> <p>Family Planning and MNC</p> <p>3. Increase the number of FCHVs and TBAs who distribute contraceptives from 5 % to 90 %</p> <p>4. Increase the number of FCHVs and TBAs who sell / distribute CHDK 20 % to 60 %.</p> <p>General</p> <p>5. Increase the number of VDCs where ORS, Clean Home Delivery Kits and Cotrimoxazole are available year around.</p>

- ❑ **Provide CDD and other baseline data from the LQAS and supplementary (page 39) regarding quantitative indicator)**

CDD and other baseline data from the LQAS and supplementary regarding quantitative indicators has been completed as follows:

Control of Diarrheal Disease

1. Increase the % of children <5 presenting at the health facility with simple diarrhea who received ORT from 29 % to 80 %
2. Increase the percentage of FCHVs and TBAs from 30 % to 90 % who can correctly demonstrate the preparation of ORS and demonstrate SCM for DD according to MOH protocols.
3. Decrease the % of children <5 presenting at the health facility with simple diarrhea who received an antibiotics of anti diarrheal from 75 % to 10 %

Pneumonia Case Management

4. Increase % of children referred in last two weeks with pneumonia who are treated with cotrimoxazole (not measured at Baseline)
5. Increase % of pneumonia cases management (in children <5) presenting at the health facility that receive an appropriate antibiotic from 69 % to 80 %

Family Planning and Maternal and Newborn Care

6. Increase percentage of FCHV, TBA and health facility staff that correctly counsel and provide FP methods according to MOH protocols from 25 % to 80 %.
7. Increase the percentage of mothers of children <12 months who had at least one prenatal visit during pregnancy from 45% to 70% (based on cards).
8. Increase from 32 % to 65 % the % of mothers with children <12 months with last delivery attended by trained provider.
9. Increase % of MCHW that are trained and practice MOH protocol for prenatal, delivery and postnatal care 55 % to 100 %.
10. Increase the % of women suffering obstetric emergency that are referred to next level of care and treated by MOH clinicians

- ❑ **Provide a detailed diagram of health information system including information on data collection, by whom, how regularly and between which entities. Also, include a more detailed description as to how this will be integrated with the existing MOH HIS.**

Records of local health facilities, district health office record, CSP records, data obtained from baseline LQAS, mid-term LQAS, biannual LQAS (being performed for monitoring ongoing progress), baseline Integrated Health Facility Assessment (IHFA) and final IHFA and several qualitative assessments (being conducted during project period) are the major sources of health information for the project.

Further, the project is also collecting information through monthly supervisory visits by using supervisory checklist developed in previous project (improved in the first year of the current project).

All the information being gathered will be analyzed at various levels (community level by FCHVs, health facility level by local health facility staff, field area level by field area supervisors and project level) and the data is used for decision levels. HMIS coordinator with the help of CS Project Coordinator has to provide assistance needed for collecting and analyzing data to the project and MOH local staff.

At the village level project is also piloting community data board aiming to display major information related to major project intervention through community volunteers (FCHVs and TBAs). The information/indicators being displayed will be in pictorial form containing information about the ongoing progress being achieved through the assistance of CS project. The following table and the diagram show methods of data collection along with its frequency and entities being involved in the data collection process and their inter-linkages. Besides, the diagram below shows how information at different levels being collected and integrated with the existing MOH HMIS.

Indicators / data to be collected	Methods	Frequency	By Whom
Behavior:			
Control of Diarrheal Disease			
1. Increased the % of children under 2 whose diarrhea is managed at home by:	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
2. Increase the % of children under 2 (who had diarrhea in the last two weeks) who were given the same or more:	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
3. Breast milk from 62 % to 80 %.	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
4. Liquids from 24 % to 65 %.	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
5. Solid/semi solid food from 27 % to 50 %	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
6. Increase the number of children < 2 years treated with ORT in past two weeks from 16 % to 50 %	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
Pneumonia Case Management:			
7. Increase the % of mothers seeking medical care from a trained provider (health facility, trained volunteers) from 79 % to 90 % when their child shows signs of pneumonia (rapid breathing, chest in –drawing)	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
8. Increase the mothers of children <2 years who know at least 3 signs of pneumonia from 15 % to 50 %.	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
Family Planning / Maternal and Newborn Care			
9. Increase from 54 % to 80 % the % of women of reproductive age who know at least one place where they can obtain a method of child spacing	LQAS Survey	Baseline LQAS, Biannual LQAS, Final LQAS	CS Project (Field staff)
10. Increase from 26 % to 50 % the % of mothers of children <2 who know at least 2 danger signs in pregnancy.	LQAS	Baseline, mid-term, final and biannual LQAS	CSP/ Local Health Facility staff
11. Increase the % of mothers with children <1	LQAS	Baseline, mid-term, final	CSP/ Local

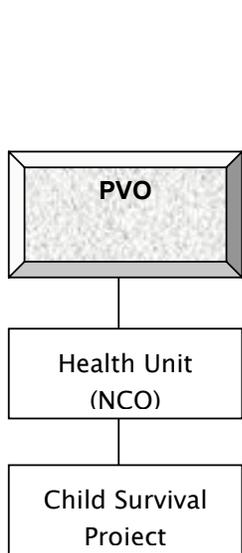
Indicators / data to be collected	Methods	Frequency	By Whom
who have had 2 TT from 13 % to 50 %		and biannual LQAS	Health Facility staff
12. Increase from 36 % to 65 % the % of mothers who consumed folic acid supplements for at least one month while pregnant with the youngest child < 2 months	LQAS	Baseline, mid-term, final and biannual LQAS	CSP/ Local Health Facility staff
13. Increase % of mothers using Clean Home Delivery Kits for last delivery from 11 % to 40 %	LQAS	Baseline, mid-term, final and biannual LQAS	CSP/ Local Health Facility staff
<u>Increased access to Services and Supplies:</u>			
Control of Diarrheal Disease			
1. Increase the number of FCHVs from 20 % to 80 % who distribute ORS and have supplies	Monthly supervisory visits (Local Health Facility records/CSP records)	Quarterly (monthly reports are collected but reports are generated by consolidating and analyzing it on a quarterly basis)	Local Health Facility Staff/ CSP Field staff
Pneumonia Case Management			
2. Increase % of communities who have access to cotrimoxazole (through FCHVs and CDP) by 50% (There is not specific operational definition for adequate access to PCM used by MOH/Nepal)	Monthly supervisory visits (Local Health Facility records/CSP records)	Quarterly (monthly reports are collected but reports are generated by consolidating and analyzing it on a quarterly basis)	Local Health Facility Staff/ CSP Field staff
Family Planning and MNC			
3. Increase the number of FCHVs and TBAs who distribute contraceptives from 5 % to 90 %	Monthly supervisory visits (Local Health Facility records/CSP records)	Quarterly (monthly reports are collected but reports are generated by consolidating and analyzing it on a quarterly basis)	CS Project (Field staff)
4. Increase the number of FCHVs and TBAs who sell/distribute CHDK 20 % to 60 %.	Monthly supervisory visits (Local Health Facility records/CSP records)	Quarterly (monthly reports are collected but reports are generated by consolidating and analyzing it on a quarterly basis)	CS Project (Field staff)
General			
5. Increase the number of VDCs where ORS, Clean Home Delivery Kits and Cotrimoxazole are available year around.	Monthly supervisory visits (Local Health Facility records/CSP records)	Quarterly (monthly reports are collected but reports are generated by consolidating and analyzing it on a quarterly basis)	CS Project (Field staff)
<u>Quality of Care:</u>			
Control of Diarrheal Disease			
1. Increase the % of children <5 presenting at the health facility with simple diarrhea who received ORT from 29 % to 80 %	Integrated Health Facility Assessment	Quarterly (monthly reports are collected but reports are generated by consolidating and	CSP/Local Health Facility Staff

Indicators / data to be collected	Methods	Frequency	By Whom
	(IHFA)	analyzing it on a quarterly basis)	
2. Increase the % of FCHVs and TBAs from 30 % to 90 % who can correctly demonstrate the preparation of ORS and demonstrate SCM for DD according to MOH protocols to MOH protocols.	Supervisory visits	Quarterly	CSP/Local Health Facility Staff
3. Decrease the % of children <5 presenting at the health facility with simple diarrhea who received an antibiotics of anti diarrhea from 75 % to 10 %	Integrated Health Facility Assessment (IHFA)	Baseline and Final IHFA	CS Project (Field staff)/Local Health Facility records
Pneumonia Case Management			
4. Increase % of children referred in last two weeks with pneumonia who are treated with cotimoxazole	Monthly supervisory visits (Local Health Facility records/CSP records)	Baseline and Final IHFA	CSP Staff and Local Health Facility Staff
5. Increase % of pneumonia cases (in children <5) presenting at the health facility that receive an appropriate antibiotic from 69 % to 80 %	LQAS	Quarterly (monthly reports are collected but reports are generated by consolidating and analyzing it on a quarterly basis)	CSP Staff and Local Health Facility Staff
Family Planning and Maternal and Newborn Care			
6. Increase % of FCHV, TBA and health facility staff who correctly counsel and provide FP methods according to MOH protocols from 25 % to 80 %.	Currently 55 % MOH SHP are staffed by trained MCHWs. These MCHWs are following MOH protocol.	Baseline, Biannual and Final LQAS Survey	CSP staff
7. Increase the % of mothers of children <12 months who had at least one prenatal visit during pregnancy from 45% to 70% (based on cards)	LQAS Survey	Baseline, mid-term, biannual and final LQAS	CSP staff and HF staff
8. Increase from 32 % to 65 % the % of mothers with children <12 months with last delivery attended by trained provider	HP /SHP and DHO records	Baseline LQAS, Biannual LQAS, Final LQAS, Quarterly	LHF staff/DHO/CSP
9. Increase % of MCHW that are trained and practice MOH protocol for prenatal, delivery and postnatal care 55 % to 100 %.	DHO and HP/SHP records	Quarterly	LHF staff/DHO/CSP
10. Increase the % of women suffering obstetric emergency that are referred to next level of care and treated by MOH clinician	Community Based Maternity Home (CBMH), HP/SHP and District Hospital Records	Quarterly	CS staff
Institutional			
1. 80 % of VDCs have at least three mothers' groups with demonstrated health promotion	CSP records	Quarterly	CSP

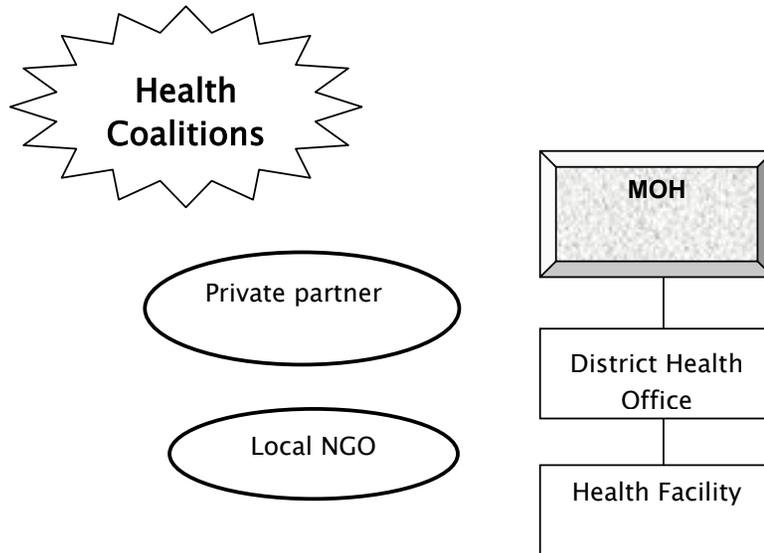
Indicators / data to be collected	Methods	Frequency	By Whom
activities and plans for future BCC activities (not included in baseline)			
2. 25 % of HFCs or mothers group that are planning and monitoring local health activities (not included in the baseline)	CSP records	Quarterly	LHF staff/DHO/CSP
3. 25 % of FCHVs have established community health funds and mechanism for cost recovery (not included in baseline)	CSP records	Quarterly	LHF staff/DHO/CSP
4. % of FCHVs who are involved in education and community mobilization efforts 8 times in last 12 months from 10 % to 70 %.	Monthly supervisory visits/review meetings	Monthly	CS Field staff and LHF staff CSP
5. All NGO partners have project plans and monitoring system in place	CSP records	Annually	CSP staff
6. 40% of VDC commit some financial support to CS activities at community level from 10 % to 60 %.	CSP records/LHF records	Quarterly	CSP/ LHF staff
7. Increase from 7% to 50 % the local health facilities that have established CDP's and community drug management committees	CSP/DHO records	Quarterly	DHO and CSP records
8. 25% of health workers had at least one supervisory visit from the MOH in the last 3 months from 20 % to 75 %.	Supervisory visits	Annually	DHO and CSP staff

