



CHILD SURVIVAL PROJECT  
*'Bal Bachau'*  
Far Western Region, Nepal  
CSXIX Expanded Impact Category

*Final Evaluation*  
August 20-September 7, 2007  
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*Child Survival XIX Project Final Evaluation*  
*CARE Nepal, August 20-September 7, 2007*  
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## Acronyms and Abbreviations

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Ante Natal Care
<b>ANM</b>	Auxiliary Nurse Midwife
<b>ARI</b>	Acute Respiratory Infection
<b>BCC</b>	Behavior Change Communication
<b>CBO</b>	Community Based Organization
<b>CB-IMCI</b>	Community Based Integrated Management of Childhood Illness
<b>CDD</b>	Control of Diarrheal Disease
<b>CDP</b>	Community Drugs Program
<b>CHD</b>	Child Health Division
<b>CHDK</b>	Clean Home Delivery Kit
<b>CHS</b>	Community Health Specialist
<b>CS</b>	Child Survival
<b>CSHGP</b>	Child Survival and Health Grants Program
<b>DDC</b>	District Development Committee
<b>DHO</b>	District Health Office
<b>DHS</b>	Demographic Health Survey
<b>DIP</b>	Detailed Implementation Plan
<b>DPHO</b>	District public Health Office
<b>EIC</b>	Expanded Impact Category
<b>EOC</b>	Emergency Obstetric Care
<b>FCHV</b>	Female Community Health Volunteers
<b>FCHV-CC</b>	FCHV Coordinating Committee
<b>FWR</b>	Far Western Region
<b>GH</b>	Global Health
<b>GTZ</b>	(Bilateral technical assistance of Germany)
<b>HA</b>	Health Assistant
<b>HF</b>	Health Facility
<b>HIDN</b>	Health, Infectious Disease, Nutrition
<b>HFOMC</b>	Health facility Operation and Management Committee
<b>HMIS</b>	Health Management Information System
<b>HP</b>	Health Post
<b>HQ</b>	Headquarters
<b>HW</b>	Health Worker
<b>IEC</b>	Information, Education and Communication
<b>IFA</b>	Iron and Folic Acid tablets
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>IMR</b>	Infant Mortality Rate
<b>INGO</b>	International Non-Governmental Organization
<b>KPC</b>	Knowledge Practice and Coverage
<b>LOE</b>	Level of Effort
<b>LMD</b>	Logistic Management Division
<b>LQAS</b>	Lot Quality Assurance Sampling
<b>MCHW</b>	Maternal Child Health Worker
<b>MG</b>	Mother's Group
<b>MMR</b>	Maternal Mortality Rate
<b>MNH</b>	Maternal and Newborn Health

<b>MOU</b>	Memorandum of Understanding
<b>MOHP</b>	Ministry of Health and Population
<b>MTE</b>	Mid-term Evaluation
<b>NDHS</b>	Nepal Demographic Health Survey
<b>NEPAS</b>	Nepal Pediatric Society
<b>NGO</b>	Non-Governmental Organization
<b>NTAG</b>	Nepal Technical Assistance Group
<b>ORC</b>	Outreach Clinic
<b>ORS</b>	Oral Rehydration Solution
<b>PCM</b>	Pneumonia Case Management
<b>PHC</b>	Primary Health Center
<b>PM</b>	Project Manager
<b>PNC</b>	Post-Natal Care
<b>QOC</b>	Quality of Care
<b>SHP</b>	Sub-Health Post
<b>STI</b>	Sexually Transmitted Infection
<b>TT</b>	Tetanus Toxoid
<b>U5</b>	Under age 5 children
<b>U5MR</b>	Child mortality rate (0-59 months)
<b>USAID</b>	United States Agency for International Development
<b>VDC</b>	Village Development Committee
<b>VHW</b>	Village Health Worker
<b>WRA</b>	Women of Reproductive Age

## A. Summary

Overview of the Project: CARE Nepal implemented a four year expanded impact child survival program in Kanchanpur, Doti, Dadeldhura and Bajhang districts of the Far Western Region of Nepal in partnership with Ministry of Health and Population and the communities from 2003-2007. The goal of the *Bal Bachau* child survival project was to reduce child and maternal mortality and morbidity through targeted interventions which empower communities and strengthen the capacity of local Non-Governmental Organizations (NGOs) and Ministry of Health and Population (MOHP) in the Far Western Region (FWR) of Nepal. To achieve these goals four strategic objectives were targeted. Improve access to services and supplies; improve quality of care; achieve behavioral change; and build local capacities. The key strategic approaches contributing to scale were - demonstrate successful and sustainable implementation of Community Based – Integrated Management of Childhood Illnesses (CB-IMCI); strengthen linkages between local government and civil society participants in health care management at the Health Post (HP), Sub Health Post (SHP) and District Health level; and evidence-based advocacy to increase support for CB-IMCI by regional and national MOHP Child Health Division. The interventions included control of diarrheal diseases, pneumonia case management and nutrition in all districts with additional maternal health interventions in Kanchanpur. The Project budget was \$3,333,370 with \$2,500,000 coming from USAID and \$833,370 provided by CARE as match fund.

Main accomplishments: The achievements of the project have to viewed within the context of conflict that ailed Nepal during the project duration; the difficult geographical terrain of the districts and the early KPC which was carried out to match the seasonality of the baseline KPC. Analysis of baseline and end line data shows that not only did the project achieve its objectives; it demonstrated some promising methodologies in community mobilization and development of local capacities. The project improved access to services by bringing health care closer to the communities through Female Community Health Volunteers (FCHVs). It improved access to supplies through effective advocacy at the local government and district levels, directly and through FCHV CCs. The quality of care was improved through improved capacities of health workers and enhanced participation of community in the management of facilities and the ensuing demand. Behaviors were changed for most key practices and are being sustained through the participation of empowered community structures. Local governments and NGOs are more confident in addressing child survival issues and are committed to carrying the activities forward. Through its rights based approach and wide usage of the Child Survival Sustainability Approach (CSSA) framework, project interventions reached the most marginalized, generated sustainable demands and left behind a larger developmental structure in the communities.

Achievement of Project Objectives: Pneumonia Case Management (PCM) was an immense success judging by the large improvements in mothers seeking care from a trained provider for their children with pneumonia symptoms (fast or difficult breathing). This changed from 40% at baseline to 87% at end line in Kanchanpur; and from 32% to 85% in the other districts. Percentage of sick children age 0-23 months who received increased fluids and continued feeding during illness decreased in

Kanchanpur (58% to 33%) and improved mildly (though not significant) in the other districts (10% - 17%). Most focus group mothers, in all project districts, were aware that 'more' needs to be given, but resorted to breast feeding. Percentage of FCHVs who correctly knew how to diagnose pneumonia cases according to protocol exceeded project targets in all the districts. It improved from 77% at baseline to 91% at end line in Kanchanpur and 30% to 92% in the other districts. Similarly percentage of MOHP staff (both at sub health post and health posts) diagnosing pneumonia correctly improved from 34% at baseline to 88% at end line in Kanchanpur and 70% to 88% in the other districts. These improvements were beyond the targets that project had set. All districts saw an immense improvement in percentage of children under two years of age (with diarrhea in last two weeks) being managed with ORS. The increase from baseline to end line for Kanchanpur is 34% to 87% and for other districts it is 36% to 83%. A very small percentage of mothers were found to be washing hands for all stipulated conditions, the increase (other districts) or decrease (Kanchanpur) in percentages from baseline to end line being insignificant. However the project did capture findings for 'hand washing for any one of the conditions'. This improved across the project area – 86% to 99% in Kanchanpur and 72% to 93 in other districts. Percentage of FCHVs who correctly know how to diagnose dehydration according to protocols improved from 84% at baseline to 100% at end line in Kanchanpur and from 63% to 94% in the other districts. The increase in exclusive breastfeeding (EBF) among children 0-6 months from 50% at baseline to 88% at the end of the project in Kanchanpur is impressive and surpasses the project target (75%). Percentage of children 6-9 months who received complementary foods in addition to breast milk did not show significant increase in Kanchanpur (83% to 82%) and demonstrated a minor improvement in the other districts (71% - 82%). The percentage of mothers reporting that their children 6-23 months received a vitamin A capsule in the six months prior to the survey showed significant decline in Kanchanpur, falling from 74% to 41%. This was related to problems associated with the supply of Vitamin A in the district. There was substantial improvement from baseline in the percentage of pregnant women who consumed IFA tablets for more than 90 days (Kanchanpur 26% - 85% and other districts 6% - 60%). Similar substantial increases in percentage of post partum women consuming Vitamin A within 45 days were made in all the project districts. However, only 41% of women of reproductive age group in Kanchanpur and 26% in the other districts were found to be consuming iodized salt. There were substantial improvements in women accessing any antenatal care and practicing positive maternal practices. There was an increase from baseline in supervisory visits for health workers and participation of VDCs and DDCs in monitoring and contributing to the health program.

Sustainability: The use of CSSA framework widely in the project enabled the identification of areas which required strengthening and the responsibilities of various stakeholders in making that possible. The enhanced levels of community awareness, demand for services, capacities of community providers and the participation of local governments will be sustained beyond project life; the lessons from the project area already are being employed beyond project districts. There is however a need for continued monitoring and supervision of the health providers for technical quality and plan for reorienting and refreshing their technical skills. This has budget implications and hence may not sustain unless local funding opportunities are tapped. There is a high degree of political commitment to the CB-IMC initiative and FCHV program; government plans to expand CB-IMCI in the entire country in the coming four years.

### Key Conclusions:

*Successful CB-IMCI Strategy:* CB-IMCI has increased access, free availability of life saving medicines for children at large and some preventive and promotive services for women. It has greatly changed behavior of the community resulting in increased utilization of health services.

*Improved Demand for Services:* Project generated an immense demand for services through its robust community mobilization strategy which was complemented by capacity building of community level providers.

*Community Ownership:* Communities through the mothers groups own this project. The MGs demand that their monthly meetings be held, that they receive information and create pressure for improvement of quality of services. The Village Development Committees (VDCs) and District Development Committees (DDCs) recognize FCHV as the 'pillar' of the CB-IMCI program and have supported her and community activities in a progressively increasing manner.

*Creation of sustainable community based resources:* Project promoted FCHV Coordinating Committees and Local Resource Persons as community based structures which have proven to be a source of continued support to the community level child survival activities.

*Inclusion of marginalized-Rights Based Approach:* The project addressed the needs of the most marginalized through the *Dabi* (pressure) groups and through increased focus of FCHV activities in *dalit* (lowest caste in the Hindu religion) areas. The use of RBA as a tool to help the community identify and address issues ailing them has generated a lot of visibility of the need for equitable service provision. The *Dabi* movement started by the project has great potential to mainstream the marginalized groups in Nepal. Through the life of the project, the *Dabi* groups expanded the issues addressed from health to development. However, the movement needs to be guided strongly within the developmental agenda.

*Improved Local Capacities:* The FCHVs and government workers are technically skilled to implement CB-IMCI activities; the health facilities are addressing improvement of health delivery through Health Facility Operationalization and Management Committees (HFOMC); and the VDCs/DDCs are monitoring/supporting community level child survival activities

### Key Recommendations:

- CARE with other PVOs should look at revised BCC strategies for influencing hand washing behaviors in the community.
- National level efforts should be made to streamline the supply of iodized salt. Efforts should be made to address the issue of salt bitterness and appropriate BCC strategy developed to improve consumption of iodized salt.
- The *Chaupadi* tradition prevalent in the FWR requires national attention. This can be addressed in a focused manner through the maternal neonatal strategy being formulated at the central level. CARE's active participation in this forum and wider dissemination can ensure that this detrimental community behavior is abolished and outlawed in the country.
- MOHP needs to support the improved capacities of FCHVs and MOHP workers by planning for new and refresher trainings. The regional and central level officials may explore the possibility of support to the CB-IMCI program from within the community. There are excellent examples of VDCs supporting

trainings of community level providers. Development of this linkage can mean faster expansion of IMCI activities in the entire country.

- Continued monitoring and supervision of HFOMC activities and the Community Drug Program is required to sustain achievements. This has to be included in district level plans and actively implemented.
- The issue of marginalized urban population needs to be studied scientifically to support policy makers to arrive at an appropriate solution.
- Process indicators to measure the participation of *dalits* in development have to be identified. This will complement the measurement of degree of participation. Suggested indicators include: number of agenda items proposed by *dalits*; number of issues identified by *dalits* addressed; number of issues identified in *dalit* communities resolved; and number of *dalits* in key decision making positions.
- PVOs have to be more realistic in their staffing patterns especially in difficult geographical terrains. Negotiate with the donor through the presentation of geographical constraints.

## **B. Assessment of Results and Impact of the Program**

CARE Nepal's *Bal Bachau* Child Survival Project is an expanded impact program. The first phase of the program was implemented in Kanchanpur district of the Far Western Region (FWR) of Nepal. In the second phase, the program was expanded to three other districts – Doti, Dadeldhura and Bajhang.

The conception of an Expanded Impact Program was based on the facilitating environment provided by 1) high priority accorded by the Ministry of Health and Population (MOHP) and external donor community to Community Based Integrated Management of Childhood Illnesses (CB-IMCI) strategies in Nepal; 2) presence of specific projects, such as the Nepal Family Health Program being implemented by John Snow Incorporated (JSI, Inc.); and 3) CARE Nepal CSXV's successful experience in collaborating with local MOHP, local governments (District Development Committees) and other partners in the implementation of CB-IMCI strategies, especially pneumonia case management and control of diarrheal disease.

The level of MOHP support for CB-IMCI strategies, coupled with CARE strategies for increasing public-private partnership in health care management, were expected to sustain the program activities throughout the FWR.

Key strategic approaches of the expanded program were:

- To demonstrate successful and sustainable implementation of CB-IMCI (especially for management of pneumonia and diarrheal disease) through improved quality of care strategies;
- To strengthen linkages between local government and civil society participants in health care management at the Health Post (HP), Sub Health Post (SHP) and District Health level;
- To develop a sustainable community supported program implementation model in Kanchanpur 1) promotion of health as an agenda in Village and District Development Committees (VDC/DDC); 2) formation of Female Child Health Volunteer Coordinating Committees (FCHVCCs); and improvement of linkages with line agencies of Government of Nepal (GoN)
- Evidence-based advocacy to increase support for CB-IMCI by regional and national MOHP Child Health Division.

### **1.1 Results: Important Contextual Note**

The results of the Child Survival program implemented between 2003 and 2007 need to be viewed in the context of two important socio-geographical aspects.