Data Collection of HIS in CS Project

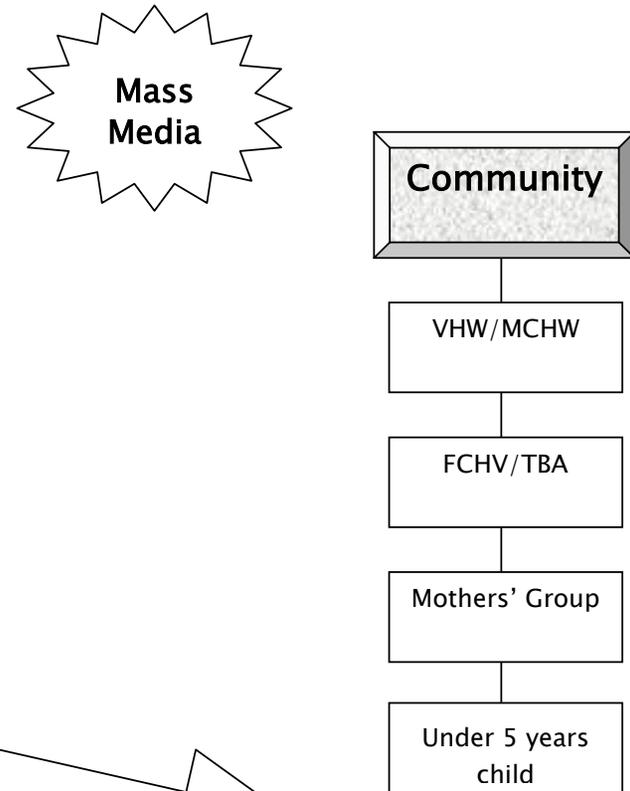
PVO



Local Partners



Community/Individual



- **Update the WHO chart (page 59) on proper diarrhea treatment with more recent MOH/MCH guidelines**

The chart for the antibiotic treatment of Shigella dysentery and cholera as mentioned in page 59 of DIP has been replaced by recent WHO/MOH/Nepal/IMCI protocol as given below:

Dysentery

First line Antibiotic: Cotrimoxazole

Second Line Antibiotic: Nalidixic Acid

Age or Weight	Cotrimoxazole (Trimethoprim + Sulfamethoxazole) 2 times/day X 5 days		Nalidixic Acid 4 times/day X 5 days	
	Adult Dose 80 mg Trimethoprim + 400 mg Sulfamethoxazole	Child Dose 20 mg Trimethoprim + 100 mg Sulfamethoxazole	Tab 500 mg	Liquid 300 mg per 500 ml
2-4 months (4-<6 kg)	½	2	1/8	1.0 ml
4-12 months (6-<10 kg)	½	2	¼	1.5 ml
12 months – 5 year (10-19 kg)	1	3	½	3.0 ml

Cholera

First line Antibiotic: Tetracycline

Second Line Antibiotic: Cotrimoxazole or Erythromycin

Age or Weight	Tetracycline 4 times/day X 3 days	Cotrimoxazole (Trimethoprim + Sulfamethoxazole) 2 times/day X 3 days		Erythromycin 4 times/day X 3 days
	Capsule 250 mg	Adult Dose 80 mg Trimethoprim + 400 mg Sulfamethoxazole	Child Dose 20 mg Trimethoprim + 100 mg Sulfamethoxazole	Tab 250 mg
2-4 months (4-<6 kg)	-	½	2	¼
4-12 months (6-<10 kg)	-	½	2	½
12 months – 5 years (10-19 kg)	1	1	3	1

- **Revisit the definition of adequate access (page 65) to PCM within 2 hours by foot as an acceptable and adequate amount of time to reach a trained health provider**

There is no specific operational definition for adequate access to PCM that has been used by MOH in regard with an acceptable and an adequate amount of time. This has been informed by IMCI national coordinator of MOH.

7.0 PHASE OUT PLAN AND STEPS TAKEN

Due to the opportunities provided by decentralization, the project expects that the MOH, partner NGOs and local community groups (VDCs, HFSCs, mothers' groups) will eventually assume all activities. This transfer will take place over a period of time, marked by specific steps (*see DIP page no. 27*). However, the following table details this process:

A. Full intervention	B. Partial Intervention	C. Sustainability
<ol style="list-style-type: none"> 1. Creation of awareness 2. Restructuring of committees 3. Management training 4. Logistic and financial management 5. Technical competence training 6. MOH coordination and support 7. Pilot of community HIS 	<ol style="list-style-type: none"> 1. Joint supervision by Plan and MOH to health facilities and volunteers 2. Refresher courses 3. HIS support for analysis and decision making, scaling up of the community HIS 4. Reinforcement of monthly health facility support committee meetings 5. Cost recovery system mechanism functioning 	<ol style="list-style-type: none"> 1. DHO supervises health facilities, and health staff supervisors volunteers 2. Health facility in charge organizes outreach sessions for immunizations and MNC 3. Logistic system functioning with cost recovery and MOH support 4. Health decision making and planning at health facility level 5. Information system are functioning 6. Empowered community representatives to demand services from the health facility

Financial support will continue from the MOH and the district government (DDC). Although Plan has a long-term commitment to Bara district and will continue to provide limited support, the expectation is that the district will not have to depend on large amounts of outside donor funding.

The largest recurring costs are in training, drugs/supplies and transportation (outreach and logistics). The project's approach to these areas promotes independence from project funds by training staff as trainers, establishing revolving funds, building the management capacity of the MOH and local government organizations and supporting decentralization. However, the project is aware that the threat of dependence on project funds is high and will closely monitor recurring costs during its periodic budget review meetings. These costs will be discussed in detail with the stakeholders in order to find solutions before the project ends.

As mentioned earlier, the project will support the establishment and strengthening of cost recovery system such as user fees, CDPs, revolving funds for supplies and drugs provided by FCHVs and TBAs (contraceptives, clean home delivery kits, cotrimoxazole, iron/folate, ORS etc.)

8.0 SETTING OF PROGRAM MANAGEMENT

The aim of the Plan CS project is to leave a sustainable local health system in place that is supported by the District Health Office. For this, project staff needs to work very closely with DHO and local health facility staff. In line with this need the project area has been divided into seven areas and staffed with project personnel. The assigned project staff worked very closely work with local facility staff and health volunteers (FCHVs and TBAs), mothers group, local health facility support committee and partners for improvement of child survival and safer motherhood activities in the area. There are 22 field staff members, which include: Community Health Officers (CHO- 7) and Assistant Community Health Officers (ACHOs-15). In addition project has also 6 core technical staff, which also includes CS Project Coordinator to support field team. Training, health information system, BCC and administrative and financial function and over all coordination and management of the project activities has been carried out by the core project team. The core group is also technically and managerially supported by Plan Nepal's Country Office through Program Unit Office Birgunj. It also receives much support from the National Health Coordinator. In addition the project is also getting technical, management and administrative backstopping from Plan's Washington Office. These back stoppers are the main link between Plan and USAID regarding the project.

The management structure of the project has been designed in such a way that the project operation and decisions will follow the participatory approach. Project staff and the different entities in the project have distinct roles and responsibilities. Daily planning and project related decision-making will occur at the field level. However overall work will be supported by project management and reviewed during monthly staff review meeting. Upper level management at Plan will receive information from monthly and quarterly reports. They will hold regular coordination meeting to discuss the project progress and share concerns.

Field teams are assigned in seven field areas. Each team consisting of one Field Area Supervisor and 1-3 Assistant Field Area Supervisors who work with FCHVs, TBAs, Mothers Group, and Local Health Facility Support Committees. Each team works with approximately 14 Village Development Committees (VDCs), a maximum of 126 FCHVs, 42 trained TBAs, 14 support committees and fourteen mothers group. The Technical Coordinators will strengthen the abilities of NGO Partners to perform these activities. The Project Coordinator and Senior Community Health Officer will coordinate work with the district MOH (DHO). The Senior Project Coordinator will be responsible for overall management and technical quality of the project as well as being the link with the country office and the technical backstopping team. The Assistant Field Area Supervisors will report the Field Area Supervisor who heads the field team. The Field Area Supervisors will report to the Assistant Project Coordinator. The Technical Coordinators and the Senior Community Health Officer will report to the Project Coordinator. The Project Coordinator will report for administrative matters to the Program Unit Manager and for technical issues to the National Health Coordinator.

In addition, a functional CS working group will be formed and briefed biannually at district level. The working group comprises, DDC Chairperson, Vice-Chairperson, LDO, DHO, PHO, Project Coordinator, National Health Coordinator and representatives from Child Health Division and Family Health Division of MOH.

9.0 FINANCIAL MANAGEMENT

The APC will send monthly financial reports to the PC. The PC will submit quarterly financial reports to the Program Unit Manager (PUM) who will receive the reports and then pass them on to the Operations Support Managers (OSM). The program will track cost incurred using the already established financial system of Plan Nepal. Expenditures are broken down with specific codes for labor, equipment, supplies, and facilities. Project expenditures reports are sent directly from Plan Nepal to the US Office of Plan where they are reviewed for USAID compliance and submitted to USAID. The budget is adjusted as necessary based upon the DIP and periodic reviews by the PC and US based administrative team. Plan and other field staff develop the budget with input, advice from HQ technical advisors and the US based administrative, and grants accounting team. Plan's corporate general ledger system assigns a project ID number to enable accurate tracking of project expenditures. After the US Office submits report to USAID and receives the reimbursement, funding transfers are made on a monthly basis from the US office to the CS project to reimburse project expenditures. Plan's organizational finance system enables Plan USA to separately track donations from USAID and non-USAID sources.

The project will work with partner organizations to ensure monthly financial reporting on funds spent through these organizations.

10.0 PROJECT MANAGEMENT

10.1 Human Resources

Community level Volunteers (4-8 hours per week): FCHVs will be responsible for working with mothers in the project intervention areas. They will be responsible for identifying Pneumonia and diarrhea and providing first level treatment as described in the intervention sections. TBAs will be responsible for working with SHPs and HPs to manage revolving drug program and will work with communities to identify health problems and solutions. Mothers' club will meet in order to receive health education and discuss health issues.

There are nine FCHVs and three TBAs per VDC (882 FCHVs and 294 TBAs). With the 1996 DHS estimate of 76,658 households, each FCHV will cover roughly 87 families.

MOH: At the SHP and HP level, staff will provide IMCI and MNC services as well as supervise FCHVs and TBAs. An Auxiliary Health Worker (AHW) is in charge of the SHP, which is staffed with a Village Health Worker (VHW) and Maternal Child Health Worker (MCHW). A Health Assistant is In-charge of the HP, which is staffed with an Auxiliary Nurse Midwife (ANM), an AHW and VHW. MOH staff will work 100% of their time on service delivery and community education as mandated by the MOH.

NGO Partners: The NGO partners will provide staff for training and BCC as needed by the project

Core CS Staff (100 % effort): Core staff consists of one each of the following: Project Coordinator (PC), Sr. Community Health Officer (Sr. CHO), Administrative/Finance Officer, BCC Coordinator, MIS Coordinator and Training Coordinator. Core staff consists of seven Field Area Supervisor and 15 Assistant Field Area Supervisors, 1 driver and 2 Office Attendants. The MIS Coordinator baselines, monitoring and LQAS. The field area supervisors and assistant field area supervisors work directly with health facility staff and community volunteers to monitor performance and provide technical assistance. Plan attempts to hire staff from the area that speaks local dialects when at all possible. Those who do not will receive intensive language training will be provided upon their recruitment.

Plan Nepal Staff: The Health Coordinator will dedicate 10 % of time. The Health Associate and the administrative backstopper will dedicate 25 % of time.