Geographical Area: This is an expanded impact program. While the first phase, implemented in Kanchanpur, is a plain area (*Terai* in Nepali); the three new districts are hilly with very poor infrastructure and few motor able roads. It takes three days of trekking to reach District Health Office of Bajhang. The evaluation team which visited Bajhang experienced this first hand. Most wards (villages) are in the valley and require three to four hours of trekking down to reach health facilities and VDCs.

Doti and Dadeldhura are extremely difficult geographical areas as well, which makes it difficult for the community to access services. The coverage area of field level project workers increased substantially compared to the first phase perhaps to keep within the available funding in the category.

Conflict: Nepal has witnessed political conflict in the last decade and was at the height of its unrest between 2002 and 2006. This affected the project - as planned project activities could not be accomplished in a timely manner owing to restricted mobility (as reported in subsequent annual and MTE reports); and on-the-job supportive supervision suffered again due to the difficult geographic area and restricted mobility (as identified during the final evaluation). CARE responded by developing a 'do no harm' strategy of working within the environment of conflict and negotiated at various levels, to ensure the implementation of the activities. FCHVs and local NGO partners are to be credited for participating in these resolution dialogues and thereby facilitating the implementation of the project.

Baseline and Endline Results: The final KPC survey was carried out nine months before project closure to minimize bias emanating from seasonality of disease. This complemented with the delayed start of community level activities may have affected the results. Some of the indicators were assessed based on the Health Information Management Systems (HIMS) data of GoN. Comparison has been made with HIMS data as well at places to explain the findings.

## **1.2 Results: Summary Chart**

Baseline and final evaluation data for the project objectives and indicators are summarized in Table Number 1. The indicators are drawn from those agreed upon in the Detailed Implementation Plan (DIP) document.

**Table 1: Results Summary Chart of CARE Nepal's Child Survival Project**

Objective 1: Access to services and supplies								Comments
Families have increased sustainable access to quality health care services and essential medicines at the community level.								
Indicator	Source	Baseline		Target		Final		
		K'pur+	Others*	K'pur	Others	K'pur	Others	
<b>Pneumonia Case Management:</b> Percentage of authorized FCHVs who have cotrimoxazole available for distribution	KPC	85%	3%	95%	65%	44%	62%	Not all FCHVs are treatment FCHVs. All treatment FCHVs were found to have adequate supply of cotrimoxazole
<b>Pneumonia Case Management:</b> Percentage of pneumonia cases seen by VHW/MCHW in HP/SHP as well as PHC-ORC	National IMCI Report 2006					3% KPur	16% BJ 16% Ddl 29% Doti	KPC captured proportion of women seeking care from trained providers and this improved substantially. Mothers were found to be approaching the FCHVs first, later the facility providers for respiratory infections.
<b>Control of Diarrheal Disease:</b> Percentage of FCHVs who have regular supplies of ORS for distribution.	KPC	68%	52%	85%	75%	97%	59%	Although project area experienced some stock outs, project team constantly monitored and ensured the availability of ORS
<b>Micronutrients:</b> Percentage of FCHVs who have supplies of IFA tablets for distribution.	KPC			80%	60%	NA	NA	Not asked in the KPC questionnaire
<b>Micronutrients:</b> Percentage of mothers who are aware of FCHVs role in Vitamin A distribution during campaigns	KPC	51%	51%	85%	85%	80%	77%	Improved, but did not reach target levels. However, mothers recognized the important role of FCHVs in health related activities and were approaching her more frequently.
<b>Others (MNC):</b> Percentage of mothers who have had TT2 during their last pregnancy in Kpur+ • based on maternity cards • based on card recall	KPC	13% 65%	46%	35% 85%	NA	94% 79%	81% 52%	Retention of cards by mothers is a problem in the project area. New strategies, are being applied to improve card retention.

+ K'pur: Kanchanpur; \* Other project districts: Doti, Dadeldhura and Bajhang.

Objective 2: Behavior change								
Caregivers of children below five years of age practice healthy behaviors and seek medical care from trained source when needed								
Indicator	Source	Baseline		Target		Final		Comments
		K'pur	Others	K'pur	Others	K'pur	Others	
<b>Pneumonia Case Management:</b> Percentage of mothers who recognizes two danger signs of pneumonia requiring medical treatment	KPC	70%	28%	85%	50%	46%	39%	Breakdown of data reveals that more than 70% of mothers in Kanchanpur and 57% in other districts knew at least one danger sign of pneumonia
Percentage of mothers who seek medical care from a trained provider (DHO, HP, SHP, trained FCHVs) for their child with signs of pneumonia (fast or difficult breathing).	KPC	40%	32%	75%	50%	87%	85%	Improved beyond set targets
<b>Control of Diarrheal Disease:</b> Percentage of children under 2 (with diarrhea in past 2 weeks) who were given the same or more breastfeeding and fluids	KPC							Mothers were relying on ORS for treating diarrhea dehydration, as ORS packets become freely available in the community.
- For breastfeeding		84%	68%	90%	75%	75%	79%	
- For fluids		84%	46%	90%	60%	75%	53%	
Percentage of children under 2 (with diarrhea in past 2 weeks) who were treated with ORS		34%	36%	50%	50%	87%	83%	This indicator improved at the expense of the previous indicator
Percentage of mothers of children under 2 years practicing appropriate hand washing**	KPC	16%	2%	30%	17%	7%	10%	Project was not able to improve this indicator. Availability of water and time taken to change this household level behavior are perhaps some reasons.
▪ all								
▪ Any one	KPC	86%	72%	90%	90%	99%	93%	Mothers washed their hands when they perceived them to be dirty. This was most commonly after defecation.

Objective 2: Behavior change								
Caregivers of children below five years of age practice healthy behaviors and seek medical care from trained source when needed								
Indicator	Source	Baseline		Target		Final		Comments
		K'pur	Others	K'pur	Others	K'pur	Others	
Percentage of mothers practicing exclusive breastfeeding for 6 months	KPC	50%	67%	75%	75%	88%	70%	Other districts did not see substantial improvements. Mothers continued to give water or cow's milk to children within three months.
<b>Micronutrients:</b> Percentage of children 6-24 m. who received vitamin A supplement in last six months	KPC	74%	NA	95%	75%	41%	51%	There were reported Vitamin A syrup stock outs in Kanchanpur
Percentage of women receiving Vit. A supplements within 45 days postpartum	KPC	64%	34%	90%	65%	80%	48%	This is direct result of improved postpartum care being received from women by FCHVs
Percentage of mothers who consumed iron folic acid supplements for at least 3 months in last pregnancy	KPC	26%	6%	55%	20%	85%	60%	Availability of IFA with FCHV and her active participation has resulted in this achievement.
Percentage of women of reproductive age consuming iodized salt to 80%	KPC	NA	NA	80%	80%	41%	26%	Availability of iodized salt has been a problem in the hilly districts. Though mothers are knowledgeable about importance of iodized salt, they are yet to completely adopt consumption as a behavior.
<b><u>General IMCI/MNC interventions</u></b> Percentage of 12-23 months aged children who complete immunization	KPC	74%	45%	85%	75%	53%	63%	Low card retention by mothers meant small sample size and high confidence limits. This indicator has to be interpreted with caution.
Increase measles immunization rate of children aged 12-23 months	KPC	87%	69%	92%	80%	79%	78%	Same as above. HMIS data indicates more than 75% coverage for measles vaccination

Percentage of mothers having used a Safer Home Delivery Kit for last delivery in Kanchanpur	KPC	32%	NA	50%	NA	32%	11%	Intervention only in Kanchanpur. The usage is proportional to number of deliveries being supported by trained providers.
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**Objective 3: Quality of Care**

Community level MOHP Personnel, FCHVs and other service providers practice appropriate case management of pneumonia, diarrhea and other CS intervention areas

Indicator	Source	Baseline		Target		Final		Comments
		K'pur	Others	K'pur	Others	K'pur	Others	
Percentage of FCHVs who correctly know how to diagnose pneumonia cases according to protocol (through cut off respiratory rates)	KPC	77%	39%	85%	60%	91%	92%	All skill based indicators improved substantially across the four districts
Percentage of MOHP (Health Post and Sub Health Post staff) who correctly diagnose pneumonia cases according to protocol (through cut off respiratory rates)	KPC	34%	70%	65%	85%	88%	88%	Project has exceeded targets. The levels of knowledge and appropriate diagnosis and management of pneumonia by MOHP workers has translated into reduced morbidity and severity of disease as well as community accessing services.
Increase % of FCHVs who correctly know how to diagnose dehydration according to protocol (through two signs of dehydration)	KPC	84%	63%	90%	75%	100%	94%	Project has exceeded targets. The levels of knowledge and appropriate diagnosis and preventive measures for dehydration by MOHP workers has translated into reduced morbidity and severity of disease as well as community accessing services.
Increase the % of FCHVs who give correct advice <sup>1</sup> regarding breastfeeding for children with diarrhea.	KPC	100%	90%	100%	92%	84%	86%	Reliance on ORS undermined the importance of breast feeding as means of preventing dehydration
Increase % of community level MOHP staff <sup>2</sup> who recommending increased breastfeeding during diarrheal episode	KPC	91%	74%	95%	80%	85%	88%	Usage of ORS is highly prevalent and is recommended more often

<sup>1</sup> more breastfeeding

<sup>2</sup> includes VHWs, MCHWs, ANM, AHW, HAS

Increase % of community level MOHP staff who correctly diagnose and manage <sup>3</sup> diarrheal dehydration cases.	KPC	73%	72%	80%	80%	69%	83%	MOHP staffs were found to be diagnosing dehydration appropriately, however mostly advised ORS for combating dehydration and missed continued breastfeeding as an advice, affecting this indicator.
<b>General IMCI &amp; MNC interventions</b> Increase % of FCHV that receive at least one supervisory visit in the last months prior to survey	KPC	65%	44%	75%	65%	25%	66%	Supervision activities suffer following project closure and prompted CARE to introduce strategies of FCHV coordinating committees. However visits from these resource persons hasn't been captured while measuring this indicator
Increase % of community level MOHP staff (VHW and MCHW) who have received at least one supervisory visit in the six months prior to survey	KPC	75%	54%	85%	70%	81%	78%	The supervisory visits were from MOHP staff/NGO partners/project staff/joint visits with VDC/ DDC representatives
Increase the % of mothers whose last delivery was attended by a trained provider		24%	NA	40%	NA	35%	15%	This has been hard to achieve owing to the entrenched <i>Chaupadi</i> tradition detailed in the report

<sup>3</sup> recommend ORS and increased fluid consumption

Objective 4: Local capacity building and other cross cutting strategy								
Local and community based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis								
Indicator	Source	Baseline		Target		Final		Comments
		K'pur	Others	K'pur	Others	K'pur	Others	
<i>Other districts</i> At least 30% project participants (from FCHV, to NGO participants) & activities will be focused on marginalized communities ( <i>Dalit</i> and other backwards) during project implementation	Project Monitoring Reports	--	--	--	30%	--	50%	50% project partners were <i>dalit</i> member based organization (in Doti, Dadeldhura and Bajhang)  Most members of <i>dabi</i> groups were from <i>dalit</i> or marginalized groups.  Participation of <i>dalit</i> and marginalized groups increased in Mothers Groups. About 30% increase of <i>dalit</i> and marginalized members in MGs (exact data not available)
Child Survival project is monitored by DDC (through district council) as well as other district level line agencies	Project Monitoring Reports	--	--	100%	100%	100%	100%	The project plan and progress was shared and approved by the DDC in all CS project districts on annual basis. DDC representative is the chair of the district level PAC and is monitoring activities regularly.
80% of health posts and sub-health posts have active CDP program with special provision for protecting the poorest of poor	Project Monitoring Reports	--	--	80%	80%	100%	34% in Bajhang Please see comments	100% HF in Kanchanpur and 34% HF in Bajhang have functional CDP Program. Bajhang has allocated CDP budgets for all VDCs. CDP is being implemented by UNICEF in Dadeldhura and by GTZ in Doti thus the project did not plan to implement CDP in these districts. All CDP HF have provision to provide free medicines for poor and <i>dalits</i> .
CS project developed joint implementation and monitoring plans with other CARE projects ( i.e. POWER, PRP)	Project Monitoring Reports	--	--	100%	100%	100%	100%	The project initiated intra-CARE project integration in all project districts. A joint plan of action and guideline for integration has been developed.

Objective 4: Local capacity building and other cross cutting strategy								
Local and community based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis								
Indicator	Source	Baseline		Target		Final		Comments
		K'pur	Others	K'pur	Others	K'pur	Others	
<b>Kanchanpur</b> 10% of mothers' groups implement extension program beyond membership	Project Monitoring Reports	--	--	10%	--	20%	--	All MGs in Kanchanpur included additional members in their MGs (from <i>dalit</i> and janajati groups) and about 20% (estimated) MGs carried out extended or mobile MG meetings in other clusters.
20% of mothers' groups in K'pur are involved with savings/loan activity with special priority to health loans	Project Monitoring Reports	--	--	20%	--	68%	--	68% MGs in Kanchanpur are involved in savings and credit activity. All MGs have provision for subsidized loan for health services (esp pregnancy and child care)
60% of FCHV-CC are registered as institutions and have financial partnerships with developmental agencies (eg. CARE)	Project Monitoring Reports	--	--	60%	--	25%	--	Five out of 20 FCHV-CCs are registered and have initiated process to amalgamate all VDCs and municipality FCHV-CC into District level federated FCHV-CC.
90% of VDCs are providing support (financial & non financial) to FCHV program in their area for supporting CS activities	Project Monitoring Reports	--	--	90%	90%	100%	100%	All VDCs are providing financial and in kind support to the FCHV program and to CS activities.
80% health facility (HP/SHP) have active health facility management committee (at least 4 meetings in previous year) managing and monitoring FCHV activities	Project Monitoring Reports	--	--	80%	80%	100%	100%	All HFs in Kanchanpur have active HFOMCs with at least four meetings in the last year.
Child Survival project is included as an agenda item in yearly DDC (district council) as well as other line agency meetings	Project Monitoring Reports	--	--	100%	100%	100%	100%	The project plan and progress has been shared and approved by the DDC Council in all CS project districts on annual basis. DDC representative is the chair of the district level PAC and monitoring activities regularly.

**Objective 4: Local capacity building and other cross cutting strategy**

Local and community based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis

Indicator	Source	Baseline		Target		Final		Comments
		K'pur	Others	K'pur	Others	K'pur	Others	
<b>Doti/Dadeldhura/Bajhang</b> CB-IMCI implementation is started in the districts -MOHP and FCHV trainings complete	Project Monitoring Reports	--	--	--	100%	--	100%	All CB-IMCI training has been completed in all districts. See training achievement sheet for details.
At least 2 CS-NGO partners in every district show increased technical capacities to support CS promotion	Project Monitoring Reports	--	--	--	100% 2/district	--	100% 2/district	All CS project districts have two NGO partners having increased technical capacities for CS activities.