10.2 Communication System and Team Development

The technical backstopping team at Plan's Washington DC Office passes on relevant technical information to the field office as they receive it, particularly resources from CORE working group. The CS Project Coordinator is in the CSTS list-serve and receive Bookmarks but does not currently have access to Internet. Until access is available the PC will contact the technical backstopping team about those Bookmarks that interests him and the information will be emailed. Other resources will be sent by courier or emailed as they become available. The PC, the National Health Coordinator and majority of project staff are fluent in English and do not require to translate documents. Due to the project staff work load, the responsibility of reviewing information and determining which resources are pertinent belong to the technical backstopping team in the U.S.

Because of Plan's experience in the field of child survival, exchange between country programs is vital. Plan Nepal is in contact with the staff in Ghana, which just completed a CS project, and the PC attends workshops in other countries as often as possible. In 1999, Plan Nepal hosted a CS Lesson Learned Workshop. In 2000 Nepal staff attended an NGO Network Workshop in Kenya and in 2001 Nepal CS staff participated in lessons learned workshop in Senegal. Recently, the Project Coordinator participated in Global Health Council Conference in Washington DC (May 2002). Likewise, he also presented a paper at data for action workshop on "Using Biannual LQAS Data to Improve Child Survival and Safe Motherhood in Nepal: Program Results From 1999-2001" organized by CSTS and CORE group in USA (September 2002).

The project office has reliable email, telephone, and fax capabilities. Although the office does not currently have a connection to the Internet, the technology is available, and plans are underway to provide that resource.

10.3 Relationship with Local Partners

The main partners of Plan CS Project are, District Health Office (DHO), Local Health Facility Centers (PHC/HP/SHP under MOH) of the project area, and Child Welfare Society (CWS). Some other partners are General

Welfare Pratisthan (GWP), Nepal Family Health Project and Nepal Pediatrics Society (NEPAS). Plan CS Project Coordinates with the local partners while designing and implementing programs in the project area. The project activities implementing through above partners are designed and implemented in close collaboration with the community. There are frequent meetings with the partners with regard to the project activities. The project had included the staff of the partner organizations in relevant training to enhance their capabilities in respective interventions. In year two, the project has aimed to organize a workshop to assess the organizational capacity of the partners. This will help to identify the need of partner organizations required to manage the CS activities being implemented.

10.4 PVO Coordination/Collaboration in Country

Save the Children UK, (SCFUK), Care Nepal and ADRA/ Nepal are the collaborating PVOs. Regular communication and sharing through e-mails and meetings have taken place regularly. This has been very helpful to enrich field level capacities in terms of technical inputs in order to meet the project objectives.

10.5 Other Relevant Management Systems

The project follows Plan Nepal's system for procurement and logistic. All requests for equipment and supplies are made to the Support Center for the Rautahat/Bara Unit. The support center examines prices and quality from several suppliers, collecting at three official bids on items costing more than \$ 250 as per USAID guidelines. The support center makes a purchase order once the vendor is chosen, and the item are shipped directly to the CS Project Office. The CS is also responsible for purchasing and delivering items bought in Kathmandu. The Administrative/Finance Officer inspects the goods upon receipt to ensure their quality. Items valuing more than \$250 are recorded in the inventory at the SC. A copy of this inventory is also maintained at the CS project office for better tracking. Each item is given a number, which is sent to regular users. Items valued at less then \$ 250 is recorded in the same way, but the inventory is maintained only at the CS Project Office.

Equipment to be purchased includes a vehicle, motorcycle, bicycles, generator, computers and peripherals, cameras and other office equipment/supplies. The project does not foresee any challenges or difficulties in procuring any equipment or supplies.

10.6 Organizational Capacity Assessment

Organizational assessment of partner organizations has not been performed yet.

11.0 FIELD VISIT

With the objective of accessing in field situation of the project area, a field supervision was also carried out while preparing this report. In this connection, field visit was made at Southern Jhitkaiya VDC, Ward No. 4 and Kawahigoth VDC, Ward No. 8 of Bara District. Based upon a brief discussion made with FCHV of Southern Jhitkaiya Ms. Raj Devi Pathak and AHW of Hardia HP Mr. Nagina Giri, both of the contacted persons were found quite satisfied in doing their job due to Plan's support in terms of institutional (FCHVs, TBA and Mothers Group strengthening), support on supplies, equipments, medicines and furniture, regular training and follow-up visit by Plan CS Project Staff and so on. Use of inventory registration forms in the HP and active participation of FCHV in the health activities were observed during the field visit. The outcome of field visit obtained from the contacted sources of various service areas is given in the following boxes:

Box: 1

Information obtained from FCHV of Southern Jhitkaiya VDC, Ward No. 4 on October 22, 2002.

The FCHV was well trained, skilled and motivated. She was working as FCHV since decades in the area and has received training from Plan CS Project in July 2002.

The FCHV was found fully aware about her own role and responsibility as well as support provided by Plan CS Project. Similarly, incentive being provided by Plan was also identified as one of the encouraging factors for FCHVs activities' performance.

One of the major changes that have been experienced after the Plan CS Project intervention was increasing in the number of mothers receiving iron tablets. As per the information received from the consulted FCHV of Southern Jhitkaiya VDC, Ward No 4, there are 15 women who are regularly receiving iron tablets including 6 women after delivery.

While asking about the problems of performing the job to the FCHV, selling medicines and other equipments and to change social behavior with regard to iron consumption and growth of children's weight vis-à-vis causing difficulties for normal delivery have been noticed to be some of the major problems. However, the effort and commitment of FCHV was observed to be quite encouraging. This was also observed in a mothers' group meeting that was held during the day of field visit in the presence of CS Project Coordinator and other field study members.

Box: 2

Some major responses Mothers Group Meeting at Southern Jhitkaiya VDC, Ward No. 4 on October 22, 2002

FCHV organized a mothers' group meeting. 25 mothers attended it. The main focus of the meeting was related to maternal and newborn care.

During the meeting the participants accepted that the needful mothers were getting iron tablets from the FCHV. The participant mothers were also aware of the reasons for taking Tetanus Toxoid.

While asked to a pregnant mother who entered the meeting during discussion about status of her TT consumption, the mother was of the opinion that consumption of iron tablets increases the weight of the baby causing difficulties for delivery.

The participant mothers were also aware about national schedule of Vitamin "A" dosing program and distribution of de-worming tablet for children aged 6 months to 59 months and 24 months to 60 months respectively.

Box: 3

**Profile of Hardiya Health Post, Kawabigotha VDC, Ward No. 8
on October 22, 2002**

- Four MOH staff including 2 AHWs, 1 ANM, 1 VHW
- Open six days/week from 10 am to 4 pm.
- Approximately 55 patients on an average receive services.
- Approximately 60 women of reproductive age were given Depo injection.
- Drug in stock: Iron, Pills, Vitamin B (Project staff assume para-citamol, Jeevan Jal, Pills and condoms are also in stock)
- AHW in-charge when asked how many essential drugs HP should stock: 150
- Active support committee meeting monthly
- VDC receives of Nrs 500,000 (Approximately US\$ 65,00) there is also budget allocation from HMG for health activities (not known).
- Collecting Nrs 2 as registration fee per visit since 1996 with Nrs 100,000 (US\$ 1,280) accumulated in bank.
- Plan CS Project recently provided equipments, materials and furniture.
- Visited by consultant, CS Project Coordinator and CHOs of the field area on 21 October, 2002.

12.0-YEAR TWO HIGHLIGHTS

- ❑ Biannual Meeting of CS Working group (review of program)
- ❑ Project activities will be assessed and monitored by collecting LQAS data from community level biannually.
- ❑ Basic Training on MNC/FP (local health facility staff and FCHVs and TBAs)
- ❑ Basic Training to remaining Local Health Facility Staff on IMCI and follow-up training/activities on the same for the participants who had basic clinical training on IMCI.
- ❑ Basic / Refresher training to FCHVs
- ❑ Training on Rational Use of drugs to Drug retailers and SHP/HP/PHC and project staff
- ❑ Training on CDP to Project Staff and Local Health Facility Staff
- ❑ Orientation on CDP to local health facility staff
- ❑ Refresher training on MNC/FP to FCHVs and TBAs
- ❑ Refresher training on IMCI to local health facility staff, community health volunteers and FCHVs
- ❑ Ongoing review meeting of FCHVs and TBAs on IMCI and MNC/FP (two times a year each)
- ❑ Training on FP counseling to MCHWs and ANMs
- ❑ Training on village drama and puppet show to local artists
- ❑ Erection of Billboards with key CS messages
- ❑ Modification of classification cards and reproduction of cards for entire project period
- ❑ On site coaching/study at work place of FCHVs/TBAs and local facility staff
- ❑ Leadership and management training to selected local health facility support communities/CDP management committees
- ❑ Training on store/inventory management
- ❑ Training on quality record keeping and reporting (local health facility and DHO staff)
- ❑ Identification of list of essential equipment required for local health facilities
- ❑ Procurement and delivery of equipment to local health facilities
- ❑ Support to national campaigns of NIDs, mopping-up and strengthening routine immunization
- ❑ Support to maternal and neonatal tetanus elimination campaign
- ❑ Support to District Health Office to run district wide biannual Vitamin A dosing campaign
- ❑ Medicinal support and the technical support required to introduce district wide biannual deworming campaign.
- ❑ Iron and Folic acid distribution to pregnant and lactating women and adolescent girls
- ❑ Establishment/strengthening of monitoring and support system through orientation of MOH HMIS forms to local health facilities staff and community health volunteers.
- ❑ Develop simple community data board and pilot it in few VDCs.
- ❑ Collect data by using supervision checklist and use it to monitor performance of local health facility staff and FCHV and TBAs
- ❑ Support to reactivate PHC outreach services
- ❑ Qualitative Study on services of TBAs and FCHVs on promoting MNC services in program area
- ❑ Evaluation of project BCC strategy and scaling up of the same as per the recommendation of study.
- ❑ Visit from headquarters.
- ❑ In Seven Village Development Committees, the project is considering to pilot a people centered health program by involving community people in identifying the problems in terms of design, implementation and monitoring the program. In this process, the project has already trained project and partner staff by having a workshop "Transformation to Community/Health."

Annex A
Training Information

Training Conducted in FY 02 and FY 03.