## **2. Results: Technical Approach**

### **a. Brief overview of the project**

#### **a. 1 Goal and Objectives**

The goal of the project was to reduce child and maternal mortality and morbidity through targeted interventions which empower communities and strengthen capacities of local Non- Governmental Organizations (NGOs) and the Ministry of Health (MOHP) in the Far Western Region (FWR) of Nepal.

The objectives of the Program were to:

- **Improve Access to Services and Supplies:** Families have increased sustainable access to health education, quality health care services, and essential medicines at the community level.
- **Improve Quality of Care:** Community level MOHP personnel, Female Community Health Volunteers (FCHV), and other service providers practice appropriate case management of pneumonia and diarrhea, and other key IMCI intervention areas.
- **Achieve Behavioral Change:** Caregivers of children below five years of age practice healthy behaviors and seek medical care from trained sources when needed.
- **Build Local Capacities:** Local and community-based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis.

The level of MOHP support for CB-IMCI strategies, coupled with CARE strategies for increasing public-private partnership in health care management, were expected to sustain the program activities throughout the FWR. Key strategic approaches contributing to scale are:

- To demonstrate successful and sustainable implementation of CB-IMCI (especially for management of pneumonia and diarrheal disease) through improved quality of care strategies, in at least four districts of the FWR;
- To strengthen linkages between local government and civil society participants in health care management at the Health Post (HP), Sub Health Post (SHP) and District Health level; and
- Evidence-based advocacy to increase support for CB-IMCI by regional and national MOHP Child Health Division.

Cross-cutting strategies employed by the program include:

- Linkages with other line agencies of GON and stakeholders
- Focus on disadvantaged (ethnic and low-caste) groups and women empowerment
- Integration with other CARE projects
- Promotion of community cohesion
- Focus on gender and child rights issues

## **a.2 Project Location**

CARE Nepal's CS project called *Bal Bachau*, in Nepali for Child Survival was implemented in four districts – Kanchanpur, Doti, Dadeldhura and Bajhang - of the Far Western Region (FWR) of Nepal. This was an Expanded Impact project, Kanchanpur having been the target of a CS project between 1999 and 2003. Though the proposal was planned for 50% of Bajhang and 50% of Accham, another district in FWR, during the DIP process it was decided to cover 100% of Bajhang and exclude Accham based on request from the Regional Health Department (RHD) to cover the whole district. The period 2002-2006 has seen conflict in the FWR, Doti and Bajhang being the districts most seriously affected.

**Table 2. Project Coverage**

SN	Basic Information	CS Program District				
		Bajhang	Dadeldhura	Doti	Kanchanpur	Total
1	Number of VDCs	47	20	50	19	136
2	Number of Municipality	0	1	1	1	3
3	Number of SHP	35	15	39	10	99
4	Number of HP	10	9	10	8	37
5	Number of PHCC	2	1	2	3	8
6	Numbers of PHC/ORC	147	97	221	91	556
7	Numbers of Imm. Clinic	141	135	236	123	635
8	Partner NGOs	2	2	2	2	8
9	Total Population	185863	138990	229504	440630	994987
10	Under 1 years population	6002	4865	7281	14100	32248
11	Expected Pregnancies	8172	5143	9804	15863	38982
12	Under five population	27494	22794	33580	68298	152166
13	Married women of reproductive age group	39001	28215	46414	86363	199993
20	FCHV	423	465	625	785	2298

## **a.3 Intervention Mix**

Within the framework of Community Based Integrated Management of Childhood Illnesses (CBIMCI) the following level of efforts were expended on various interventions:

**Table 3. Intervention Mix**

Intervention	Kanchanpur	Doti	Dadeldhura	Bajhang
Nutrition	25%	35%	35%	35%
Control of Diarrheal Disease	25%	30%	30%	30%
Pneumonia Case Management	25%	35%	35%	35%
Maternal and New Born Care	25%	-	-	-

#### **a.4 Project Strategies**

The project strategies were aimed at increasing community demand for maternal and child health services and improving quality of services.

The project worked in close partnership with MOHP and local NGOs and coordinated the implementation of CB-IMCI strategies at the Health Facilities (Health Post, Sub Health Post) and community level. While technical and managerial capacities of the health providers were enhanced to improve quality of services, community based FCHVs were trained to provide basic preventive IMCI care and educate and influence health seeking by mothers and children. The project promoted the establishment of population based FCHVs as opposed to the norm of ward (urban unit) or VDC based FCHVs. Further the project built the capacities of local NGO partners to implement, train and co-ordinate CB-IMCI activities in partnership with MOHP, FCHVs and communities.

The project improved linkages between local governments, community and D(P)HO by facilitating their representation in HFOMCs and orienting them to the various aspects of improving child health.

The project employed a Rights Based Approach (RBA) to enhance the participation and provision of health services to the Poor Vulnerable and Socially Excluded (PVSE) groups.

The project benefited from the presence of CARE's infrastructure project ASHA, Poverty Reduction project *Ujalo*, HIV/AIDS project GIPA and NFHP (CARE was an implementing partner in this USAID funded project).

The CS XIX project spans the period from October 1, 2003 to September 30, 2007. The Project budget is \$3,333,370 with \$2,500,000 coming from USAID and \$833,370 provided by CARE as match fund.

#### **b. Progress report by intervention area**

*Note:* The results of the final KPC survey has been segregated to reflect findings in Kanchanpur (which saw implementation of IMCI activities for eight years) and other districts (includes Doti, Dadeldhura and Bajhang where implementation started in 2003). However, where relevant districts are discussed separately.

The CB-IMCI program of the GoN was first implemented in 1997 and was gradually expanded to cover 48 districts in 2007. Of these forty eight districts, thirty are supported by external agencies. The strategies adopted under this program are to improve health systems (including supplies) for delivery of quality health services; improving skills of health workers; and improving family and community practices. The FCHVs are an integral part of the CB-IMCI strategy and are trained to diagnose and provide preventive and curative (only that category of FCHVs who are called the treatment FCHVs) care for pneumonia and diarrhea; and promote positive nutritional and health behaviors among mothers and their under five children. MOHP plans to expand the CB-IMCI program to the entire country in the coming three years. The

strengths of the program are a) capacity building of FCHVs to identify, refer and/or manage identified childhood illnesses; and b) build capacity of facility level workers in IMCI.

## **D) Pneumonia Case Management**

The IMCI interventions of the project were within the framework of the National CB-IMCI program. This was complemented by strengthening the implementation of the Community Drug Program (another National Program) within which medicines are purchased from the market and sold at subsidized rates or free to identified marginalized poor; and for all others it is sold at a mark up for profit.

The project built the capacity of FCHVs and facility based workers; supported CDP implementation, activated Mothers Groups (which every FCHV is supposed to operationalize, but were not optimally active); supported Health Facility Management Committees; improved linkages between local governments (Village Development Committees) and the health providers and applied various cross cutting strategies, listed in the earlier section.

### **I.i) Results Baseline to Final**

Knowledge of danger signs: Pneumonia Case Management (PCM) was an immense success judging by the large improvements in mothers seeking care from a trained provider for their children with pneumonia (fast or difficult breathing). This changed from 40% at baseline to 87% at end line in Kanchanpur; and from 32% to 85% in the other districts. This was despite the fact that the mothers knowledge about two danger signs of pneumonia actually came down drastically in Kanchanpur 70% to 46%. Project staff felt that this was perhaps due to the increased migration into Kanchanpur. However, analysis of KPC sampling units revealed that the samples covered very few migrant populated VDCs. Breakdown of responses revealed that about two thirds of mothers mentioned either fast breathing or chest in drawing; half mentioned cough or fever; and one fourth mentioned inability to suck. In all women were aware of the critical pneumonia signs and symptoms.

The participating mothers of the focus group discussions in Kanchanpur were found to be fairly knowledgeable; almost all women mentioned fast breathing as an indication of a sick child or for approaching health facility.

Health seeking behavior: The impression that the evaluation team carried back was that mothers trust FCHVs and approach her in the initial stages of ARI. Most mothers were also found to be practicing household measures for ARI and cited FCHV as the source of their information. When a child presents with a danger sign they prefer taking the child either to the health facility or a private clinic. This is also reflected in the KPC results where very few mothers mentioned FCHVs as their first resort. This is perhaps because not all FCHVs are 'treatment FCHVs' or in other words have authority to store and prescribe cotrimoxazole.

The KPC survey does not capture the indicator ‘percentage of pneumonia cases managed by government health workers or facilities’. This figure was obtained from MOHP’s IMCI report for year 2006. It is interesting to note that though 87% of mothers in Kanchanpur and 85% in the other districts reported getting care from government providers, the report puts ‘percentage of pneumonia cases managed by government health workers or facilities’ at 3% and 16% for these respective districts. The difference in the calculations could not be ascertained. The qualitative findings however suggest that in all probability mothers are seeking timely care either from government providers or from FCHVs.

Feeding practices during illness: Percentage of sick children age 0-23 months who received increased fluids and continued feeding during illness decreased in Kanchanpur (58% to 33%) and improved mildly (though not significant) in the other districts (10% - 17%). Most focus group mothers, in all project districts, were aware that ‘more’ needs to be given, but resorted to breast feeding. This not only appeased the irritated child but also had the perception of having given more. Mothers admitted difficulties in feeding an irritable child. Mothers did however say that they offered the child more food. The message perhaps did not receive much importance from the FCHV, as reflected in discussions - not many focus group FCHVs mentioned this advice in their list of responses unless prompted.

FCHV capacity: Percentage of FCHVs who correctly knew how to diagnose pneumonia cases according to protocol exceeded project targets in all the districts. It improved from 77% at baseline to 91% at end line in Kanchanpur and 30% to 92% in the other districts. These improvements were beyond the targets that the project had set. FE team found that all FCHVs and MOHP workers had adequate and appropriate knowledge and skills to manage ARI and or Pneumonia. All treatment FCHVs were found to have adequate supplies of cotrimoxazole and respiratory rate timers. The FE team found the same. Further most health facilities visited had two months supply of cotrimoxazole.

Quality of services at HF: The proportion of MOHP workers who were correctly diagnosing and managing pneumonia went up from 34% to 88% in Kanchanpur and from 70% to 88% in the other districts. Project achievements have exceeded targets. The increased capacity of MOHP workers has translated into increased care seeking by the community. Furthermore, strengthening of the HFOMC has meant the availability of drugs at reduced prices for all and free of cost for the identified marginalized families. All the HFs visited by the FE teams displayed price lists of drugs and maintained a list of people who were to receive free drugs. CSP strengthened the implementation of the Community Drug Program (CDP) which is managed by the HFOMC in collaboration with the community. Project efforts have put health on the agenda of VDC meetings and this has further strengthened their participation in HFOMCs. VDCs were found to be funding various complementary activities, including, annual acknowledgements to the FCHVs; funding refresher training for FCHVs; monitoring of activities at the health facilities; participating in HFOMC meetings; and bridge funds for identified gaps in service provision.

The overall impact can be summarized in the words of a Village Health Worker (VHW) from Ashigram VDC in Dadeldhura – ‘we rarely see severe cases and I

haven't seen a pneumonia death in the last three years'. This was echoed in all districts across various levels of facilities.

### **Lii) Factors Affecting Achievement of Program Objectives**

CARE's supported CB-IMCI training for FCHVs and the Health Facility (HF) providers; and strengthened supervision of activities by these community providers. The immense success was a result of strengthened community level services and supplies. Mothers knew about signs and symptoms and sought care for their children during sickness. The providers were capable and had ample support from CDP and government in terms of supplies. This is a good example of improved demand generation and adequacy of supplies working together to improve an indicator.

The intervention further received impetus from improved linkages and increased health focus of local governments (covered in detail under the capacity building section).

### **Liii) Contributing factors for objectives not fully achieved (constraints)**

The decreased proportion of mothers who did not cite two signs of danger in pneumonia cannot fully be explained with available data. Breakdown of data reveals that more than 70% of mothers in Kanchanpur and 57% in other districts knew at least one danger sign of pneumonia. Inability to closely supervise (due to restricted mobility) led to some of the knowledge not being translated to behaviors. Delayed training activities also meant that the project spent about two years on community BCC activities. Final KPC survey captured results of only 15 months of community level efforts.

### **Liv) Successes and Lessons Learned**

#### Successes

- Knowledge regarding danger signs of pneumonia increased tremendously
- Mothers are offering more food and breast milk to children during illness
- Health seeking for pneumonia increased tremendously
- Mothers seeking care were given prompt and quality care by community based providers
- Local agencies were found to be active in addressing health related issues in the community
- CB-IMCI as an approach to decreasing childhood mortality and morbidity is successful as demonstrated by decreased severity of cases and case fatality rate.

#### Lessons learned

- The messages pertaining to offering a sick child more food and fluids/breast milk should be complemented with development of support system for the caregiver. Mothers found it easier to give breast milk to sick children who were not amenable to eating. This meant that children above six months of age

did not benefit as much. Mothers or the care givers need extra support to manage a sick child while meeting the demands of household/economic work. One possible strategy could be to identify a person - another mother/adolescent/elderly lady/husband who would share feeding responsibilities/household chores so that adequate attention could be given to a sick child.

- Basic message of splitting the intake of the child into 6-8 small meals (as appropriate for age) should be reinforced to improve feeding practices during sickness.

#### **I.v) Special outcomes and unexpected successes**

The project activities generated an immense amount of demand in the community. Mothers who were not a part of mothers group demanded to be a participant. When they could not join the group owing to number restriction (laid down informally for ease of management), they formed subgroups and demanded FCHVs to address these additional monthly meetings as well. Wherever FCHVs could not include *dalit* (socially excluded) mothers, subgroups were formed to enroll their participation. The *Dabi* (RBA groups formed to claim rights- explained in detail in community mobilization section) strategy expanded beyond its maternal child health agenda and promoted the demand for overall quality of health services and development.

#### **I.vi) Potential for Scale up**

This has been collectively discussed at the end of the section.

### **II. Control of Diarrheal Diseases**

The key family health practices directly related to diarrhea, which the project committed to promote, as outlined in DIP are

- Proper disposal of feces, including children's feces, and washing hands with soap after defecation, before preparing meals, and before feeding children.
- Promote use of safe water.
- Continue to give appropriate food and offer more fluids, including breast milk to children when they are sick.
- Give sick children appropriate home treatment for illness.
- Recognize when a sick child needs further care and seek appropriate outside care from trained provider promptly.
- Follow FCHV/health worker's advice about treatment, follow-up and referral.