SN	Name of Training	Level	From	To	# Days	Venue	# Participants			
							# MOH	# Plan	Other	Total
1	GTOT	ALL	27-Feb-02	5-Mar-02	7	Kalaiya	20	3		23
2	GTOT	ALL	7-Mar-02	13-Mar-02	7	Kalaiya	15	6		21
3	GTOT	ALL	14-Mar-02	20-Mar-02	7	Kalaiya	21	2		23
4	GTOT	ALL	12-Apr-02	18-Apr-02	7	Kalaiya	19	4		23
5	GTOT	ALL	29-Apr-02	5-May-02	7	Kalaiya	20	4		24
	GTOT Total						95	19	0	114
6	IMCI	ALL	8-Apr-02	18-Apr-02	11	Birganja	3	19		22
7	IMCI	ALL	28-Apr-02	7-May-02	10	Birganja	23	1		24
8	IMCI	ALL	12-May-02	21-May-02	10	Birganja	21	3		24
9	IMCI	ALL	27-May-02	5-Jun-02	10	Birganja	22	2		24
10	IMCI	ALL	9-Jun-02	18-Jun-02	10	Birganja	22	1	2	25
11	IMCI	All	23-Jun-02	2-Jul-02	10	Birganja	25			25
12	IMCI	All	8-Jul-02	17-Jul-02	10	Birganja	16	1	1	18
13	IMCI	All	21-Jul-02	30-Jul-02	10	Birganja	24			24
14	IMCI	All	31-Jul-02	4-Aug-02	5	Birganja	16	2		18
	IMCI Total						172	29	3	204
15	FP/MNC	AHW	12-Apr-02	18-Apr-02	7	Kaliya	17			17
16	FP/MNC	AHW	28-Apr-02	4-May-02	7	Kaliya	12	11		23
17	FP/MNC	AHW	14-May-02	20-May-02	7	Kaliya	20	3	2	25
18	FP/MNC	AHW	24-May-02	30-May-02	7	Kaliya	25	1		26
19	FP/MNC	AHW	1-Jun-02	7-Jun-02	7	Kaliya	27		2	29
	AHW Total						101	15	4	120
20	FP/MNC	HA	15-Mar-02	18-Mar-02	4	Kaliya	18	11		29
	HA Total						18	11	0	29
21	FP/MNC	VHW/MCHV	14-Sep-02	20-Sep-02	7	Kalaiya	23			23
22	FP/MNC	VHW/MCHV	14-Sep-02	20-Sep-02	7	Kalaiya	20			20
	VHW/MCHV Total						43	0	0	43
23	FP/MNC	TBA	7-May-02	18-May-02	12	Kabhigoth	22			22
24	FP/MNC	TBA	14-May-02	25-May-02	12	Bariyarpur	25			25
25	FP/MNC	TBA	14-May-02	25-May-02	12	Simraungadth	18			18
26	FP/MNC	TBA	14-May-02	25-May-02	12	Ganjbhawanipur	19			19
27	FP/MNC	TBA	14-May-02	25-May-02	12	Kalaiya	19			19
28	FP/MNC	TBA	14-May-02	25-May-02	12	Chiuthaha	22			22
29	FP/MNC	TBA	14-May-02	25-May-02	12	Parsauni	23			23
30	FP/MNC	TBA	14-May-02	25-May-02	12	Kolbi	22			22
31	FP/MNC	TBA	26-May-02	6-Jun-02	12	Kalaiya	18			18
	TBA Total						188	0	0	188
32	FP/MNC	FCHV	26-May-01	1-Jun-02	7	Itiyahi	17			17
33	FP/MNC	FCHV	30-Apr-02	6-May-02	7	Dharamnagar	18			18
34	FP/MNC	FCHV	30-Apr-02	6-May-02	7	Pheta	18			18
35	FP/MNC	FCHV	30-Apr-02	6-May-02	7	Kolbi	18			18
36	FP/MNC	FCHV	30-Apr-02	6-May-02	7	Simara	18			18
37	FP/MNC	FCHV	13-May-02	19-May-02	7	Motishar	18			18
38	FP/MNC	FCHV	13-May-02	19-May-02	7	Paterwa	18			18
39	FP/MNC	FCHV	13-May-02	19-May-02	7	Golaganja	18			18
40	FP/MNC	FCHV	26-May-02	1-Jun-02	7	Chiutaha	18			18
41	FP/MNC	FCHV	26-May-02	1-Jun-02	7	Khutuwa	18			18
42	FP/MNC	FCHV	26-May-02	1-Jun-02	7	Bariyarpur	17			17
43	FP/MNC	FCHV	26-May-02	1-Jun-02	7	Kabahigoth	18			18
44	FP/MNC	FCHV	26-May-02	1-Jun-02	7	Nijgadh	18			18
45	FP/MNC	FCHV	26-May-02	1-Jun-02	7	Kabahigoth	18			18
46	FP/MNC	FCHV	5-Jun-02	11-Jun-02	7	Chi Pakadiya	18			18
47	FP/MNC	FCHV	7-Jun-02	13-Jun-02	7	Hardiya School	27			27
48	FP/MNC	FCHV	7-Jun-02	13-Jun-02	7	Piparadhi	16			16
49	FP/MNC	FCHV	7-Jun-02	13-Jun-02	7	Ammarpatti	18			18
50	FP/MNC	FCHV	7-Jun-02	13-Jun-02	7	Piparadhi	19			19

SN	Name of Training	Level	From	To	# Days	Venue	# Participants			
							# MOH	# Plan	Other	Total
51	FP/MNC	FCHV	7-Jun-02	13-Jun-02	7	Majhriya SHP	18			18
52	FP/MNC	FCHV	7-Jun-02	13-Jun-02	7	Kolbi SHP	18			18
53	FP/MNC	FCHV	14-Sep-02	20-Sep-02	7	Jeetpur	27			27
54	FP/MNC	FCHV	14-Sep-02	20-Sep-02	7	Barainiya Shp	28			28
55	FP/MNC	FCHV	14-Sep-02	20-Sep-02	7	Bagwan	19			19
56	FP/MNC	FCHV	14-Sep-02	20-Sep-02	7	Rahuyahi schoo	19			19
57	FP/MNC	FCHV	14-Sep-02	20-Sep-02	7	Parsauni school	18			18
		FCHV Total					495	0	0	495
		FP/MNC Total					845	26	4	875
		Grand Total					1112	74	7	1193

Events	MOH	Plan	Other	Total
GTOT (All Categories)	95	19	0	114
IMCI (All Categories)	172	29	3	204
FP/MNC (All Categories)	845	26	4	875
Grand Total	1112	74	7	1193

ACRONYMS:

- GTOT: General Training of Trainer (Facility Skill Training)
- IMCI: Integrated Management of Childhood Illness
- FP: Family Planning
- MNC: Maternal and Newborn Care
- AHW: Auxillary Health Worker
- ANM: Assistant Nurse Midwives
- TBA: Traditional Birth Attendant
- FCHV: Female Community Health Volunteer
- HA: Health Assistant

Refresher training conducted in FY 02/03

Name of training	Level	From	To	Days	Venue	VDCs	Participants		
							FCHV	TBA	Total
FP/MNC	FCHV/TBA	11-Aug-02	12-Aug-02	2	Dharhari SHP, Rautahat	Dharhari, Pothiyahi	18	5	23
FP/MNC	FCHV/TBA	12-Aug-02	13-Aug-02	2	Dharampur SHP, Rautahat	Dharampur, Madhopur	18	2	20
FP/MNC	FCHV/TBA	13-Aug-02	14-Aug-02	2	Debahi SHP, Rautahat	Debahi, Gonahi	18	5	23
FP/MNC	FCHV/TBA	14-Aug-02	15-Aug-02	2	Samanpur HP, Rautahat	Samanpur Madanpur	18	11	29
FP/MNC	FCHV/TBA	19-Aug-02	20-Aug-02	2	Laxminiya SHP, Rautahat	Laxminiya	9		9
FP/MNC	FCHV/TBA	19-Aug-02	20-Aug-02	2	Khesrahiya HP, Rautahat	Khesrahiya, Depahi	18	5	23
FP/MNC	FCHV/TBA	20-Aug-02	21-Aug-02	2	Nijgadh PHC, Rautahat	Nijgadh	9	9	18
FP/MNC	FCHV/TBA	21-Aug-02	22-Aug-02	2	Sakhuawa SHP, Rautahat	Jingadawa, Sakhuawa	18	5	23
FP/MNC	FCHV/TBA	21-Aug-02	22-Aug-02	2	Jayanagar SHP Rautahat	Jayanagar, Gedahiguthi	18	3	21
FP/MNC	FCHV/TBA	26-Aug-02	27-Aug-02	2	Jethariya SHP Rautahat	Jethrahiya, Mithuawa	18	4	22
FP/MNC	FCHV/TBA	26-Aug-02	27-Aug-02	2	Bariyapur SHP Bara	Bariyapur, G. Parsa	18	8	26
FP/MNC	FCHV/TBA	3-Sep-02	4-Sep-02	2	Tetariya SHP Bara	Teariya, Sihorawa	18	3	21
FP/MNC	FCHV/TBA	3-Sep-02	4-Sep-02	2	Dhari SHP Bara	Dohari, Bhodaha	18	4	22
FP/MNC	FCHV/TBA	5-Sep-02	6-Sep-02	2	Prastoka SHP Bara	Prastoka, Banjariya	18	6	24
FP/MNC	FCHV/TBA	5-Sep-02	6-Sep-02	2	Haraiya HP, Bara	Haraiya, Karaiya	18	6	24
FP/MNC	FCHV/TBA	5-Sep-02	6-Sep-02	2	Gadahal HP, Bara	Umjan, Gadahal	18	6	24
FP/MNC	FCHV/TBA	7-Sep-02	8-Sep-02	2	Narahi shP	Narahi, Dahiyar	18	6	24
				Total			288	88	376

Annex B
Completion Report of the
MATERNITY HOME CONSTRUCTION PROJECT



Plan Nepal

Rautahat/Bara Program

Child Survival Project

NEPAL

**COMPLETION REPORT OF THE
MATERNITY HOME CONSTRUCTION PROJECT**

**Babu Ram Devkota,
Child Survival Project Coordinator
Plan Nepal, Rautahat/Bara Programs
JULY, 2002**

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EXECUTIVE SUMMARY

Plan CS Project has constructed a Community Based Maternity Home at Nijgadh of Bara district. The vicinity also comes under the area of Plan CS Project. The basic objectives of establishing the maternity home are:

- Quality antenatal, delivery and post-natal services
- Basic essential obstetric cares
- Interventions that will be linked with special attention to the needs of the newborn
- For the evacuation of emergency maternity cases which need comprehensive obstetric care from the Regional Maternity Hospital, which located at the distance of about one-hour drive from Nijgadh

In order to make the project successful and to make the services sustainable and self-reliant Plan also involved a users' committee from the very beginning of the process. The members of the users' group are local people of Nijgadh having representation from different walks of life.

As the community of the project area are self motivated their active participation helped to implement the project from the very beginning to the period of project completion stage. Besides, community member' s initiation on arranging their contribution even in terms of cash and kind (land), formation of project construction committee at the community level, active involvement of community member during building construction, monitoring, supervision and enthusiasm to make the newly constructed maternity home self-reliant etc. have been identified as some of the additional strengths of the committee that helped to complete the project smoothly with a possibility of making the home sustainable and self reliant even after the Plan. Now the community has also realized about the need of reorganizing the executive member of committee in a way to make the home service oriented and sustainable.

As of the view of committee members and the local people they have very good understanding and clear vision to takeover and handle the maternity home independently. Besides, the committee and the local people have also given significant contribution that reflect their willingness to enhance and sustain their own initiation boosted by the technical support of Plan CS project.

1.0 INTRODUCTION

Plan Nepal in Rautahat/Bara with Child Survival XIII and Cost Extension project has been implementing activities that support local communities through TBAs and FCHVs in reducing maternal and neonatal mortality since October 1997. The Maternal and Newborn Mortality of the country is one of the highest in the world, which is 549 per 100,000 live birth and 62 per 1000 live birth (DHS 1996). In realization to this alarming situation, considerable efforts have been made by Plan CS Project to improve the health services quality being provided by the local health facilities of the project area.

Plan CS Project realized lack of credible referral center with reliable ambulance services in the project area to be one of the major shortcomings to address the local health issue in regard to maternity and newborn care. In order to address this issue, the CS Project seriously felt a need of maternity home as a reliable referral center. Besides, the significance of the maternity home has been urged for making the services credible and acceptable in all the periphery level activities.

Accordingly, Plan CS Project initiated the process of assisting local community of Nijgadh, which is a centrally located site of both Rautahat and Bara district to establish and run Community-Based Maternity Home and linking this to Comprehensive MNC initiative that was functioning at community and local health facilities. This process remained specific and fruitful since the fiscal year 1999 after the grant from USNO with concentration in the areas of:

- i) Establishment of Maternity Home
- ii) Support, supply of medicine and equipment for local health facilities center at periphery level
- iii) Institutional Support

Since then, series of activities were carried out by Plan CS Project as well as the local community. As a result, the construction project of Community Based Maternity Hospital (CBMH) has just been completed in the site of Nijgadh with a collaborative approach of Plan and the local community. As a result, the construction project of Community Based Maternity Home has just been completed in Nijgadh with a joint approach of Plan and the local community.

II. OBJECTIVES

The objectives of the project are to:

- 2.1. Construct and run Community Based Maternity Home (CBMH) in Nijgadh to provide health services for Plan non-Plan families of Rautahat/Bara, especially in the areas of:
 - Quality antenatal, delivery and post-natal services
 - Basic essential obstetric cares
 - Interventions that will be linked with special attention to the needs of the newborn
 - Emergency evacuation of maternity cases which need comprehensive obstetric care to Regional Maternity Hospital, which is one-hour drive from Nijgadh
- 2.2. Introduce Behavior Change Communication Intervention (BCCI) at community level that facilitate prompt recognition of danger signs during pregnancy, delivery and postnatal period and prompt reaching to appropriate institution during emergency.