Further CB-IMCI training for FCHVs and MOHP health workers covered home care for diarrhea; diagnosis and management of dehydration; proper use of ORS; and referral for severe dehydration.

#### **II.i Results Baseline to Final**

Household management of dehydration: While the proportion of mothers giving more fluids and breastfeed to children who had diarrhea in the last two weeks decreased

(not significant) in Kanchanpur, they improved in the other districts (again not significant). However, all districts saw an immense improvement in percentage of children under two years of age (with diarrhea in last two weeks) being managed with ORS. The increase from baseline to end line for Kanchanpur is 34% to 87% and for other districts it is 36% to 83%.

**Knowledge and behavior of mothers:** The results of diarrhea control were more or less similar to pneumonia management. While health care seeking improved tremendously, behaviors did not see much change. Almost all mothers from the focus group were aware of signs of dehydration; were aware of ORS as treatment for dehydration and accessed it from the FCHVs; and more than two thirds knew how to prepare the ORS as well.

**Hand washing:** Very small percentage of mothers were found to be washing hands for all stipulated conditions, the increase (other districts) or decrease (Kanchanpur) in percentages from baseline to end line being insignificant.

**Table 4: Hand Washing Practices**

District	Kanchanpur		Doti		Dadeldhura		Bajhang		Other Districts	
	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL
<b>Hand washing practice</b>	%	%	%	%	%	%	%	%	%	%
Before preparing food and having food	43	30	38	54	29	42	52	70	NA	55
Before Feeding Children	22	22	10	16	8	14	8	31	NA	20
After defecation	86	94	71	69	75	76	62	66	NA	70
After attending to a child who has defecated	58	44	29	40	30	32	27	42	NA	38
Others	-	33	23	39	47	68	34	22	NA	43
Never	4	1	23	11	12	3	17	7	NA	7
<b>Fulfilled 4 conditions of hand washing</b>	16	8	1	7	2	4	2	20	2	10

As can be seen from the above table, mothers were washing hands with soap/ash and water when they perceived them to be dirty. This was mostly after defecation and when hands were visibly dirty. They used water to wash before cooking food and feeding a child. FE team in focus groups observed mothers feeding children without washing hands. Many mothers knew the four stipulated conditions for washing hands. FE team found posters in the health facilities depicting this message pictorially. However, mothers have not adopted this behavior; and due to the difficulty of monitoring change in personal hygiene practices this gap could not be identified and reinforced by the FCHV. Inadequate water supply close to households in Bajhang and Doti was cited as one of the possible causes by the project team. It is noted that the 2006 draft list of rapid catch indicators requires the demonstration of hand washing for any two conditions, perhaps taking into consideration the difficulty in changing this behavior. Available data was insufficient to calculate this indicator. However the project did capture findings for 'hand washing for any one of the conditions'. This improved across project area – 86% to 99% in Kanchanpur and 72% to 93 in other districts.

Complementary activities – general sanitation: The Accessing Services for Households (ASHA- a CARE Project) project was instrumental in building toilets and establishing water connections in some CSP communities which promoted sanitary practices. Besides building toilets, the ASHA project, with help from child clubs in some VDCs, generated a great demand for toilets. Communities contributed their resources to acquire toilets. Percentage of homes with toilet increased from 36% at BL to 47% at EL in Kanchanpur. One thirds of households in the other districts had toilets. Among the households with a toilet the daily usages of toilet was also found to be high (about 90%). Almost all houses in the visited VDCs (except those visited in Kanchanpur Municipality) had toilet facilities. The issue of sanitation also received impetus wherever child clubs (Child to Child approach) were formed. Children took up various activities to promote cleanliness, hygiene and disposal of waste.

FCHV capacity: Percentage of FCHVs correctly knew how to diagnose dehydration according to protocols improved from 84% at baseline to 100% at end line in Kanchanpur and from 63% to 94% in the other districts. This improvement was way beyond the project targets in all the districts. However, the percentage of FCHVs recommending increased breast feeding to children with diarrhea came down slightly in all districts. It was found that FCHVs were putting more emphasis on ORS for management of dehydration. Percentage of FCHVs receiving regular supply of ORS improved from 68% to 97% in Kanchanpur and from 51% to 77% in the other districts.

Quality of services at HF: Similar findings were seen MOHP workers. All workers met during the KPC were found to be knowledgeable about signs and symptoms of diarrhea; management of dehydration; and use of ORS. Adequate supplies of ORS were found in the HFs visited by the FE teams.

Many VDCs provided FCHVs with blue cups to aid preparation of ORS (detailed in the MTE report) and through their VDC meetings monitored availability of ORS in the community.

## **II. ii. Factors Affecting Achievement of Program Objectives**

CARE's supported CB-IMCI training and strengthening supervision of FCHVs and the health facility providers in the new districts and supervision in Kanchanpur. The immense success was a result of strengthened community level services and supplies. Mothers knew about signs and symptoms of dehydration and gave ORS and sought care from the FCHV or the facility. The providers were capable and had ample supply of ORS. Keen monitoring led to identification of ORS stock outs and project successfully negotiated for its replenishment most of the times.

The intervention further received impetus from improved linkages and the increased health focus of local governments. Further, the water and sanitation activities carried out under CARE's ASHA program complemented the community level efforts of CSP. Children actively advocated for cleaner environment, usage of toilets and personal hygiene.

### **II. iii. Contributing Factors for Objectives Not Fully Achieved (Constraints)**

The hand washing and feeding practices did not improve. While hand washing behavior was also dependent on availability of water near the household, the feeding practices suffered due to over emphasis on ORS. Delayed start of training activities by the project meant that the project spent about two years on community BCC activities. Final KPC survey captures results of 15 months of community efforts. The inability of frequent monitoring due to restricted mobility led to some of the knowledge not being translated to behaviors. Again this could have been identified and reinforced had the project been able carry out adequate community supervision.

### **II. iv. Successes and Lessons Learned**

#### Successes

- High level of awareness has been created in the community. Mothers recognize signs of dehydration and approach FCHV for ORS.
- Mothers are practicing improved feeding practices during illness.
- Mothers seek treatment from HFs for severe disease.
- Availability of ORS in the community through the capable FCHV has meant that communities receive prompt care.
- VDCs and HFOMCs are participating in the program rendering the outcomes sustainable.

#### Lessons learned

- The adequate supplies of ORS through the government and its availability close to the community have made mothers reliant on ORS for managing dehydration. This needs to be complemented with the knowledge of home based rehydration as well. Mothers talked about providing home based fluids only when prompted.
- Mothers need additional support to be able to practice 'more' feed during illnesses.
- MOHP needs to strengthen systems to ensure timely and regular availability of essential life saving supplies to complement the improved health seeking behaviors of the community.

#### **v) Special Outcomes and Unexpected Successes**

High level of demand has been generated in the community. This demand is similar across marginalized population as well possibly due to the presence and activities of *Dabi* groups. CARE's complementary activities of providing toilets and water connections in the community; along with participation of children through schools has ensured the sustainability of achieved outcomes. While *Dabi* groups seem to have given a voice to the socially marginalized, there is a need of continued action to include the PVSE. The only deaths reported to the FE team were from a *Dalit* community.

### **III Immunization**

Improving immunization coverage was not a committed project intervention. Nevertheless, immunization (especially completion of immunization) was promoted as a part of the overall CB-IMCI strategy and to support government's efforts through immunization days. The project inputs included BCC for promoting complete immunization; participation in national immunization days and Vitamin A campaigns; capacity building of community level providers; supervision/monitoring and reviews at facility and district level; and strengthening linkages between local governments and health facilities.

### **III.i Results baseline to final**

The proportion of children aged 12-23 months fully immunized before their first birthday decreased in Kanchanpur (74% to 53%) and improved significantly in the other districts (45% to 63%). The drop in immunization rates was highlighted as one of the concerns during MTE and it was recommended to the project that secondary data be reviewed to ascertain the validity of LQAS data. Proportion of children aged 12-23 months who received measles vaccine decreased in Kanchanpur (87% to 79%) and improved in the other districts (60% to 78%).

These indicators have to be viewed with caution however. Sample size of those with a card was very small and therefore confidence intervals wide to comment on the significance of findings. The team further analyzed HMIS data for Kanchanpur and found no significant changes in coverage rate for measles between 2004-2006

Mothers in focus groups displayed a fair knowledge of immunization and were accessing care either through the outreach immunization clinics or the health facilities. The facility workers were found to be collaborating with the FCHVs to follow up drop outs and complete their immunization. FCHVs were actively involved in counseling mothers who dropped out of the immunization schedule. FCHVs also participated in national immunization days and ensured that all children receive their vaccination. Most FCHVs interviewed confidently claimed that no child in their community was not immunized.

However, very few mothers were found to have cards in their possession. Identifying this as a barrier to monitoring status of a child, MOHP and the project (in the last year) actively promoted the retention behavior of mothers by indicating more than one use for the card. Mothers are being told that this card is important for school admissions and would be useful when the child grew up and wanted to go abroad. The behavior may take time to develop though.

The project actively managed supply related issues in close coordination with the District Health Office. Project monitored the supply of vaccines and actively followed up on any shortages at the central level.

### **III. ii) Factors affecting achievement of program objectives**

The creation of *Dabi* groups resulted in communities pressurizing the facilities to conduct the outreach clinics; *Dabi* groups highlighted underserved areas and ensured that health providers from MOH respond to demands promptly. The project built capacities of FCHVs and facility providers to counsel mothers about the importance

of immunization. It also strengthened the outreach component through keen monitoring. In close collaboration with the DPHO CSP ensured that adequate vaccine supplies were available and monitoring data was utilized for identifying and resolving coverage related problems. This ensured that the increased demand was met by immunization services available close to the community. Besides the improved capacities of FCHVs and facility providers, some VDCs were found to be taking special interest in improving outreach for immunization and other activities. One VDC was contemplating hiring contractual health workers to include five more days of outreach through the facility. The improved focus of VDCs on health can be contributed to the project efforts.

### **III. iii) Contributing factors for objectives not fully achieved**

The failure of mothers to retain immunization cards makes it difficult to ascertain the actual coverage and this barrier was identified and addressed. However, the results of the efforts to promote card retention might be visible only in the coming years. There is a possibility that migration and conflict has also caused the deceleration of immunization uptake. This cannot be said conclusively though. The geographical difficulties adds to the problem of a vaccine being delivered regularly to all locations.

### **III. iv Successes and Lessons Learned**

#### Successes:

- There is a high degree of awareness about immunization and demand for services in the community.
- The *Dabi* groups are active in ensuring that the services due to them are provided by the facilities and workers.
- The outreach clinics have the potential to become need based, as being promoted by the VDCs.
- There is greater collaboration between health workers and FCHVs in tracking defaulting children.

#### Lessons learned

- In the absence of cards, especially among highly aware population, the rapid catch indicators do not necessarily capture the true nature of achievements.
- A rights based approach to development transfers the implementation of the interventions to the community to a great extent and is an excellent tool to sustain outcomes beyond any project life.

### **III. v) Special outcomes and unexpected successes**

The VDCs recognizing the need for immunization and responding to the needs of the community by promoting additional out reach sessions is indeed an unexpected but desired outcome of CSP's community mobilization activities.

## **IV. Micronutrients and Maternal Health**

The nutrition interventions included promotion of Exclusive Breast Feeding (EBF); IFA for pregnant women; vitamin A for children and post partum women; deworming; and consumption of iodized salt by women of reproductive age group. The maternal health intervention covered promotion of antenatal care, delivery by a trained provider, tetanus vaccination and postpartum care. Both the micronutrients and maternal health interventions were carried out in Kanchanpur district.

### **IV.i) Results baseline to final**

Breastfeeding: The increase in exclusive breastfeeding (EBF) among children 0-6 months from 50% at baseline to 88% at the end of the project in Kanchanpur is impressive and surpasses the project target (75%).

This quantum of improvement in EBF was not seen in other districts collectively. However, 91% of mothers in Bajhang were found to be practicing exclusive breast feeding. Continued breast feeding among children between 6 months to 23 months though did not show any significant improvement, it was being practiced by 92-98% of mothers in project districts.

Percentage of mothers who initiated breast feeding in the first hour of birth increased considerably in Kanchanpur but not so in the other districts. In the other districts the figures reflected a modest improvement (not significant) or decline (again not significant). More than 90% of mothers had initiated breast feeding between one to eight hours of birth. Focus Group Discussions (FGDs) with mothers (both members and non members of Mothers group) revealed that though they were aware of the need to feed the baby at the earliest, not many quoted one hour as the time. Further knowledge did not translate into behavior as other factors like fatigue and lack of support resulted in mothers delaying breast feeding. Considerable improvements were seen in mothers feeding their first milk to their infants, especially in the other districts (37% BL – 73% EL). Further more most mothers were feeding colostrum as demonstrated by feeding within three days of delivery. Most infants of mothers met received the benefit of colostrum. However the same cannot be said for the benefits that accrue to the post partum mothers due to early initiation of breast feeding in relationship to control and prevention of post partum hemorrhage.

The results for early initiation of breast feeding seem to be a direct result of project intervention. This message received considerable emphasis and was heard from mothers, FCHVs and health workers in focus groups and interviews. However, emphasis on exclusive breast feeding may have been less as indicated by minor improvements in the other districts. CARE will have to keep this in mind when they implement their maternal/neonatal project this year in Nepal. CARE will also have to develop BCC geared towards initiating breast feeding in the first hour so as to benefit the mother as well.

Complementary Child Feeding: The project promoted optimal complementary feeding through messages disseminated by the FCHV and at NGO meetings, though this is not clearly included in the DIP document as an objective for BCC. Percentage of children

6-9 months who received complementary foods in addition to breast milk did not show significant increase in Kanchanpur (83% to 82%) and demonstrated a minor improvement in the other districts (71% - 82%). Complementary feeding is initiated either in the fifth or the sixth month through a cultural rite where infants are introduced rice. The practice of feeding the child before four months of age has come down significantly owing to the projects emphasis on exclusive breast feeding. A mere two percent of mothers in Kanchanpur and five percent in other districts were found to be introducing complementary feed before the age of four months.