III. ACTIVITIES

3.1 Activities Planned

Following are the major activities proposed and carried out to implement the above project:

- Formation of Community Based Maternity Home (CBMH) Management Committee and to legalize it by registering at local District Administration Office of His Majesty's Government of Nepal
- Obtain land from community for the purpose of constructing proposed CBMH building in appropriate location
- Prepare business plan to:
 - Examine the organizational and management system of CBMH
 - Assess market situation and capacity utilization of the home
 - Analyze financial viability and cost-effectiveness of the Home
 - Point out future strategies for running the Home

- Get/buy ambulance in cost sharing basis to transport emergency maternity cases to appropriate health care facility.
- Prepare detail-engineering design required for Building construction.
- Construction of CBMH as per proposed/approved design and following all legal procedures.
- Get approval for the construction of CBMH from appropriate Plan authority installation of incinerator at Birgunj Hospital (added activity)
- Supply of essential drugs and equipment required to 125 health facilities for managing common childhood illnesses and maternal and newborn care. (added activity)
- Construction of 4 health facilities in the project area (added activity)

3.2 Activities Completed

All the planned activities have already been completed by the end of June 2002.

IV. PROJECT BENEFICIARY TYPE AND NUMBER

The total population of the CS Project area is about 250,000. The beneficiary population, which is women of childbearing age, has been calculated to be about 52,896. In addition the Maternity Home also caters services even for many women who do not belong to Plan CS project area due to accessibility of Nijgadh from many VDCs of Rautahat and Bara districts.

V. PROJECT IMPLEMENTATION METHODOLOGY

5.1 Construction of CBMH

- "A" Class contractors with 5 years experiences ("A" Class contractors who had accomplished similar hospital projects works within last three years of Rupees Twenty-five million) were invited to purchase the Pre-qualification document to secure the quality of the work and complete on time.
- Submitted Pre-qualification documents from the interested contractors were evaluated on the basis of scoring criteria fixed earlier and short listed contractors were asked for tender submission.
- Submitted tender documents were evaluated for awarding the contract. Awarded contractor was informed and then the construction activities were initiated.

- Community Based Maternity Home (CBMH) was included in all supervision, monitoring and support activities of the CS project. CBMH hired a consulting firm upon the approval of Plan Rautahat/Bara for technical input. Plan International Rautahat/Bara CSP Project played the role of supervising and monitoring its activities.
- The task of constructing CBMH activities was supposed to be completed within seven months after signing the agreement by the contractor. The time, however, could not be maintained due to interruption in construction works caused by strikes, unavailability of materials according to the standard and specimen fixed during the design.
- CBMH in approval of Plan Rautahat/Bara hired a consulting firm to get all technical support.

VI. DIFFERENCE BETWEEN THE TARGET AND ACHIEVEMENT

Any major differences have not occurred between the target and achievement. However, some difference has occurred in the area of financial part resulted from some added activities. As of the financial status immediately after the completion of construction work, around NRS. 3200,000 have been estimated to be the balance amount.

Then the CS Project decided to utilize the amount for enhancing CS initiatives. In this connection, Rs. 2,523,959. 07 (\$ 32,370.99) was already spent on supplying medicine and consumables to 125 health posts and sub health post, which were observed as deprived of essentials drugs and equipment required to manage the child survival initiatives. Besides, the CS project also decided to install an incinerator at Narayani Sub Regional Hospital and to construct three health post buildings in the project area.

The actual expenditure, incurred for the Maternity Home construction project in this year including the installation of incinerator and three health post construction was NRS. 9,676,232.09 (\$ 124,102.17). Apart from the expenses as quoted there are still some small amounts that need to be paid. The dues are supposed to be paid for the final bills coming from the Maternity Home.

However, the actual expenses amount has yet to be calculated after receiving final bills from the NGOs contracted.

VII. COMMUNITY PARTICIPATION AND CONTRIBUTION

The community of the project area is self-motivated. Their active participation was found from the very beginning of the project to the project completion stage. This is one of the major strength of community participation/public partnership for the project.

Likewise, community contribution in terms of cash and kind (land and formation of project construction committee) involvement of community member even during building construction, monitoring, and supervision are some additional strength of the community. The performance as revealed by regular meeting, follow-up of the decision made by the committee as well as Plan, transparency, good mutual understanding etc are some other instances of good participation of the community that really helped the project to complete smoothly.

Now the community has also been self-motivated to reorganize the member of committee in a way that will lead the physical existence and services of maternity home to be reliable, self reliant and sustainable as well.

VIII. EXPECTED PROJECT IMPACT

Broadly, the expected impact of the project is to reduce mortality rate of newborns and mothers of child bearing age in the project area. Therefore, the expected project impact has been overviewed in terms of the number of beneficiaries. They are classified in the following table:

1. Output type & code	2. List of Beneficiaries	3. Plan Families	4. Non-Plan Families	5. Total Beneficiaries
GUH Institutional Development 1D10	Pregnant women at high risk of 50 VDCs	12,052	40,848	52,900
Health Center / Unit Construction 1A21	Pregnant women at high risk of 50 VDCs	12,052	40,848	52,900

IX. AMOUNT SPENT IN US\$ PER OUTPUT AND ACTIVITIES AS PER GL (IN USD)

Output Code	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002 Budget after PO Revision	FY 2002 Actual amount disbursed	Total
1A18	-	-	-	2,762	35,097	32,371	2,762
1A21	-	-	-	-	134,536	134,102	169,633
1D10	-	21,864	16,364	39,377	-	-	77,605
TOTAL		21,864	16,364	42,139	169,633	156,473	250,000

X. COMMENT OF CBMH

The concept of local people towards the Community Based Maternity Home committee has been found quite **positive** in regard to the performance and future prospective due to construction of the new maternity home. The members of the committee are prepared and well organized to take the responsibility of making the home self reliant and sustainable even in the days to come. The community level health workers and health volunteers have been reported apparently realizing the positive response from the community after the initiation of maternity services in the community and construction of a new maternity hospital.

Local TBA, Mrs. Mana Maya Chaulagain says, *"Construction of a new maternity home tremendously helped to generate credibility on our job and also helped to make our message effective in regard to maternity and child care practices."*

At present the local community are expecting some sort of training to handle the maternity home effectively with reliable service. The members of the CBMH, are of the opinion that they need to hire female Medical Doctor/Staff Nurse in the near future to make the service more acceptable to the community.

Their realization on the contribution made by Plan CS project to translate the concept of establishing maternity home and their awareness and willingness to take the responsibility of operating the maternity home even after the project period is one of the commendable characteristics of the comments made by the community after the construction of new building. These were the remarks expressed by CBMH committee members during the meeting with Plan's Health Coordinator. The committee members who attended the meeting were Mr. Kishor Nepal, (Vice Chairman), Mr. Krishna Pd. Upadhayaya (Member Secretary), Ms. Netra Kumari

Poudel (member), Mr. Chandra Singh Lama (member), and Mr. Bishnu Bahadur Lama (member).

Immediately, the community members are expecting to have some sort of exposure either through workshop or through the observation tour of similar project to the technical as well as managerial staff to develop their vision for handling the maternity home effectively and independently.

XI. COMMENT OF THE CLIENT

Due to the initiation of maternity home services in the village local people in the area and vicinity remain self-motivated about the need of obtaining maternity services and newborn care.

Mrs. Januka Lama (19 years), local resident of Nijgadh says, *"Due to the existence of maternity hospital in the area, I realized by myself about the necessity of maternal and new born care during pregnancy and after delivery. So, I voluntarily, obtained antenatal and delivery services from the maternity home during my pregnancy and delivery."*

The community have been found aware of the need of maternity home not only for the antenatal and post natal services but also for other health services like; sanitation, personal hygiene, spacing, STD and HIV/AIDS etc. This sort of social perception and willingness of acquiring health services provided by different sources at the local level have been found further enhanced after the initiation of constructing maternity home. Thus, to a large extent, the clients have been found satisfied with the terms and conditions and type of health care being provided by the CBHM. This can be regarded as some sort of social basis to expect social support even in the future in the process of delivering services from the maternity home in a reliable and sustainable way.

This sort of social recognition and support has also been found reflected from the valuable suggestion provided by the community for making the services of the hospital more effective and sustainable.

Mrs. Januka Lama of Nijgadh who have just received delivery services from the maternity hospital says, *"If there would be provision of home visit service for women with exceptional cases (over bleeding, fever, diarrhea, abdominal etc.) the service of maternity home could be more effective".*

Maternity Home Construction Project

The local FCHVs, TBAs, and CBMH Committee have also same sort of opinion. In this regard, **Mrs. Netra Kumari Poudel, CBMH Committee member says,** *"Since women are playing vital role on disseminating information about the maternity home, additional services like home visit before and after delivery may help to meet the desired type of services needed for the community."*

Besides, the community has encouraging response about the services of maternity hospital and the construction of new hospital building. In this connection even the hospital level staff have also been found actively involving in communicating about the new hospital building. **Ms Bhim Maya Maharjan, The ANM of the maternity says,** *"Patients coming to our contact are happy with the message about new hospital building with added facilities."*

Annex C
**List of equipment and materials for health
facilities in Bara**

**Plan Nepal
Rautahat/Bara Program
Child Survival Project**

List of Equipment/Material for TBA

S.No.	Particulars	Unit	Required quantity
1	Towel	„	300
2	Mucus Extractor	„	300
3	Tourch light(Geep Indian)	„	300
4	Battery	Pair	300
5	Breast pump	Pcs	300

List of Equipment/Material for FCHV

S.NO.	Particulars	Unit	Required quantity
1	Clean Home Delivery Kit(CHDK)	PCs	3650
2	Chinese scissor	„	730
3	Towel	Pcs	730
4	Soap Case	Pcs	730
5	Soap Soltee	„	730
6	Nail cutter	Pcs	730
7	Thumb forcep	„	730

List of Medicines and Consuable for Health facilities, TBAs and FCHVs

S.No.	Particulars	Units	Required quantity
1	Gloves reusable	Pair	450
2	All glass Syringe 10 ml	Pcs	150
3	Clean Home Delivery Kits(CHDK)	Packet	3000
4	Bandage 4 "	Roll	1460
5	Cotton Roll 100 gm	Roll	730
6	Gention Voilet powder 25 gm	Bottle	730
7	Tincture iodine 200 ml	Bottle	730
8	Cetamol Tablet 500 mg	Strips	2000

**Plan Nepal
Rautahat/Bara Program
Child Survival Project**

List of equipment and materials for health facilities in Bara

S.No.	Particulars	Unit	Required quantity
1	Examination Table	Pcs	75
2	Bedside screen	„	75
3	Wooden Stool	„	150
4	Wooden Bench	„	75
5	Set of drawer 4 racks	„	75
6	Wooden Chair Simple	„	150
7	Wooden Chair with arm/cushioned	„	75
8	Wooden Stool with stand	„	75
9	Steel Almira	„	75
10	Salter Baby scale	„	75
11	Bath Room Scale	„	75
12	Plastic Bucket 15 liter with tap/cover	„	75
13	Plastic basin	„	75
14	Plastic Jug with cover	„	75
15	Plastic waste recepticle	„	75
16	Twel	„	75
17	Soap Soltee	„	75
18	Soap case	„	75
19	Macintosh rubber sheet 2 meter	„	75
20	Cheetle forcep with Jar	„	75
21	Stich cutting scissor	„	75
22	Artery forcep	„	75
23	Disecting Forecnp	„	75
24	Forecnp needle holder	„	75
25	Knifeholder	„	75
26	Surgical blade	Packet	150
27	Suture needle cutting body	„	150
28	Universal dental forcep	„	75
29	Bandage cutting scissor	„	75
30	Tongue deppressure	„	150
31	Blood pressure instrument	„	75
32	Stethoscope	„	75
33	Instrument with cover 6/9, s/s	„	75
34	Diagnostic set	„	75
35	Sterilizer boiling type with cover	„	75
36	Spirit swab bowl with cover	„	75
37	Thermo meter, Chinese	„	150
38	Pressure stove, Brass	„	75
39	Plain cathetar different size	„	450
40	Butterfly needle	„	375
41	Mucus Extractor	„	75
42	Breast Pump	„	75
43	Nylon gut(thread)	Hank	75

44	Kidney tray Smal size	Pcs	75
45	Haemoglobinometer Shali type	„	25
46	Pricking needle	„	25000
47	Baby scale pan type	„	25