Most children in all four districts received two or more solid meals within 24 hrs prior to the survey and this was an improvement over the baseline. However, children receiving four or more solid meals decreased in all districts except in Dadeldhura. Focus group mothers stated that they offered food to the child but mostly depended on breast milk to soothe an irritated and possibly hungry child. In future projects more focused messages should be delivered to ensure that breast milk is not construed as replacement for solid food especially in children above one year of age. The key message of 'one year old should eat half of what the mother eats' (provided mother is consuming adequate calories (!) should be delivered. It must be kept in mind that some families do face food insecurity and the child feeding practices may reflect this as well.

Although half the mothers in Kanchanpur and more than one third in other districts were aware of *Sarbottam Pitho* (an enriched fortified food), less than one fifth of the mothers fed this to their children. Perhaps better utilization could have complemented and improved the project achievements in nutritional status of children.

The project achieved mild to moderate improvements in the proportion of houses with kitchen gardens and availability of Vitamin A rich foods in this garden. More than four fifths of the households visited had a kitchen garden.

Some improvements seen in the percentage of children age 0-23 month who were underweight (Kanchanpur 38% - 28%; and other districts 38% - 31% ) could have been amplified but for the loss of emphasis on 'more' solid meals and reliance of breast milk for a meal.

Vitamin A supplementation: The percentage of mothers reporting that their children 6-23 months received a vitamin A capsule in the six months prior to the survey showed significant decline in Kanchanpur, falling from 74% to 41%. This was related to problems associated with the supply of Vitamin A in the district. Further migration of population into the region following conflict could possibly have added to the figures, though this cannot be conclusively stated. In the other districts this improved from 41% at baseline to 51% at end line. This improvement could have been more substantial but for the non-availability of Vitamin A for long periods during the project duration in Bajhang district.

Growth monitoring and the Hearth nutrition model: The project has implemented PD/Hearth Sessions in nine sites of Kanchanpur (from two VDCs and Municipality). Out of total of 155 malnourished children enrolled in the Hearth Sessions, 89 (57%) gained normal nutritional status. Mothers in the community were found to be practicing positive nutritional behaviors. They reported feeding their children calorie

and vitamin rich food; and were accessing growth monitoring services. Community workers managing health reported developing confidence in nutritional interventions and receiving support from community members (teachers and social leaders) and DPHO. Community members were willing to run the program and contribute efforts but expressed a need for continued facilitation by CARE.

It is MOHP policy to promote growth monitoring of all children under the age of five years. FCHVs and health workers are expected to monitor growth at the community and facility level. Project emphasized the importance of growth monitoring and birth weight through MG and FCHV meetings. Project through IMCI trainings ensured transfer of growth monitoring skills to FCHVs and Health workers.

All health facilities visited were observed to have weighing scales and workers were found to be adept at weighing and recording in the cards.

Improvement in growth monitoring is not a committed indicator in the project log frame; however, this indicator has been captured in the KPC. Proportion of children being weighed at birth increased significantly in Kanchanpur and marginally (not significant) in the other districts. The actual increase is perhaps not captured as many mothers do not retain their cards. This has been addressed by the project and MOHP and concerted efforts are being made to promote the retention of cards (including antenatal and immunization cards). Although about 50% of children had been weighed in the last four months (except in Dadeldhura – 29%), less than half of them did not possess growth monitoring cards.

Maternal Nutrition: There was substantial improvement from baseline in the percentage of pregnant women who consumed IFA tablets for more than 90 days (Kanchanpur 26% - 85% and other districts 06% - 60%). The unavailability of IFA at the community level in Kanchanpur was identified by project staff and efforts were made to make them available through government channels. Though maternal interventions were undertaken in Kanchanpur as an added area of expansion, it is interesting to note that the other districts fared well too. This might lead to the question of whether the improvement in this indicator was due to the natural impetus being given to the maternal child health program across Nepal. The basic impression however indicates that the improvement was more due to the projects induced enhanced role of FCHV. The basic training of FCHVs covers all important public health issues. This training complemented by the CB-IMCI training and project support led FCHVs to perform better and expand their scope of work. This was stated very succinctly by one FCHV who said *'we did not know we were FCHVs, we would be contacted once or twice a year by the government to participate in the Vitamin A or the pulse polio program. Now we understand the larger role we can play to the improvement of our community'*.

Similar substantial increases in percentage of post partum women consuming Vitamin A within 45 days were made in all the project districts. Mothers were found to be more aware about the availability of Vitamin A with FCHV when compared to baseline.

However, only 41% of the women of reproductive age group in Kanchanpur and 26% in the other districts were found to be consuming iodized salt. Focus group women

conceded to knowing the importance of iodized salt, but complained of a bitter taste, higher price and non-availability in market as some of the reasons for not using iodized salt. In geographically difficult areas like Bajhang, government supplies subsidized salt at the district level. Various stakeholders in Bajhang felt that availability closer to the community would improve the usage. Another important factor to keep in mind is the increasing use of iodized salt for cattle. Communities may use the subsidized salt for their cattle and continue to consume non-iodized rock salt. Any future strategy to improve consumption of iodized salt should be based on reasons for bitterness of the salt, modalities of making it available close to the community and monitoring consumption of subsidized salt by humans.

BCC did include messages aimed at increasing quantity and quality of diet among pregnant and lactating mothers; however, this was not measured. Some mothers – in-law who joined the focus groups towards the end talked about how women today ate more during pregnancy and seemed accepting of the fact.

Maternal Health: There were substantial improvements in women accessing any antenatal care and practicing positive maternal practices. The indicators in Dadeldhura are better than the other two mountainous districts as it receives increased attention from two more agencies – UNFPA and UNICEF, which are implementing maternal interventions with the support of local partners. HMIS data indicates major improvements in maternal health indicators. Some key indicators from the final KPC report are detailed below:

**Table 5. Maternal Health Indicators**

Indicators	Kanchanpur		Doti		Dadeldhura		Bajhang	
	BL	EL	BL	EL	BL	EL	BL	EL
Sought ANC	NA	74	32	49	62	73	16	47
ANC from trained provider		82	82	95	92	97	94	92
Has ANC card	14	19	18	5	8	3	6	8
At least 4 ANC visits (verbal)	32	50	14	23	30	43	27	26
2 TT shots			BL	EL combined for three districts				
Based on card	13	94	NA	81				
Card + recall	65	79	46	52				
Using safer delivery kits	32	32	NA	11				
Knowledge of at least 2 danger signs	NA	67	NA	55	NA	43	NA	76
Skilled attendance at birth	NA	35	9	10	23	27	9	9
Post natal care	18	16	7	8	5	10	5	10

A greater number of women are accessing antenatal care and accessing it the least recommended number of times. A woman has to go to the nearest facility for ANC. This could mean trekking substantially to reach the center, at least in the hilly districts. Though FCHVs provide IFA and support consumption behaviors in the

community, TT shots can be received only in the health facilities. Similarly pregnant women receive health education and many deliver at home though few with skilled assistance. It is important to note here that the tradition of *Chaupadi*, where a woman is isolated (confined to a separate hut – sometimes to a corner of the cowshed) when she is menstruating or about to deliver, is entrenched in the society and is reflected in the poor indicators for skilled attendance at birth and post natal care. Project efforts to address this harmful custom are detailed under the community mobilization section.

The percentage of mothers whose last delivery was attended by a trained provider increased marginally in Kanchanpur from 24% at base line to 35% at end line. The proportion of women in other districts whose last births were attended by trained provider however remains low at 15%.

In Dadeldhura and Kanchanpur it was found that a certain amount of duplication was taking place between various agencies. While CARE was implementing maternal activities, Save the Children was implementing maternal neonatal activities through the same groups albeit in fewer VDCs. Similarly in Dadeldhura other agencies were carrying out capacity building activities for the same structures. Though the operational details were being addressed through the district based reproductive health coordinating committees, there is a need to address this at the National level. The Social Welfare Council, which is the nodal agency for coordinating PVO activities, can play an active role in the project design phase to prevent this in future.

HIV/AIDS: The project identified the need for generating awareness on HIV/AIDS as many women were testing positive for HIV. Since migration to India from the FWR is high, men bring the ‘Indian’ disease back to their wives often affects the quality of life of the women in reproductive age group and their children. In Doti 33 of the 73 selected for VCT tested positive in 2003-2004. Almost all of them were women (widows). CARE complemented pilot activities to help address the affected families and communities through GIPA framework (Greater Involvement of People with living with HIV and AIDS) with financial support from CARE Asia Regional Management Unit. The project aimed at promoting the well being of people infected and affected by HIV and AIDS in Doti district. Details of the project are well reported in the last annual report submitted by the project.

FCHVs, who were oriented by the project educated the mothers group and helped improve awareness in the community. The percentage of mothers with children age 0-23 months who were able to cite at least two known ways of reducing the risk of HIV infection improved from 38% at baseline to 52% at end line in Kanchanpur and from 10% to 18% in the other districts.

#### **IV. ii) Factors Affecting Achievement of Program Objectives**

The project used an intensive BCC strategy which led to the improvement and maintenance of some crucial behaviors – early initiation of breast feeding, exclusive breast feeding, IFA/Vitamin A consumption and antenatal care. Project effectively enhanced the capacities of the FCHVs to educate and counsel mothers in group meetings; and monitor behaviors in the community. Group members further were encouraged to and did counsel other mothers in the community. There were no large differences in the knowledge and behaviors of member and non-member mothers.

Although knowledge levels were high some did not translate into behavior. The BCC strategy will be discussed further in BCC section.

Increased participation from FCHVs and government health workers also resulted in overall improvement in the nutritional status of the women and children. The project also applied the Child to Child approach and facilitated creation of child clubs in schools which took up various activities geared towards improvement of maternal child health.

#### **IV. iii) Contributing factors for objectives not fully achieved (constraints)**

The project achieved some substantial improvements. This could have been enhanced further with adequate support from the supply side – availability of iodized salt and Vitamin A; adequacy of on site supervision – which could not be carried out to desired levels owing to conflict and entrenched socio-cultural traditions – which though received enormous attention from the project through its *Dabi* approach.

In focus groups, it was clear that behaviors which improved received more attention from the project than those which did not improve. The numbers of messages being received by the women were too many, as the project looked at multiple child survival interventions. This was compounded by the fact that the community level interventions could not be started before the completion of FCHV trainings, which were in turn delayed due to the conflict.

Hearth project implemented in limited VDCs could not be supported following cessation of activities as adequate linkages for providing nutritional material could not be created.

Child clubs were not adequately linked to other informational and development activities. This is a missed opportunity. The scope for participation of students is very high and has a lot of visibility in the community besides providing an opportunity for future mothers to be educated.

#### **IV. iv) Successes and Lessons Learned**

##### Successes:

- The national attention now being given to *Chaupadi* system is a direct result of CARE's promotion of a right based approach to health and development. The enhanced capacities of communities to demand services have indeed resulted in a gradual yet certain positive response from the care providers.
- Complementary HIV/AIDS activities by CARE addressed an identified need of the community. The involvement of FCHV ensures that the project leaves behind some community capacities to deal with prevention of HIV and support for people affected with it.

##### Lessons learned:

- It is important to ensure that breast feeding is initiated within the first hour of birth to ensure the mother also benefits from the improved hormonal secretions. BCC messages need to incorporate this aspect adequately.
- It is important to link nutritional activities with other interventions which ensure food availability so that the most marginalized are able to practice the learned behaviors.
- Pregnant women in geographically difficult areas face hardships in accessing antenatal checkups. CARE can address the availability of tetanus toxoid vaccination and antenatal checkups closer to the community by expanding the scope of the out reach sessions, which currently provide childhood vaccinations.
- The existing strategy for promoting consumption of iodized salt needs to be revisited to ensure that availability of salt and adoption of positive behaviors can be achieved.
- The right based approach and *Dabi* movement are excellent approaches to building community capacities to identify and address developmental issues in a sustainable manner and should be applied in future projects to achieve amplified outcomes.
- Retention of immunization and growth monitoring cards needs attention to enable quantification of outcomes effectively.

#### **IV. v) Application to future activities**

The lessons learned will be taken up in the upcoming CS project ‘CRADLE’ this year which focuses on the health of mothers and newborns. CARE will continue to work with FCHVs as their participation has meant services closer to the community and increased community capacities. Furthermore CARE plans to advocate at the national level for better supplies of vital inputs to overcome some of the constraints faced during this project. The excellent relationships that CARE has developed with the regional health directorate and the national child health division; and its participation in advocacy forums will help ensure that some of the lessons learned will be applied in future projects of all partners.

#### **IV. v) Special outcomes and unexpected successes and application to future activities**

The *Dabi* (literally means ‘claiming rights’) movement initiated by this project has caught on quickly across the adjoining districts and else where in Nepal. *Dabi* groups have put the cause of *Chaupadi* on the national agenda and have influenced the participation of Poor Vulnerable and Socially Excluded (PVSE) in health and development. The *Dabi* approach is discussed in detail in the community mobilization section.

#### **IV. vii) Potential for scaling up or expanding**

MOHP actively promotes the participation of FCHVs in maternal child health activities. FCHVs will continue to be the focal community contact for MOHP. The most crucial support would be that of adequate supervision so as to maintain the

quality of her services to the community. MOHP is in the process of developing maternal neonatal guidelines for the country and the maternal interventions are expected to be scaled up once they are operationalized. CARE is a participant in this process and will share lessons learnt in the maternal and neonatal working group.

## **V. Malaria**

Malaria interventions were not specifically stated in the objectives. The project committed to exploring possibilities of funding malaria activities through other sources, as this was a demand from the local population. The Project was able to find this funding through Nepal Family Health Project (USAID funded) and MOHP, in both the phases of CSP.

Malaria Control activities were implemented in Kanchanpur for a period of twenty one months between January 2005 to September 2006. The aim of the initiative was to support the District Public Health Office in Kanchanpur to increase the availability, accessibility and quality of the services provided to control malaria at the household and community levels.

CSP established malaria laboratory facilities; strengthened capacities to ensure early diagnosis and proper management of cases at the health facility and community level, generated awareness to prevent vector transmission of disease; and strengthened monitoring mechanism of district health system.

Of the twelve labs with malaria microscopy facility in Kanchanpur, nine were established through the project by mobilizing HFOMC. Furthermore CARE Nepal supported the recruitment of one local laboratory technician for seven malaria microscopy centers on a cost sharing basis between DPHO, HFOMC and CARE Nepal. The establishment of these functional laboratories has resulted in a wide range of lab services becoming available to the community, in addition to malaria microscopy services. More than 18,000 people benefited from malaria microscopic services during the project period.

Training and orientation programs for lab assistants, health facility staffs, schoolteachers and FCHV were carried out by CSP. Seven-day malarial microscopy training was given to the five newly recruited laboratory technicians in coordination with NFHP Infectious Disease Coordinator. To ensure that quality of malarial microscopy services provided by the private sector, a lab accreditation process was carried out and 14 private labs were oriented to this process. A total of 748 FCHVs and 45 health functionaries were oriented in malaria control activities. Furthermore, 218 treatment FCHVs were trained to collect blood slides, provide Chloroquine, maintain records, report and refer complicated cases.

In the community CSP focused on enhancing the participation of mothers through FCHVs and school children through teachers in malaria control and positive treatment seeking. Fifty teachers were given two-day orientations and school health education program for grades VII-IX was conducted through five sessions for 49 schools jointly by teachers and health facility staff.

Free distribution of insecticide treated nets (ITN) and a social marketing approach has been promoted in the district as a method of vector control and transmission risk-reduction. About 30,000 ITN were distributed and socially marketed between 2005 and 2006 in the high-endemic areas of Kanchanpur both by DPHO and PSI/Nepal. Estimated 103,494 people are thought to be benefiting from the free-distributed nets. Indoor residual spraying was also carried out in the district by the DPHO office.

The project's success has been to garner community support to malaria control activities and ownership it has been able to generate within the community.

#### **V. i) Results baseline to final**

Baseline KPC survey found that though 91% mothers knew about bed nets as a mean of preventing malaria and 93% of households had bed nets, only 66% of adults and children were found to be sleeping under it. Additionally a mere 3% of households have Insecticide Treated Nets (ITN). Through regular reviews project staff monitored and negotiated for availability of treated nets through the MOHP. The quantity that was made available in the project period did not help improve coverage. The percentage of children age 0-23 months who slept under a ITN the previous night did not improve from baseline (2%) to end line (2.4%), perhaps owing to non-availability of ITNs.

However, since overall health seeking improved, children who had fever were taken to a health provider (as depicted in previous sections) and labs established under the project served to identify malaria. The project does not have additional information to capture indicators which have now been listed in the 2006 draft rapid catch indicators. Proportion of children with fever and convulsions decreased from 9% at baseline to 2.7% at end line.

#### **V. ii) Factors affecting achievement of program objectives**

CSP responded to a felt need. It built on the availability of mothers groups, FCHVs and schools in the community to generate demand for malaria services. It further strengthened the management and technical capacity of health providers; and supported establishment of quality laboratory services. The malaria control activities received impetus through CARE's advocacy at VDC, DDC and DPHO level.

#### **V. iii) Contributing factors for objectives not fully achieved (constraints)**

The lack of improvement in percentage of children sleeping under ITN can be attributed to the supply related problems in MOHP.

#### **V. iv) Special outcomes and unexpected successes**

The labs which were primarily established for improving availability of malaria diagnostic services were found to be providing a wide range of lab services to the community. The HFOMC has successfully taken over the complete responsibility of providing salaries to the lab technicians. The FE team was informed that the HFOMC in neighboring VDCs have also established labs inspired by the success from CSP areas.

Community members mentioned that they would earlier take an antipyretic for a fever. Now with the availability of a lab and the awareness which has been generated in the community, they approach the health center within 24 hours of fever for a blood examination.

School children are actively promoting the buying of ITN through social marketing outlets. They are convincing their parents and communities of the benefits versus the cost of the ITN.

#### **V. v) Potential for scaling up or expanding all activities**

Political commitment: CB-IMCI is a MOHP program and expansion is imminent. As mentioned earlier, government identifies CB-IMCI as a key strategy to improve health of children and has committed to expanding the program to the entire country in the next three years. Barriers to expansion are limited funding from within the government; and barriers to quality of implementation - supply regularity and need for managerial and community capacities in MOHP facilities.

Mothers groups: The outcomes achieved by the project will be sustained as women from the mothers group are sharing their knowledge and influencing behaviors of other mothers in the community. FCHV is being sought by mothers for care. These behavior change outcomes will be sustained through adequate monitoring and supervision; refresher trainings for providers; adequacy of supplies; and continued effective management of CDP through MOHP facilities. The role of FCHVs in strengthening mothers group has been well acknowledged by the government and other developmental agencies and one can see evidence of their involvement within other developmental bodies.

FCHVs: MOHP actively promotes the participation of FCHVs in CB-IMCI activities. They have a potential to be change agents of development. MOHP is however concerned about expanding their role to more than health as they fear dilution of focus. This was discussed in detail with various stakeholders. Personnel who have visited project sites changed their opinion after observing the active participation of FCHVs.

The concept of FCHV CCs has caught on and is being experimented beyond the project areas. FCHVs will continue to be the focal community contact for the CB-IMCI program. How well they will continue to be supported is the question that needs to be asked. There are anecdotal instances of VDCs funding FCHV trainings both the basic training on CB – IMCI and refresher trainings. DDCs and VDCs have created an endowment fund to support FCHVs. However the most crucial support would be that of adequate supervision so as to maintain the quality of her services to the community. The development of FCHV capacity is discussed in detail elsewhere in the report.

Participation of VDCs: MOHP's CDP program envisions a management role for the VDCs. Through effective enrolment of VDCs in health activities has been able to demonstrate the role that local governments can play in pushing health on the developmental agenda.

### **3. Cross-cutting approaches**

Some of the background information and analysis for this section has been covered in the above sections. The following sections will build on them to avoid repetition.

#### **3.1 Community Mobilization**

With mothers as the core of the community mobilization strategy, the project partnered with NGOs to facilitate the strengthening of Mothers' Groups (MGs); empower a mother nominated from each group to work as a Female Community Health Volunteer and organize FCHVs as a Coordination Committee empowering them for self-mobilization.

In the second broad layer of community mobilization, the project facilitated linkages between these entities and district level government, local government (LGs), District (Public) Health Office (DPHO) and VDC level Health Facility (HF) and Health Facility Operation and Management Committee (HFOMC), media and political parties.

##### Mothers' Groups

The Community Mobilization strategy was focused on Mothers' Groups which were present in each ward. These groups were found to be in varying stages of formation and activation at baseline by the project. The main mobilization activity of the project was to energize these groups; and build the capacity of the nominated FCHVs through NGO partners.

Many of the MGs are also savings and loans groups. The baseline survey found that communities had groups formed around other developmental issues as well (poverty reduction, water users, farmers etc). MOHP's FCHV program which earlier stipulated selection of one FCHV in one ward for capacity building activities was later revised to a population based system. FCHVs were to be selected for 300-500 population depending on the vulnerability of the area. The project promoted this in all four districts and actively supported the selection of additional FCHVs.

This translated into strengthening of additional MGs. The project was reaching out to 2332 MGs at the time of the final evaluation. Not only were MGs strengthened by population based FCHVs, additional sub-groups were formed as a result of community demand for participation in group activities.

Each group holds a monthly meeting which is moderated by the FCHV, who is a member of the MG as well. She uses the meeting as a platform for educating mothers on CB-IMCI behaviors, sharing information on services available and promoting activities beyond the group. FCHVs, members of the MG, and local NGOs are actively involved in these meetings. CSP staff and the MOHP staff are peripheral to this activity but they support the meetings. The FE team also found that mothers who were not members of the group were well aware of the groups activities and their knowledge and health behaviors were similar to the women in groups. Empowered MGs have meant better linkages with local VDCs. In some of the wards groups have enrolled VDCs into contributing financially for building toilets for the poorest

households. The DPHO and DDC members of the Kanchanpur shared the story of how MG members put pressure on FCHVs to take up the issue of separating the DOTS and immunization activities, which were being provided through the same room in the health facility.

The savings and loans activity is common to many MGs. The savings from the group was being used for emergency health needs. Women within the group received loans with a small interest whereas some groups gave loans to other mothers at a slightly higher interest, albeit lesser than the commercial money lender. The FE team found that the collective savings of mothers in Kanchanpur district is USD 150,000. The groups however lack the financial management skills to protect and build on this fund.

While savings activity provided cohesion to the group, this also resulted in some poor mothers being excluded from the group. Recognizing this, the project promoted the formation of non-savings group as well which was well received by the poor mothers.

*FCHV Coordination Committees:*

The final evaluation of phase I activities in Kanchanpur recommended that the empowered FCHVs be supported through formation of coordination committees (FCHV CCs) This would provide a platform for them to develop better linkages, provide peer support and enhance their outputs due to collective action. Project supported the formation of 20 FCHV CCs in Kanchanpur and strengthened and worked together with these FCHV-CCs during phase II. Project found immense success and unexpected results through their partnerships with FCHVCCs. The support from the project was in the form of organization development activities, proposal writing skills and linkages. These CCs have performed beyond their CB-IMCI role; They:

- are playing an active role in the management of health facilities;
- are instrumental in building separate toilets for women in the health facilities where there were none;
- have supported numerous MGs in initiating community level activities including improving the hygiene and sanitation of the village members.
- are able to voice community concerns collectively and put it across to various stakeholders in an emphatic manner. When they were not heard at one level they took up the case of immunization and DOTS (described in the previous paragraph) to three other levels and ensured resolution of the MG identified issue.
- have led campaigns to promote equity resulting in increase of *dalit's* participation in health related activities and MG meetings.

FCHV-CCs have been active in supporting their peers. There was found to be no animosity between members and non-members of FCHV CCs.

CARE carried out an independent study to analyze the comparative advantage of organized FCHVs over their unorganized peers. This study analyzed both quantitative secondary data and gathered qualitative data from three districts, three municipalities and 12 VDCs. The general trend as depicted by the figures and views expressed by the FCHVs is that the organized FCHVs (both registered and non-registered) have

better track record as an organizer, counselor and educator. Their engagement with mothers groups have been more intensive and they have been more assertive in bringing pressure to bear on the health service providers for better care and support

**Table 6 Comparison of activities by organized and unorganized FCHVs**

<u>Organized</u>	<u>Non-organized</u>
i. Hold monthly meeting to discuss community health agenda	i. Report to Health Facility every month with Ward Register. Submit performance record and return
ii. Ensure the VHW attend the FCHV meet and verify the monthly performance record	ii. No monitoring unit. VHW and MCHW visit sometimes to verify the performance record
iii. Forum created to share problems faced by individual FCHVs and find solution	iii. FCHVs face problems/challenges individually. No forum to share with colleagues
iv. Monitoring unit comprising 5-7 FCHVs set up to monitor performances of FCHVs	iv. Limited endowment fund. Started saving scheme.
v. Endowment fund set up	v. Few mother groups have saving
vi. Mother Groups have saving scheme	vi. Fear to speak against injustices for job dismissal/loss of community position.
vii. Unity emboldened FCHVs and their confidence boosted	vii. "do what has been asked to do attitude" and no questioning
viii. Informed about health rights of citizens	viii. Reluctant to speak about community health issues for fear of displeasing the health providers
ix. Community health issues are taken up to the health facility, launch struggle for resolution	ix. Mothers though happy with FCHV not happy with health delivery
x. Won trust of mothers and relations cemented	

However, the general trend in terms of distribution of key commodities like distribution of ORS packet, iron tablets, condom and other FP devices, and vitamin A etc., the non-organized FCHVs are equally or sometimes even better than the organized ones as shown by the figures gleaned from the secondary data. However it is important to note that the distribution is contingent on drug supply which is done by the health facility. The organized FCHVs, by the nature of their better advocacy skills have been mounting pressure for better supplies which in the long run will benefit the service being provided by both the organized and unorganized FCHVs.

The savings schemes are more prevalent where there is a presence of FCHVCCs. The endowment funds from VDCs are more common again where the FCHVs have organized themselves as a group highlighting the fact that organization perhaps contributes to the sustainability of capacities and outcomes in the community.

The study put forth certain concerns about the FCHVs registering as an NGO. The concerns pertained to the possible loss of health focus and lesser accountability to the mothers they represent.

The response to these fears (also expressed by government officials and other developmental agencies) came from an articulate FCHV, while she made a

presentation at this FE's dissemination workshop. *'Why are you afraid of us? We understand best the needs of our communities. Our sole purpose is to serve our communities better. We will ensure that the mothers continue to receive attention from us. We will train more FCHVs to take our place, if we are perceived as losing our community focus.'*

It can be concluded that the organization of FCHV has certainly given the community the negotiating power with the service providers and any growth opportunities for the FCHVs will only add to the community's development.

#### Municipality FCHVs

The design of the national FCHV program does not provide for the selection of FCHVs in urban areas. However, due to an articulated high demand for a FCHV by the communities, the project identified and trained FCHVs in Kanchanpur Municipality (urban administrative unit) in phase one of the CSP. These FCHVs were further strengthened in phase two to form FCHVCCs. The FCHVs who were instrumental in addressing maternal child health issues in marginalized urban areas and are now (after forming the committees) negotiating with the government that they be formally recognized as FCHVs and registered for future trainings and inputs. The FCHV CCs in Kanchanpur have taken up this matter at district level and are making an appeal at the national level.

#### Local Resource Persons

Another additional link that the project generated (initially in Dadeldhura but later in Doti) was a Local Resource Person (LRP). The LRP in many cases is an FCHV, selected by a team of local health facility staff, CSP staff, and FCHVs. This strategy emerged from difficulties faced by the MOHP, project and local NGO partners during periods of restricted mobility. The LRP who was provided additional training, including skills of a trainer, was able to provide the following benefits to the program:

- She acted as a specialist support to her peers
- Acted as a linkage between health facilities and FCHVs for monitoring and provision of essential supplies.
- Was a much valued resource in geographically difficult areas and was deeply appreciated by FCHVs and the community as revealed in focus groups.

One NGO partner, The Women Development Society (WDS) has offered the LRP an honorary membership on their board in recognition of her valuable contribution to the community.

#### National Campaigns

In addition to the concerted MG focused activities in the community, project also participated in the national Vitamin A and Deworming Campaign Day. All stakeholders - VDCs, HFOMCS, MGs, local NGOs, and FCHVs participate actively in this campaign.

#### Dabi Groups : Rights Based Approach

In the second year of project's four year life, CSP introduced REFLECT techniques to empower communities. The initiative enabled the women and men together in various

parts of the communities to analyze their situation and social conditions that have implications for their health and social status. Using the lens of CARE's programming principles, CSP integrated a Right Based Approach (RBA) in its implementation strategies such as establishing and strengthening community-based process and networks, strengthening the leadership role of communities and enhancing engagement, transparency and accountability of local service providers. This strategy also helped build the confidence of MGs; strengthen capacity of FCHV CCs and HFOMC; and facilitate linkages amongst the groups to generate synergies.

CSP initiated its efforts to make the communities aware of their rights to basic services and ways to access them. At the same time, the providers were also made aware of their responsibilities and accountability and facilitating the connection between communities and service providers at village and district level which helped them understand each others and their own limitations and strengths. Such exercises at the community level helped the community groups understand their roles and responsibilities in ensuring quality of services, increasing the access to services to all regardless of gender, ethnicity and caste, and encouraging the communities to give up malpractices and adopt positive behavior.