Annex D
Status of Drug Recovery Process

**STATUS OF DRUG COST RECOVERY OF SELECTED LOCAL HEALTH FACILITIES OF PROJECT AREA
JULY 2001 TO JUNE 2002**

SN	Name of Health Facility	Total cost of drug used by HF in FY	Cash carried over from previous FY	Income generated in FY			Total Expenditure	Cash Balance	% of drug cost recovery
				Selling Drug	Registration Fee	Total Income			
A	B	C	D	E	F	G = (E+F)	H	I=(D+G-H)	J=G/C*100
1	Paurahi SHP	31,909.00	6,475.00	14,231.00	1,226.00	15,457.00	10,061.00	11,871.00	48.44%
2	Santapur SHP	21,627.00	3,550.00	12,431.00	2,260.00	14,691.00	1,200.00	17,041.00	67.93%
3	Judibela SHP	20,093.07	2,334.67	13,628.80	2,389.00	16,017.80	2,110.00	16,242.47	79.72%
4	Uttarjhitkaiya SHP	30,525.00	15,745.60	18,884.40	2,370.00	21,254.40	1,000.00	36,000.00	69.63%
5	Chhatapipara SHP	35,000.00	885.50	7,979.75	4,660.00	12,639.75	885.50	12,639.75	36.11%
6	Prastoka SHP	15,000.00	0.00	9,500.00	1,078.00	10,578.00	0.00	10,578.00	70.52%
7	Inarwasira SHP	29,921.00	14,871.00	18,550.00	1,216.00	19,766.00	14,871.00	19,766.00	66.06%
	Total	184,075.07	43,861.77	95,204.95	15,199.00	110,403.95	30,127.50	124,138.22	59.98%

Annex E
Monthly Work Plan

E D	N D	Day	Description of activities	Location/Place	Remarks

Prepared & submitted by:

Approved by:

Plan Nepal
Rautahat/Bara program Unit
Child Survival Project (CSP)
Monthly Reporting Form

Name _____

Month_____

Position_____

Field Area # _____

E D	N D	Day	Activities	Summary of work done

E D	N D	Day	Activities	Summary of work done

NB: write main functions, problems and challenges under work done column.

Annex F
Transformation for Health Workshop

TRANSFORMATION

FOR HEALTH

Workshop Report

For

PLAN INTERNATIONAL, USA, Inc.

Workshop Held at:

Godivari Resort
Kathmandu Valley
Nepal

October 7 - 11, 2002

Submitted by

Sandra Wilcox and Bethann Witcher
Workshop facilitators
October, 2002

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Annexes

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- B List of Workshop Norms & Godavari's Definition of "Community"
- C Transformation for Health Concept Paper

Transformation for Health Workshop

Background

Plan Nepal has been implementing a USAID BHR/PVC funded Child Survival project in the Terai region of Nepal since 1997. They began their second or extended five-year project in October 2001. Having successfully strengthened the MOH services in the project area and increased demand for these services through education and promotional activities, they realized that in order to reach the project's sustainability goals, they would need to further strengthen community participation in the project. As a first step in this process, the project decided to participate in a Transformation for Health training workshop in order to become more familiar with community development strategies and begin thinking about how to implement them in a self-sustaining manner. The following is a description of the purpose, goals and objectives of the workshop, an outline of activities conducted and recommendations for next steps.

Purpose

The purpose of this workshop is for Plan's health/child survival staff and others who work in local communities to experience a process for personal and community empowerment. The Transformation for Health training is in line with the Child Survival program's objectives for training, application and reflection with the intent of empowering local communities to meet self-identified needs.

Goals and Objectives

The goals of the workshop were to:

- To provide Plan staff and those with whom they work, with the skills to more fully engage community participation in the work of effective community development
- To offer leadership development skills to Plan's staff so as to enhance their work with men and women in local communities
- To provide Plan's staff with skills to facilitate their project's community members abilities to identify needs and work in a participatory process to meet those needs

Some of the learning objectives of the workshop were to:

- Demonstrate listening skills that encourage people to speak and identify their own needs
- Identify key issues within a community about which the members have strong feelings
- Utilize problem-solving educational materials to mobilize a community to action

- Evaluate resources available for community development
- Justify empowering individuals to take social improvements into their own hands as a means for assuring conditions in which a community can thrive economically, socially, culturally, spiritually and politically

The methodologies employed in the workshop included interactive and participative strategies that encouraged participants to dialogue among themselves to understand and pose problems, determine solutions to problems and discover their own diagnostic capabilities. Most of the activities were conducted in pairs, small groups and large plenary discussion groups.

Workshop Activities

Day One

Introductions: 1) A **Stand up** activity was used to show commonalities; and 2) **The Tree of Life** allowed participants to share themselves with others looking at their roots, accomplishments and hopes and dreams.

Norms: Established guidelines by which the community would operate together over the next 5 days. Norms are posted and reviewed during the week as necessary.

Social Organization: Committees were formed to address the needs of the community.

Committees were formed for starting the day, transportation, clean-up and social activities.

Expectations: Small groups listed and presented their expectations for the workshop. These expectations were categorized and compiled by the facilitators (see annex). The expectations became the basis for the course objectives and activities.

Health is... a sentence completion activity that has participants examine their concepts and definitions of health. Discussion focused on the World Health Organization's 1998 definition of health, elaborating on the fact that health is not primarily medical.

Faucet code: A picture was presented to the group with analysis questions, which they discussed in small groups. The discussion focused on the root causes of ill-health stressing that interventions must deal with the cause of health problems not simply their results.

Feedback committee: Three participants met with the facilitators to provide them with feedback on the day and to offer any suggestions as we progress through the course. This feedback process is repeated daily throughout the course with three different participants each day.

Day Two

Start up: a meditation exercise was led by the start up committee.

Highlights: a discussion by participants of highlights from the previous day's activities.

This activity is repeated daily following the start up.

Flower Story: A story with analysis questions was given to participants to discuss in small groups. Discussion dealt with themes of teacher centered learning versus student centered learning and the results of these two different kinds of education. Input was provided on these two kinds of education. One style encourages thinking and creativity and leads to change. The other style encourages dependency on the teacher for learning and keeps everything status quo.

Fly Over: participants were asked to be a helicopter and “fly over” their place of work to identify those things which were “domesticated” and those things which “liberated.” Most of the analysis fell to their work in community where they examined ways in which they themselves “domesticated” the community by giving and doing for them.

Draw community: During the first part of the afternoon, the participants ‘drew community’ in small groups and presented them to the large group. This allowed them to explore the components of community and determine the meaning of community. The group came up with their own definition of community.... (see annex)

The Rabbi’s Gift: During the last part of the afternoon, participants watched a video and read a story entitled “The Rabbi’s Gift” dealing with the destruction and rebuilding of community. Analysis was done in small groups and discussion in the larger group. The need for listening to others, respect and self-discovery were identified as necessary for building community.

The day ended with the facilitators receiving comments and suggestions from the feedback committee (each day had different feedback committee members).

Day Three

Start Up

Highlights

The Monkey Salvation: a short parable was provided to the group for small group analysis dealing with how we provide “help” to each other and to communities. This was followed by a large group discussion about two kinds of help: that in which we do things for people, which encourages dependence on us and keeps the status quo; or the kind of help whereby we listen to others, facilitate their thinking which leads to empowerment and allows them to change thus producing health and well-being.

Mid-week Evaluation. During this period participants returned to their original small groups to review their expectations for the workshop in order to see what had been addressed and what was still left to do. After discussing this in small and large groups, each person identified a figure on the “Gumby tree” depicting where they were with the course. These were shared in the group.

The day ended at mid-day for the mid-week break. The facilitators met with 3 new members of the feedback committee and received their comments and suggestions.

Day Four

Start Up:

Highlights:

Listening Triads: Since listening is the basis of the process of community empowerment, time is spent in the listening process. This is done in groups of three whereby each member alternates between the roles of Listener, Speaker and Observer as they share a time in their life of pain and healing.

The significance of truly listening and of being fully listened to was examined. Participants realized the full impact of listening through this exercise. Handouts were provided on basic listening techniques.

The Bird Cage: a problem-posing picture of a bird in a cage with an open door was given to participants to analyze in small groups. This led to further discussions of domestication, our frequent acceptance of the status quo and our resistance to change. How this relates to work in the community was discussed. The full cycle of the Freire process was presented linking listening for/to generative themes and then, to problem-posing education. Ideally, this then leads to the point of decision-making on the part of the group and action.

Code Practice: Having been exposed to the full process, participants were now ready to practice. They were divided into small groups, asked to select a generative theme from one of their communities and present it as a problem-posing socio-drama to the larger group. This is a very difficult session and clearly demonstrates how health care workers have a difficult time differentiating between their agenda and that of the community. Skits were excellent and depicted the problems of treatment of women, women's health issues and folk traditions that can be harmful.

Tools and Principles: The last session of the day addressed the use of tools, methods and strategies used in the workshop that they can replicate in their work in the community. The basic principles of the methodology were presented and reviewed in discussion with the group.

At the end of the day, the facilitators met with the feedback committee and received their comments and suggestions. In the evening, the social committee organized dancing, poetry reading, story telling, singing and other activities for workshop participants.

Day Five

Start Up:

Highlights:

Action Planning: Afterwards, participants broke up into groups composed of individuals who worked together in the field, to develop an action plan that used the methods presented in the workshop. The groups were instructed to listen for and use generative themes from their communities and base their action plans on these. Although each group did develop plans, they did not all grasp how to identify the communities' most strongly felt themes/problems and build their plans on the communities' agenda.

Evaluation: The second session comprised workshop evaluations and the closing.

Participants developed questions that they would like to use to evaluate the workshop. Each person then selected 3 questions from the various lists to answer individually.

In closing, participants distributed the certificates to each other. Standing in a circle, comments were made by various members as to the value of the workshop and the hope for more to come.

In accord with the group-determined norms and schedules, the workshop closed before lunch.

Evaluation

In general the course evaluations were very positive. Most respondents felt that course objectives had been met, that they had learned many new and useful skills and methods for working with communities and groups. Many also were impressed with the course structure and the way that the workshop had been designed to meet their expectations. They also really liked the venue and the logistical arrangements. Several participants felt that the workshop should have been longer. A few suggested that it would have been useful to add a few days and include practical field experiences, particularly for the analysis of generative themes and design of action plans. Given the difficulties that participants had in identifying these within the workshop timeframe, this seems like a useful suggestion.

The group clearly felt that the workshop content was what they needed at this time. They realize that they need to focus on empowerment issues and how to facilitate change at the community level. They stated that the workshop had provided them with a perspective and many skills to initiate this kind of work.

Next steps

The facilitators met with the CS project director and the PLAN IH Child Survival Coordinator to discuss next steps. It was concluded that after the holidays, the CS project staff would meet and review their situations and plan some initial TFH community development activities. The facilitators recommended that they start with trying to listen to their communities and identify generative themes, or areas/problems that people feel strongly about. The facilitators also recommended that the project staff and other participants begin trying to identify and design appropriate “codes”¹ that reflect important issues in Nepali society. This would be the first step in developing a “tool box” for PLAN staff to use to work with the communities.

Once some of this research on generative themes and development of Nepali codes has taken place, then it might be appropriate to meet with facilitators and conduct a field based planning process. During such a follow-up event, participants could receive additional training that builds on the first workshop and they could also begin dialoging with their respective communities regarding how to respond to the generative themes using the Nepali codes to stimulate discussion and debate. The facilitators would be available at the time of the follow-up training to guide project staff in the TFH community facilitation process.

It was concluded that during the next few weeks, the CS project staff will review these suggestions and their needs and communicate their desires and interests to the PLAN IH CS

¹ A code is a concrete presentation of a familiar problem that raises questions but does not give answers.

Coordinator in Washington (Dr. Pierre Marie Metangmo). Dr. Metangmo will then make a decision regarding what steps to take next and how they should be implemented.

EXPECTATIONS

Transformation for Health Plan Nepal

7-11 October, 2002

Transformation for Health

- To know about Transformation for Health workshop
- What is Transformation for Health?
- Transformation for health?
- What is transformation?
- Why do we need transformation?
- History of TFH
- Objectives of TFH
- Factors of Transformation for Health?
- How do we use it in daily life?

Skills

- Process/skills to work with TFH in community
- Methods and tools
- Skills required to facilitate marginal/poor people to:
 - Identify their problems
 - Plan, manage and evaluate the programs
- To use problem-solving education

Community Implementation

- How to apply TFH in community
- How to implement in community
- Role of communicator and community
- What is the role of community?
- How to sustain it in the community?
- To understand the community transformation process?