From the dynamics of mothers' groups emerged the first indications of the *Dabi* movement. Realizing the difficulties in enrolling the participation of *dalits* in health activities the project initiated *Dabi* groups. *Dabi* is a rights - based group which promoted the claiming of rights by marginalized lowest caste people - the *dalits*. Groups members through a REFLECT approach were oriented to various developmental avenues and the need for *dalits* to consider development as a fundamental right.

*Dabi* groups were responsible for large scale community mobilization throughout the project districts. There are 68 *Dabi* groups in the project area and they have actively campaigned to highlight the ill effects of the '*Chaupadi*' practice. In the FWR of Nepal, women are isolated in a separate hut or to the corner of a cowshed during menstruation and parturition as these are perceived as 'dirty' states of being. Here in the unhygienic condition women deliver unassisted and live without support seven days postpartum. Initially conceptualized to be a forum for the *dalits* and excluded groups, *Dabi* now has a more diverse group of participants cutting across caste, gender and community location. *Dabi* activities go beyond the issue of '*Chaupadi*' to issues of alcohol consumption in the community; trafficking of women; demanding facilities of the municipality in their area like drinking water provision; call for increased government funding; access to basic services; and attention to women and children issues.

*Dabi* groups, aligning with other networks and advocacy alliances, have put the cause of *Chaupadi* on the national agenda and have influenced the participation of Poor Vulnerable and Socially Excluded (PVSE) in health and development.

The RBA mode of action pursued by CARE Nepal however suffers from some deficiencies. They are lack of sufficient information on rights as provided by national laws and by-laws. A case in point is the mothers groups in Daiji and Kalika VDC of Kanchanpur who launched an organized movement against *chaupadi* and even went to the extent of dismantling the *Goth* (shed). Though the health hazardous practices

have waned to some extent, there are orthodox sections that have resisted change and defended the practice. Since the customary practice was not declared illegal by any State law, at least not to their knowledge, their anti-Chaupadi movement had no legal or rights basis. However this has become a national agenda and has the possibility of being ratified as a law.

Even as the rights-holders lack sufficient knowledge and information about rights, their organized shape and strength has been the source of their energy and confidence. Organized mother groups demonstrate enough zeal for rights struggle and are working as pressure groups for better service delivery. The *Dabi* Kendra (localized version of REFLECT) has been instrumental in organizing the community, identifying community agenda/issue, and building social movements around them. Many a struggle against corruption and lack of transparency in health and school facilities are successfully waged.

### Child Clubs

Community Mobilization took place through the School Health Initiatives in Dadeldhura district. School children are actively taking an interest in the problems facing them and have initiated several actions to specific situations. Children have actively taken up the cause of cleanliness in their communities; have promoted the use of toilets; have also pressured their parents to build toilets in their homes; promoted that fevers be screened for malaria; and children are completely immunized. The club members of Ashigram secondary school in Dadeldhura were very articulate, cited child rights and brought out a monthly wall news page for the benefit of other children in their school. The project made minor monetary contribution to support activities like quiz contests. The teachers of the school expressed their inability to continue emphasis with the cessation of these minor contributions to the child clubs. They also expressed a need for being updated on the latest health information to be able to take adequate community action. The FE team encouraged them to approach other agencies in the area and gather latest information and explore the possibility of contribution for the planned activities.

#### **i) Effectiveness**

Overall, the community mobilization strategy was extremely successful. All communities visited had active MGs, which held regular monthly meetings. The MG members were actively sharing the information about childhood illnesses and available services with other mothers in the community. Mothers were found to be demanding that the FCHV hold meetings and identifying facility and supply related issues which affected health of the community. The *Dabi* has certainly influenced the articulation of '*Chaupadi*' as a detrimental tradition. If impressions of the FE team are to be believed, it has increased the participation of PVSE in development as a whole. However, the indicators chosen by CARE to assess achievement of equity do not adequately measure the extent and quality of their participation.

#### **ii) Were the objectives met?**

The specific objectives for mobilization were mostly met. However, it is difficult to develop measurable indicators for such a subjective area and difficult to predict the shape the community mobilization takes at the beginning of the project.

The community mobilization indicators included:

- a) Intention: At least 30% project participants (from FCHV, to NGO participants) and activities will be focused on marginalized communities during project implementation

Findings: 50% project partners were *dalit* member based organization (in Doti, Dadeldhura and Bajhang); all members of *dabi* groups were from *dalit* and marginalized groups; and participation of *dalit* and marginalized groups increased in Mothers Groups (estimated 30% though the exact data is not available).

- b) Intention: 10% of mothers' groups implement extension program beyond membership

Findings: All MGs in Kanchanpur included additional members in their MGs (from PVSE population) and about 20% (estimated) MGs carried out extended or mobile MG meetings in other clusters.

- c) Intention: 20% of mothers' groups in Kanchanpur involved are with savings/loan activity with special priority to health loans

Findings: Sixty eight percent MGs in Kanchanpur are involved in savings and credit activity. All MGs have provision for subsidized loan for health services (especially for pregnancy and child care). Of the 609 groups studied in Kanchanpur (there are 837 groups there) 409 were found to have savings and more than one third of the fund (USD 47,000) was being loaned out to health activities.

- d) Intention: 60% of FCHV-CC are registered as institutions and have financial partnership with developmental agencies (eg. CARE)

Findings: Five out of 20 FCHV-CCs are registered and all 20 have financial partnership with at least one development organization.

### iii) Lessons Learned

- The rights based approach to community mobilization has a huge potential for sustainability. It throws up unexpected results, given that the local needs and solutions are best anticipated by the communities and cannot be foreseen by the best of project designing efforts. RBA tool was effectively utilized to include the most marginalized.
- There is a need for developing specific indicators which will reflect the nature of community participation. The process and quality of participation needs to be documented regularly to understand the attribution out outcomes.
- Organization of FCHVs into coordinating committees has ensured that the developed capacity sustains.
- An important lesson learned cited by the evaluation team was the need to provide financial management capacity to FCHV CCs to help investment of the MG funds.

- Another is the great value of community providers in urban marginalized pockets. Consultant would like to add that often urban areas are neglected as they are perceived to be places with high availability to services. What is often ignored is the capacity of the community to access these services. The municipality FCHVs demonstrated adequately that there are indeed pockets of marginalized communities within urban areas and they have benefited through the presence of MGs and FCHVs. The dissemination meeting underlined this while recommending to the government that it carry out a needs analysis in urban areas and considers replication of FCHV selection and training for urban areas as well.

#### **iv) Demand for Continued Activities**

In focus groups, all communities were confident that community-based activities would continue after CARE ceased to provide ongoing support. As one mother commented *'we will picket if necessary, the FCHV has to conduct regular meetings and the health facilities have to provide services.'* The FCHV CCs have demonstrated the ability to function as a CBO and may go on to become NGOs maintaining the focus on continued demands. The participation of VDCs and health facilities resulting from these demands are expected to continue with the increased awareness generated in the community, though they will require adequate monitoring from the government.

#### **v) Plans for Sustainability**

The project used CSSA framework extensively to focus on sustainability of outcomes. CARE's CSP defined the local systems within which the project works; identified all stakeholders; and defined their roles in the overall impact of the project. Through a CSSA workshop with participation from all stakeholders in Kanchanpur, the roles and responsibilities were collaboratively agreed upon. The sustainability dashboard further defined the areas requiring focus. These areas were: strengthening systems to improve organizational capacity, organizational viability and enabling environment.

The project's emphasis on developing organizational capacity and viability translated into its work with FCHV CCs, VDCs and DDCs. The FCHVs are volunteers and will continue to work. With the support of FCHV CCs, they have received a much required community support for their activities. The increased negotiating power has also given them more recognition and say in the community. Further the endowment funds they receive from the VDCs and DDCs act as a support for their activities.

The sustainability of the quality of services delivered by FCHVs and HWs is dependant upon continued supervision and on-site support to the FCHV; and regularity of supplies from the MOHP. Health seeking behavior is expected to last the longest. Please see Annex H

### **3.2 Communication for Behavior Change**

The communication for behavior change was targeted at MOHP staff, community (FCHVs, VDC, DDC and HFOMC members) and individuals (mothers, married women of reproductive age, mothers-in-law and husbands to a limited extent).

The project developed a comprehensive BCC strategy with technical support from the Linkages project and formative research done by an external consultant. Key messages and available IEC material were identified. IEC material was adapted to the needs of the project and produced for distribution and use.

The project team enrolled the services of FCHVs and MOHP Community Health Workers to carry out home visits for counseling, deliver educational talks, use the monthly meetings of mothers group to discuss identified health topic and educate mothers of children when they visited facilities for accessing services. HFOMC meetings were also used to disseminate information regarding new health initiatives to community representatives.

To disseminate the identified messages, development of radio content was planned. However this could not be carried out. CARE relied on special digital radio broadcasts (through ACCESS project – CARE partners with Save the Children, local NGO FOLD and Action Aid) to reach its communities. CARE supported the formation of listener's groups; logistics for delivery of radios to the field; and supported the NGO FOLD in disseminating messages through digital radio program in the beginning of this project. The messages broadcast included essential health education on child care, maternal health, nutrition, FCHVs works and MG initiatives. With the small support from project, FOLD published a compilation of these messages for wider dissemination. The radio messages were listened in all the districts of FWDR.

CARE also utilized a TV program called 'Asal Logne' (The real man) produced by the government and funded by USAID as means of promoting good maternal practices. Project communities were informed about this and encouraged to watch the program.

The enabled FCHVs were the main route through which BCC was carried out in the other districts. This worked well as mothers were not only knowledgeable and practicing many positive behaviors, they were found to be promoting it among other women in the community.

#### **i) Effectiveness of Approach**

The project achieved impressive changes in health seeking behaviors within the communities which led to a decrease in severity of morbidity and early resolution of disease among under five children.

In the entire project area, the high levels of knowledge did not always necessarily lead to positive behaviors in some interventions. For instance behaviors like hand washing, feeding more solid food during illness and use of iodized salt were less practiced. The external barriers to some of the practices include unavailability of water close to the households; intermittent availability of iodized salt; and overall poverty resulting in lesser importance to buying the (subsidized) salt. The secondary reason for this was inability of the project to supervise the community sessions to desired levels during the conflict period.

The evaluation team reviewed the IEC materials and found them to be appropriate in terms of understanding, ease of use and utilization pattern. The IEC materials were the form of cloth charts, flip charts and posters. The messages on these material pertained to danger signs of pneumonia, dehydration, hand washing, maternal health, nutrition and breast feeding.

Flip charts were most popular amongst the FCHVs for the ease of their use. The FCHVs used these during their monthly meetings with the MGs. The FCHVs reporting format captures whether she gave a health talk during the monthly meeting and the topic she covered. The FE team could not analyze the details of this coverage.

Further, the FCHVs developed some street plays based on the messages in their charts and used them to communicate to a larger audience in the community.

IEC material for hand washing was seen in most facilities visited and was found to be available with the FCHVs as well. However, the team could not assess the availability of IEC material for promoting iodized salt.

Although planned in the DIP, radio programs could not be implemented. However the project benefited from radio programs being aired by other agencies.

## **ii) Objectives Met?**

The behavior change objectives were largely met for the most critical indicators: early initiation of breast feeding; improved complementary feeding for children; improved health seeking behavior for pneumonia and diarrhea; and consumption of IFA and Vitamin A by mothers.

Consumption of iodized salt and hand washing were two behaviors which did not improve. The reasons for this have been discussed in respective sections earlier.

The most important message (though unplanned) that got communicated perhaps was that the 'FCHV is able'. The behavior that changed the most was that mothers approached the FCHV and the health facility for problems for which they earlier had approached the traditional healer. This meant that the messages communicated by the FCHV during the MG meetings were further reinforced during these visits.

## **iii) Lessons Learned**

There is a need to address consumption of iodized salt and hand washing through renewed communication strategy. The fact that mothers wash hands when they perceive the hand to be dirty should be central to the development of a behavior change message. Perhaps there is a need to inform mothers about what can be invisible and still be dirty in an emphatic manner.

Achieving high coverage through the FCHVs participation in MG and further dissemination by mothers from MG was important in achieving behavior changes.

## **iv) Sustenance of Behaviors**

All community workers are volunteers and have a high commitment towards their work. There is hope that the activities will continue after the end of the project. As mentioned earlier, the sustainability of the behavior changes is dependant upon continued supervision and on-site support to the FCHV; and regularity of supplies from the MOHP. The FCHV CCs give a platform to the community to demand more information on a timely basis as well. Health seeking behavior is expected to last the longest.

### **3.3 Capacity-Building Approach**

#### **3.3.1 CARE Atlanta**

The project led to increased capacity of the CARE HQ. For example,

- CARE Nepal's RBA were theories that have been put in practice for the first time in a CARE CS project. Lessons learned from here are being shared within CARE and may be put to test in other program areas.
- Working with a *dalit* focus has helped CARE understand how the socially excluded and marginalized populations can be empowered to access health care especially for women and children.
- The CSSA framework was used extensively in CARE-Nepal and has encouraged other CS Projects to use the framework.
- Overlaying Savings & Loans groups in existing 'health' groups and their interplay with each other is also a very important lesson learned which CARE can use in other non-health projects.
- Commitment of the local civic bodies towards CDP and FCHV Endowment fund and its impact on the communities access to medicines and the morale of the FCHV due to the endowment fund are lessons that CARE-Atlanta would like to replicate.

#### **3.3.2 Local Partner Organizations**

In addition to the DPHO and health facilities, the project partnered with local government (VDC and DDC); community structures – HFOMCs and FCHV CCs; and local NGOs to improve local capacities.

Inputs included:

- development of partner selection guidelines to select local partners
- conducting program orientation for partners (e.g. CSP introduction, CARE partnership strategy, rights based approach in CSP)
- capacity building training for partner staff (pre service-training, CB-IMCI, Social inclusion and public auditing, concept of RBA, techniques of carrying out LQAS, evaluation and monitoring workshop)
- on-site guidance and support for partner by CSP staff
- regular interaction during monthly coordination meetings and preparation of a joint work plan
- representation of CSP partners in district level project advisory committee (PAC) and reproductive health coordination committee (RHCC)
- development of different operational tools, guidelines, and materials to partner staff

### *Local NGO partners*

The project had eight implementation partners, two in each new project district. CSP also supported the formation of a FCHV CC (expansion activity) in Kanchanpur which built the capacity of the committees as recommended in the final evaluation of the first phase. The project partnered with a Rights Based NGO - Samajik Samanata Abhiyan in Kanchanpur to expand *Dabi* activities.