Integration

- To integrate TFH with other community development programs
- How does it incorporate with other sectors?
- Role of implementing agencies

Evaluation

- How to evaluate
- Process and impact indicators
- Methods of monitoring and evaluation

Workshop Norms

- Timeliness
- Responsible
- Respect others
- Active Participation
- Listen to Others
- Open Minded
- No side talks
- Confidentiality
- No hierarchy

Godavari's Definition of Community

“COMMUNITY” is characterized by a group of people with common interests and understanding and sharing goals.

CONCEPT PAPER

Training For Community Transformation/ Transformation for Health (Experiencing the Paulo Freire Method)

The purpose of this workshop is for Plan health/ child survival staff and others who work in local communities to experience a process for personal and community empowerment. The Training for Community Transformation is in line with the Child Survival Program's objectives for training, application and reflection with the intent of empowering local communities to meet self-identified needs.

"A process of learning to listen so that others would speak."

Goals:

- To provide Plan staff and those with whom they work, with the skills to more fully engage community participation in the work of effective community development;
- To offer leadership development training to men and women in local communities where Plan is presently working;
- To provide community leaders with skills to empower their community to identify needs and work in a participatory process to meet those needs.

Background/ Rationale:

Many of Plan's child survival and health staff is currently working in localized settings on issues related to community development. Experience has shown that community participation and empowerment are based on skills that must be learned like "removing an appendix or tracking an epidemic." Plan's health and CS staff want and need to learn these skills to be more effective agents of change in low income and marginalized communities. These skills were developed out of Paulo Freire's pedagogy over a fifteen-year period in East Africa into a process called "Training For Transformation." Sally Timmel and Ann Hope were instrumental in adapting this method to train women in local communities in Africa. This training intends to make this methodology available to people working in communities throughout Plan's child survival network.

Participatory methods involve far more than skills. There is a whole mind-set and way of believing and being that are the backdrop for trust and the corner stone of participation. It is a process that needs to be modeled and lived. Thus the Training will enable participants to consider a basic question, how do we build strong bases of collective organization? Training for Community Transformation (for Health) is an experiential workshop where participants not

only learn a process but also live the process. They experience the building of trust, the equality of voice, the profound value of listening and being listened to and yes, in many instances, are transformed... or, at least, are repositioned along a pathway towards a new understanding of community development and a way of creating conditions that support it.

Participants will be challenged to ask themselves how they presently engage the community and how they are prepared to do so. As field staff and community workers, are they prepared to be engaged in a participatory process? Or, is their training designed to fortify themselves as experts who have the answers? If field staff are to initiate and be active partners in participatory community processes then they need to experience an educational process that involves learning to listen not speak, engage in dialogue not monologue, facilitate not teach, serve not lead, be team players not stars and value the deep intrinsic knowledge of the community above their own technical expertise.

In summary, the Training for Community Transformation (for Health) is intended to prepare leaders to live and work in their communities as reflected in these words by Jean Vanier:

“To love is not to give of your riches
but to reveal to others their riches,
their gifts, their value,
and to trust them
and their capacity to grow.
So it is important to approach people
In their brokenness and littleness
Gently,
So gently
Not forcing yourself on them,
But accepting them as they are,
With humility and respect.

Often, even with participatory intentions, it is the community (health) workers looking upon the community that seeks to determine the needs of that community. They make decisions to involve community members in programs on health, child survival, education, justice and other problems that are surely pressing and need attention. However, to return to the work of Paulo Freire, it is only when people have strong feelings about an issue that they are willing and capable of moving beyond apathy to action. Many issues that health workers deem critical are seen as part of everyday life to those who face them continually. So, the professionals chosen point of entry is often not the community’s point of entry.

Finally, the Transformation for Health training will challenge participants to ask fundamental questions regarding their role as change agents in local community settings:

Can we relinquish our “experts” role and become facilitators of the community’s vision?

Do we trust the people enough to work in their community with no agenda such that they build their own agenda?

Do we have the patience to be engaged in a participatory process that is time consuming and on going?

Can we redefine our results and find new ways to assess them?

Do we have any other choice in the face of the multiple failures of the status quo of traditional community agencies in addressing entrenched social problems?

Workshop Description

Training for Community Transformation (Transformation for Health) is a five day workshop which will provide an opportunity to learn the method, Training for Transformation, by experiencing it. The focus is to engage the participants in the process of listening, dialogue,

action and reflection and to provide them with new skills needed for effective community development.

Through the experience of the workshop, participants will learn:

How to listen to be a skilled listener, so people will speak

How to listen for key community issues

How to use problem-posing education

How to facilitate group discussions

How to make sure that help is always helpful

Why empowering people to become problem-solvers for their own community is the key to effective and sustainable community development.

Learning Objectives:

- 1) Demonstrate listening skills that encourage people to speak and identify their own needs
- 2) Identify key issues within a community about which the members have strong feelings
- 3) Utilize problem-solving educational materials to mobilize a community to action
- 4) Evaluate public resources available for community development
- 5) Justify empowering individuals to take social improvements into their own hands as a means to assuring the conditions in which a community can thrive, economically, socially, culturally, spiritually and politically

Outcomes:

After the workshop, participants will be able to:

- Identify critical issues of concern within their community
- Identify existing resources necessary to build a healthy community
- Identify solutions to community problems
- Move planned solutions into action

Associated content:

Freire model of empowerment education

Health issues associated with community development

Other?

Methodology:

Participatory

Small group dynamics

Interactive

Plenary discussions

Annex G
Proposed Structure and Functions
of CS Project Support Group

Proposed Structure and Functions of CS Project Support group

Background

Plan Nepal, a PVO with its headquarter in London has initiated a Child Survival Project (CSP) in Bara District of Nepal since October 2001. The project has been supported by USAID. After successful implementation of first phase in 33 Village Development Committees (VDCs) of Rautahat district and 17 VDCs of Bara district for a period of four years (September 30, 1997–September 29, 2001) the project has been further extended in 98 VDCs of Bara district for next five years starting from October 2001.

The overall project goal is to assist the MOH to improve the health status of children under five and women of reproductive age (15–49 years) in Bara District in Nepal. The project will closely support MOH health care facilities in improving management of childhood illnesses, supervision, monitoring, drug supply and community mobilization through training of health workers and volunteers, community drug program, supervision and monitoring and incentive for volunteers.

The project has given high priority in mobilizing local authorities and communities for implementing child survival initiatives in the district. Due to complexity of the program, careful inter–sectoral collaboration and partnership is essential at various levels of program operation. Particularly, the District Development Committee (DDC), Village Development Committees (VDCs) and District Health Office (DHO) will have to play major roles in the program implementation at the district level and VDC levels along with the Child Survival Project. Better communication and commitment of all potential partners is essential for producing coordinated efforts at all levels of operation.

Taking all these factors into consideration, the Child Survival Project has initiated a strategy of working with various partners in Bara district for the successful implementation of child survival program. These strategy aims at providing a forum for sharing child survival program activities with various levels of partners and improve communications for better coordination. The Child Survival Support Group at district level is to maximize the function of health facilities and communities and its impact on

the health of children and women of reproductive age in Bara district through improved relationships and coordination of all partners.

Structure of Child Survival Project Support Group

The support group will be formed as follows.

1. DDC Chairperson	Chairperson
2. Convenar, DDC Social and Health Committee	Member
3. DHO, Bara	Member
4. Public Health Officer, Bara	Member
5. Secretary, DDC	Member
6. Women Development Officer, Bara	Member
7. District Project Coordinator, CWS, Bara	Member
8. CS Project Coordinator	Member Secretary
9. Senior Com. Health officer, CSP	Member
10. Program Manager, Plan Bara/Rautahat Branch Office	Member
11. Chairperson, VDC Federation, Bara	Member

Guest members or Special invitees will be as follows.

1. Representative, Child Health Division, DoHS
2. Representative, family Health Division, DoHS
3. Representation, Logistic Management Division, DoHs
4. Representative, Regional Health Directorate, Central Region
5. DPC, Plan Nepal, Rautahat/Bara program
6. Health Coordinator, NCO, Plan Nepal
7. Representative, JSI, Central Region

Role and functions of the Support Group

1. Collect and analyze information relating to child survival program in Bara district.
2. Discuss issues relating to health service delivery, health service management and health service infrastructures at various health facilities levels.
3. Coordination among CS project, line agencies, NGOs and communities.
4. Assign responsibilities among partners involved in Child Survival initiatives.
5. Prepare annual district plan of action for child survival program.

6. Mobilize resources for CS program in Bara district
7. Review the progress of CS program quarterly.

Role of the line agencies (DHO/PHO)

1. Ensure communication on CS activities at district and peripheral level.
2. Provide human and other resources for effective implementation of CS program at various levels.
3. Involve in supportive supervision and follow up of CS program.
4. Ensure good working relationships with CSP and other partners.
5. Work closely with CSP to upgrade quality health services through local health facilities.
6. Prepare and initiate joint annual monthly supervision plan from DHO to local health facilities.

Role of DDC and VDCs

1. Maintain effective communication regarding CS Program.
2. Initiate and involve communities in managing health facilities for effective implementation of CS program at various levels.
3. Develop and implement plans for motivating community health volunteers.
4. Facilitate VDCs to take lead role in operating CDP program in respective VDCs.
5. Monitor activities and services being rendered through local health facilities and provide required /needful support.

Role of CS project.

1. Provide technical and financial resources for CS program in Bara district.
2. Collect, analyze and disseminate information necessary for planning, implementation and monitoring of CS program in Bara district.
3. Provide continued technical backstopping to health managers, health workers and volunteers relating to CS interventions.
4. Review and monitor CS activities and make recommendations for improvements in health systems for effective delivery of CS health services at various levels.
5. Furthermore, CSP will explore the possibilities of Developing District Health Development Board and Village Health Development Board for ensuring decentralized health planning in Bara district.

Annex H
People Centered Development Approach

People Centered Development Approach
(A strategy for transferring knowledge and skills to the
community for promoting maternal and child health in Plan
Nepal/Child Survival Project)

Plan Nepal
Rautahat/Bara Program
Child Survival Project

Introduction

Plan Nepal Child Survival Project has been working in Bara district aiming to improve the health status of mother and child. The overall strategy of the Child Survival Project is to work with MOH line agency at local level through the capacity building of health workers, volunteers and health committees in respective areas. Besides training on health care delivery and management Child Survival Project has been contributing in necessary logistics and monitoring, and supervision at local level. In the mean time Child Survival Project has planned to initiate alternative approach of implementing CS interventions with local communities. This approach will focus participation of local community in planning, implementation, supervision and evaluation of CS intervention in the respective VDCs, selected for piloting this initiation.

Working according to this strategy can be described as:

"Working in a way-as process-that focuses on mobilizing, promoting and strengthening the potential of people to understand their own situation better and their own role within it. To increase their capacity to effectively analyze situation and implement action within a continually changing context."

How does this approach work?

This approach emphasizes the mobilization and organization of the community at the grassroots level in to groups that indicate needs and priorities and decide about development activities that they wish to undertake.

As an instrument for gaining insight into development potential and into the interventions the population want, the process approach has proved its value.

Techniques other than the process approach are needed to chart development potential.

Role of facilitator organization

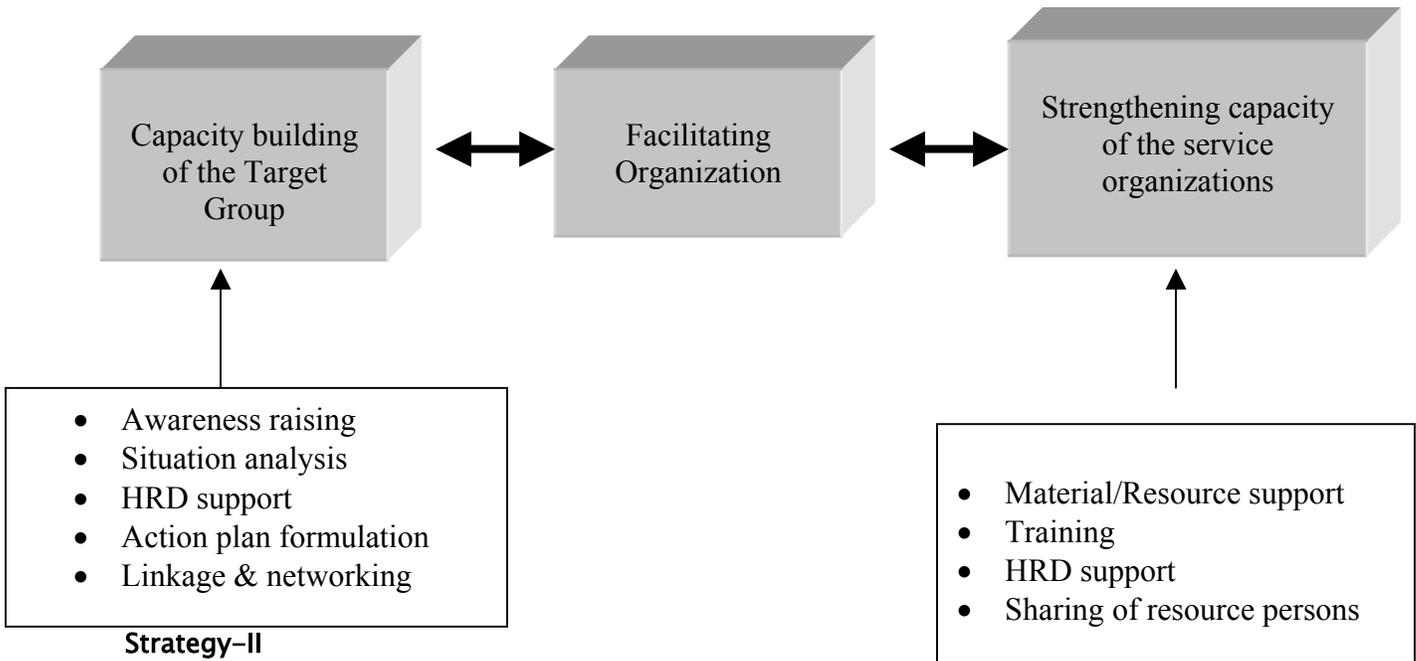
The role of facilitating organization is to assist/guide these target groups and to function as intermediary between them and various development organizations already operating in the area until the groups are strong enough to stand on their own feet.

Some basic assumptions for success of process Approach

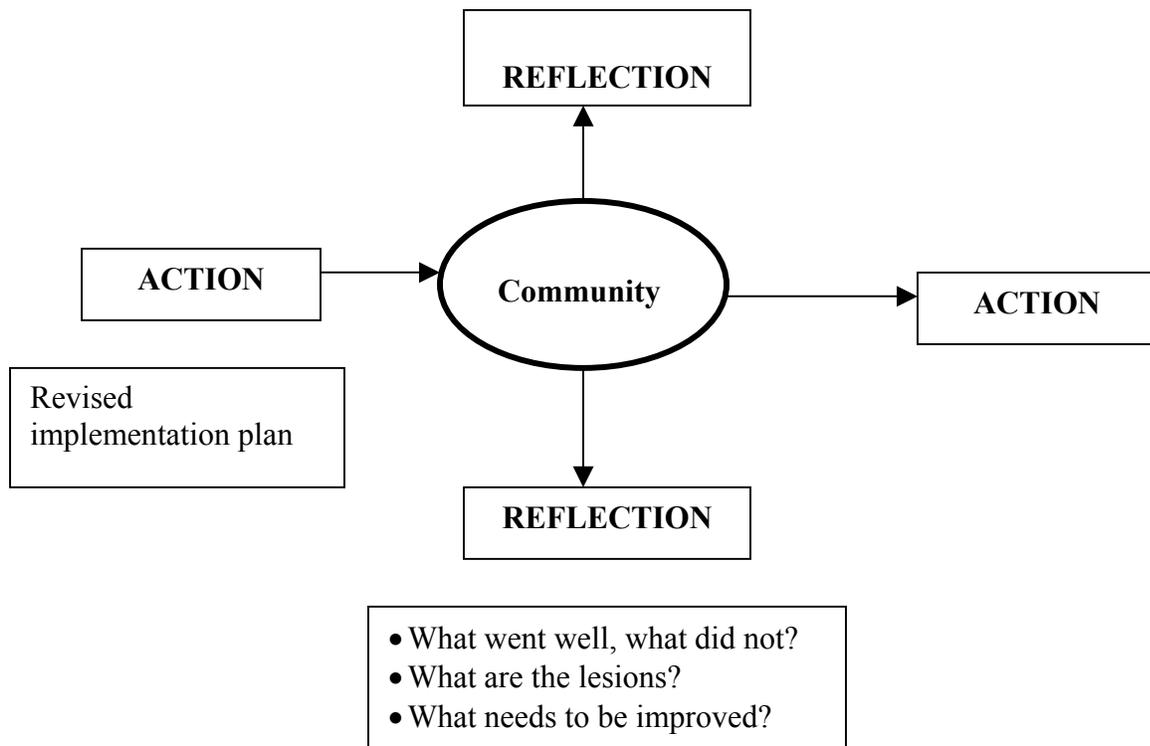
- Participation of all stakeholders in project cycle
- Room for experiment and learning by doing
- Flexibility to incorporate new learning in the project cycle

The working modality:

Strategy-I



Analysis of situation



Stages of implementing this strategy

Stage-I: Orientation and Situation Analysis

- Establish trust in the community and relationship with VDC and health facility committees.
- Select two VDCs for piloting this initiatives.
- Collect information on the situation of Maternal and Child health in selected VDCs.
- Assess the survival strategies of maternal & child health in the VDCs.
- Start the process of analysis and awareness raising amongst VDC and health committee members.
- Identify root causes of the problems of maternal and child health in the VDCs.

Stage – II: Action planning and implementation

- Determine the goal for maternal and child health in the VDC.
- Develop strategies
- Form action plan and determine resources
- Evaluate the outcome
- Define a new goal

Stage – III : Capacity building and strengthening

- Develop strategies for transferring skills to the committees
- Select 2–3 people for leading the group and provide necessary training on group action process and leadership.
- Provide information on networking and linkage with relevant organizations on CS interventions.

Activities

1. Situation Analysis: Facilitate the group how they can collect the following information relating to CS interventions,

Demographic information

- No. of pregnant mothers
- No of MWRA
- No of under five children
- No of under one year children
- No of children under one month

Service information

- No of children completed all vaccines within one year of age
- No of pregnant mothers receiving AN check ups
- No of pregnant mothers immunized with TT vaccine
- No of pregnant mothers receiving Iron tablet
- No of children receiving Vita A and Albendazole

Access and coverage information

Provoke discussion using above said information. Facilitate the group for analyzing the problems. Ask people to find the answer of following questions:

- Are all people receiving the services? If not, then why?
- Which area has the highest service utilization rate? And Why?
- Which area has the lowest utilization rate? And why?
- Do they want to improve the situation? If yes, then how?

The role of facilitator is to help the group to get possible right answers of above said questions. Facilitator must have skills in mobilizing the group and should not give answers to the questions.

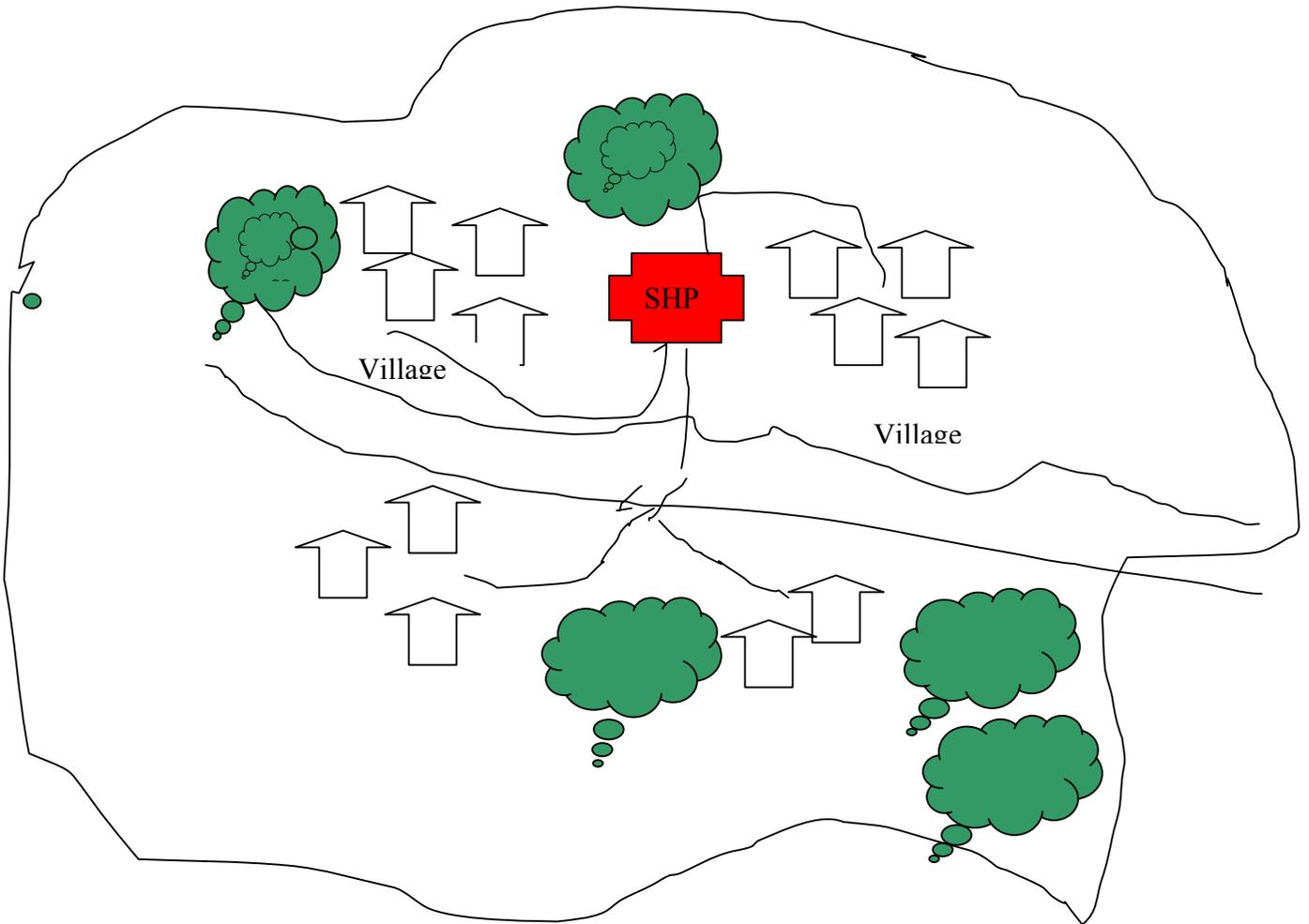
Community Data Board

It is very difficult for rural people to understand rate and ratio. But there are ways that rural people can make their own tools for collecting, analyzing and interpreting data. Community data board is one of the tool which can be used for recording important CS related data and this will help people to understand the problem and it will serve as a strong tool for monitoring the success.

How to use CDB

Local materials can be used for making community data board. In terai flat mat made from straw is very good. This mat can be covered by a white cloth. This board can be put on the wall of VDC or health post. Ask the group to make the map of their VDC on the board. The map should have following information;

- Villages with households and population of CS target group
- Houses of TBA/FCHVs
- Immunization/ORT centers
- HP/SHP
- School/market
- Road/condition



You can facilitate the group to put all CS data in this map. You can use color pins, color diagrams or color paper cuts to represent different data. Just you have to play with people and ready to help them.

Action planning: when people have knowledge on their problems let them facilitate to find out the solutions. Help them to plan an activity which will improve the situation of maternal and child health.

- Facilitate to set the goal and objectives: what people would like to achieve
 - Develop the strategy: how these objectives will be met? What CS activities? How these activities will be implemented and monitored?
 - Facilitate the group to prepare a detail plan of action for each CS activities
 - Help them to implement the plan activities
2. Reassess the situation: after the implementation of CS activities, help people to reassess the situation using above said process. Ask people to compare the situation. What changes have been made by the people? Encourage them to plan another activity.
 3. Transfer the skills: The aim of this approach is to enable the community to act as a long term problem solving group. In order to achieve this goal group members have knowledge and skills on problem solving. For this 2-3 group members should be trained on basic group dynamics, so later on they became the facilitator of their group and the group will sustain itself.