NGOs chosen for project implementation activities (mainly community mobilization and supportive supervision) did not have a large health focus. However, they had excellent community presence and were involved in complementary developmental activities. The project supported the development of health capacity which is evident from the expansion of health portfolios of some of these partners.

The consultant met and carried out in depth interviews with representatives and staff members of four of the partner organizations. They attributed their increased capacity to implement CB-IMCI programs and improve linkages with the government health delivery structure to the support received under the CSP project. The other useful inputs included organizational development training, documentation skills, and financial management skills. They felt that the credibility of their organization has increased following their partnership with the project, has provided them representation at various forums, and local and national visibility. They are valued partners now and are invited to participate in various health coordination committees.

Some, not all NGOs were participants in the DIP process, however all of them were familiar with the DIP document and have been participants in subsequent planning, reviews and evaluation processes.

They echoed the constraints related to conflict and geographical terrain and cited them as reasons for not being able to carry out adequate supervision of community providers. The MTE report identified duplication of activities by NGO and CARE staff as one of the issues that needed to be resolved. This was addressed by the project and misunderstanding arising from lack of clarity on working *modality* was resolved. Earlier NGO staff members perceived CARE as a 'big brother' policing their work, but later appreciated the technical support CARE's staff provided to the NGO team.

Special comments on *Samajik Samanata Abhiyan* (Social Equity Movement), NGO partner contributing to the rights based activities: The project partnered with this *Dalit* (Socially excluded) focused NGO to improve social inclusion of PVSE population in Kanchanpur. It was a mutually contributory relationship where CARE's own understanding of Rights Based Approach got honed. The resultant formation of *Dabi* (literally 'claiming rights', pressure) groups generated a lot of interest in the community. The *Dabi* centers are an adaptation of famous educationist, Paulo Freire's non-formal education tool, REFLECT. The *Dabi* center's members became pressure groups and were instrumental in empowering the PVSE communities; and educating them about their rights to health and health services, and their right to development opportunities. Initially the project funded formation of 25 *Dabi* groups (group of PVSE community members who meet to discuss and plan health priorities and activities facilitated by the NGO and supervised by CARE), later owing to the success and expansion of rights as a movement in the community. The project funded the

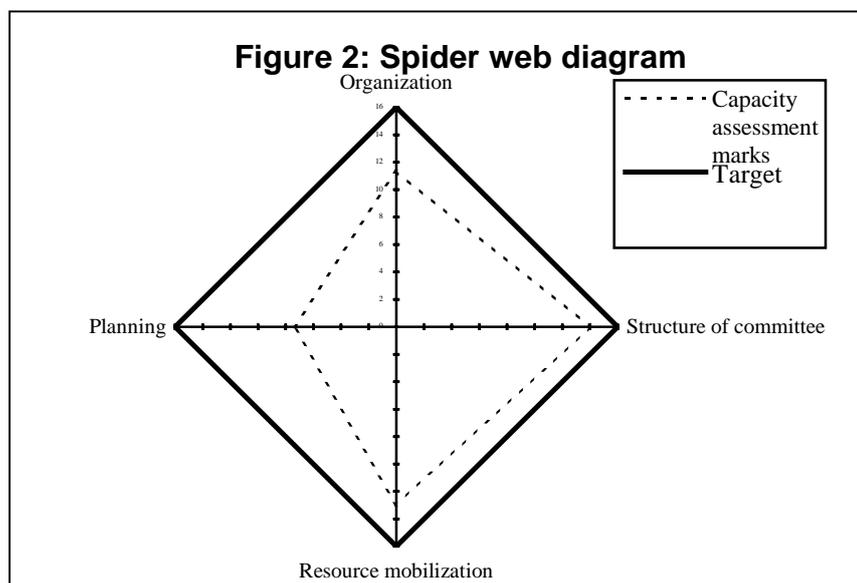
formation of an additional 15 groups. Sixty eight groups were functional at the time of FE. The *Dabi* groups have high visibility and have proved to be a good advocacy strategy for communities to demand quality services. Not only has it empowered PVSE communities, the ripple effects is reflected in how the communities in general have been applying pressure on health facilities and influencing them to provide quality services. This forum was utilized to highlight the harmful practice of *Chaupadi*, which is now being taken up as a national issue. The news that the government may be considering a policy to ban *Chaupadi* was received while the FE was being carried out. This has positive implications for maternal and infant survival and should be considered as an extremely successful model for promoting health among marginalized and vulnerable communities.

The NGO partner however felt that CARE was pushing the agenda of ‘pressure’ as opposed to ‘rights’, as CSP was comfortable in using the approach for inclusion. NGO partner felt that CSP was not keen on supporting larger political issues of quotas for marginalized communities in education and employment. Based on the experiences and history of *dalit* movements in India, the consultant concurs with the caution exhibited by CARE. In the socially sensitive environment of Nepal, the positive aspects of this movement stand a chance of being sidelined by vested political groups, unless the focus around development is strictly maintained.

NGOs were asked to share their perspective on sustainability of project activities and outcomes. They expressed confidence in the continuity of activities currently being carried out in the community, improved health seeking behavior, improved participation of the FCHVs, improved health focus of local governments and their own viability as a health NGO. One of the NGOs – Woman Development Society – informed the FE team that they had offered honorary membership to the LRP (Local Resource Person – basically a FCHV who is trained as a trainer and acts as a support to other FCHVs in the area). NGO representatives expressed that their own improved linkages with the DPHO will help them to advocate for focused participation of the government in CB-IMCI activities.

### 3.3.3 Health Facility Strengthening

CARE Nepal has used the Spider Web Chart to assess the Capacity of the Health facility Operation and Management Committee.



The Spider Web is the visual display of the score of the capacity of the HFOMC on four aspects – i.

Organization, ii. Structure iii. Resource mobilization, and iv. Planning, implementation, monitoring and evaluation. The members are sensitized due to the score that is displayed on the spider web chart and prepare plans to improve the situation.

Effectiveness of approach and the tools employed: The project strengthened health facilities by improving the quality of services provided by its workers; making available and accessible good quality essential medicines to all members of the community at an affordable cost (only applicable to Kanchanpur); increased ownership and support of the health facility by the community, through MGs, HFOMCs and the VDC; Improved the reliability and frequency of reporting and level of communication between the FCHVs, HF, District Health Office, Regional Health Office; increased the capacity of local NGOs and work with other Health/Development plans to channel resources into the community.

While most of the above have been discussed; the role of the project in HFOMC strengthening needs elaboration. The project supported the initiation and reactivation of HFOMCs through joint meetings and orientation programs for VDCs. Further, it organized TOT for capacity assessment and strengthening of HFOMCs for district level officials and health facility staff. The project also supported the development of training plans for further dissemination at HF level. Monthly meetings with VDCs project further strengthened the activities of the HFOMCs.

The project aimed for 80% of the health facilities to have active HFOMCs (at least four meetings in previous year) and aimed for the committee to actively monitor FCHV activities. The final evaluation found that the project has surpassed targets and was able to achieve this indicator for 100% of health facilities.

The HFOMCs has the participation of health facility in charge, FCHV, *dalit* representative, VDC members and other community level stakeholders. In depth interviews with HFOMC members revealed that these committees have been actively meeting regularly to identify, prioritize and explore funding activities for the improvement of quality of health service delivery and community health in general. One such example of the HFOMC deciding to hire lab technicians for their labs has been highlighted in earlier sections of this report.

HFOMCs are also the forum for operationalization of the CDP program. The project supported orientation trainings on CDP program for district officers, district supervisors and HFOMC members. Additionally, project provided basic accounting capacities to HFOMC managers at district level. The CDP program was found to be operational in all VDCs visited, albeit it had been functional for a month in Dadeldhura and six months in Bajhang. All facilities visited had a rate chart for the drugs being distributed under CDP program. Furthermore, HFOMCs in partnership with community members come to a decision regarding those individuals/families who are to be provided the drugs free of cost. The list of such people was also found in the facilities. All facilities in Kanchanpur and 34% of them in Bajhang have functional CDP Program. CDP is in the process of expansion in other facilities of Bajhang. Of the 47 VDCs in Bajhang, forty three have allocated budgets for CDP. In the remaining districts, CDP is being gradually implemented by UNICEF in

Dadeldhura and by GTZ in Doti. Since the CSP had to rely on other agencies for CDP implementation in Bajhang and Doti, the project could not intervene to the desired levels to strengthen linkages between CDP and CB-IMCI.

Lessons learned: The representation of a *dalit* community member in the HFOMC has been achieved. However there is a need to document the level of their participation through identification of monitoring indicators. For example: number of issues articulated by the *dalit* member and number of such issues taken up for resolution by the committee would throw light on the quality of *dalit* member's participation and comment on equitable service provision.

Sustainability: The HFOMCs are a government policy and are being formed in every health facility. They require strengthening however through capacity building efforts. CSP has demonstrated that once the capacities of the HFOMCs have been built, the community can take over the responsibility for quality of services being provided through the health facilities. The DPHOs offices in project districts were monitoring the work being done by the HFOMCs and have found it an effective way of responding to the community needs.

### 3.3.4 Capacity Building (including training) of Health Workers

FCHVs and various cadres of MOHP staff of all four districts received exposure to CB-IMCI training along with many other capacity building inputs. These have been adequately discussed in the MTE report.

Table number 7 details the various trainings held for community level and facility level MOHP staff. It further provides details of follow up monitoring sessions held.

**Table 7: Training of MOHP staff**

Name of Activity/Training	Target	Achieved
IMCI clinical training	218	184
Clinical MToT Training	20	20
Facilitation training	--	13
Clinical training for managers	--	8
IMCI supervisor training	30	27
District supervisor training	10	10
District level training of trainers	40	38
Two days management training	247	189
Training to VHW/MCHWs	212	191
Training to FCHVs (first phase)	1510	1560
Traditional healers orientation	468	456
Second phase FCHV training	1510	1528
Review /monitoring meeting		
• District level	140	138
• Community level	1510	1571
Follow up after training	--	105
3 day training to transferred in staffs	69	60

In addition to CB-IMCI training, new FCHVs were recruited in Dadeldhura and Doti received basic FCHV training as well. The level of knowledge and skills among the FCHVs and the MOHP workers have been adequately discussed under the technical approach sections.

The capacity of health workers were further built by encouraging supportive and regular supervision from their supervisors. This combined with the increasing demands from the community resulted in enhanced performance of the providers. The enhanced participation of VDCs in monitoring activities of workers; community representation in HFOMCs resulting in articulation of community problems; increased budgetary allocation by VDCs to health issues encouraged the quality of services provided by the health workers.

The indicators for assessing the support provided to health workers, stated as objectives in the DIP and the findings thereof are as follows:

- % of FCHVs who receive at least one supervisory visit in the month prior to survey

Findings: The supervision of FCHVs went down drastically in Kanchanpur (65% at baseline to 25% at end line), with the decreased project staff in the second phase. Whereas it improved in the other districts (54% at base line to 74% at end line). This indicates how critical it is for CARE to advocate for adequate supervision of FCHVs by MOHP following the closure of project. The supervision of FCHVs is meant to be done by the facility based health workers and could not be sustained perhaps after the intense activities of the first phase slowed down in the second phase of implementation in Kanchanpur. It can be anticipated that the same could occur in the other districts following withdrawal of project staff.

- % of MOHP workers who receive at least one supervisory visit in the last six months prior to the survey

MOHP workers are supervised by Health Facility in charge and the DPHOs and therefore did not see the same proportion of decreases in supervisory support. It improved from 75% at baseline to 81% at end line in Kanchanpur and from 54% to 78% in the other districts.

Lessons Learned: The health facilities need not be viewed as a government input but more as a community asset. The project was able to bring about this realization in the community stakeholders and successfully enhance service provision. Often projects find the adequate supply of quality of services as out of their control and as a barrier to maintaining changed outcomes. Effective promotion of linkages between communities and facilities and their participation in supporting and demanding services help overcome this issue.

Sustainability: The training of health workers is a mandate of the government and will sustain. However, this is dependant on availability of adequate funding in the government. There is a need to tap local resources which have become available due

to the project's ability to increase the health focus in the VDCs. Continuing focus on supervision is also required to sustain the increased capacities.

### **3.3.5 Capacity Building of Traditional Healers**

through baseline KPC and formative research the project identified that the lack of able and trained providers close to the community meant that community members were using the services of the traditional healers. These healers were therefore invited to orientation on CB-IMCI sessions. These sessions involved training the healers on signs and symptoms of dehydration and pneumonia. Key BCC messages were shared with them and they were involved at the community level to disseminate these messages. Of the targeted 468 healers the project was able to orient 456 healers. The FE team had planned to conduct in depth interviews with the healers, but could not do so owing to restricted mobility. The project team and the district official however affirmed that the healers were active in identifying and referring pneumonia and diarrhea cases to the FCHV or the health facility. The project did well in bringing the traditional healers into its fold. The effectiveness of this approach however could not be documented.

### **3.3.6 Capacity Building of Local Governments**

CARE worked closely with DDC/VDC for implementation of this project. The objective of this association was to build capacity of elected bodies to monitor and support community health activities. The main capacity building activities planned under the project were:

- Orienting DDC/VDC members to project activities
- Orientation training on HFOMC/CDP management
- Enrolling DDC/VDC participation in development of district plans
- Conducting joint supportive supervision visits
- Supporting their linkages with districts health office
- Strengthening their capacity to manage activities of HFOMC and CDP program

#### *Findings*

The DDC representative is the chairperson of the district level Project Advisory Committee (PAC). Through the annual PAC meetings DDCs of all four districts were actively involved. In depth interviews with the representatives revealed their comprehensive understanding of the project, their impressions of field level activities and their appreciation for the project strategies.

The VDCs were similarly involved in monitoring project activities and managing HFOMCs and the CDP program as already described in previous sections. The local governments (VDCs) have been dissolved since 2001 and elections have not been held since. This has meant that the elected representatives are not in key positions leading to absence of leadership in the community. The project however held a series of meeting with major political parties and advocated for a temporary nomination of

one representative from each party for effective management of the VDCs. This was an excellent example of community mobilization by the project.

All VDCs are contributing financially towards health activities. The proportion of investment has gone up from 0% to 20% in their meager budget of 100,000 Nepali Currency. Many VDCs have provided an endowment fund for FCHVs, contributed to the annual recognition ceremony of the FCHV, have negotiated for labs in facilities and have funded temporary staff at the facilities.

The FE team discussed the sustainability of capacity building activities for the FCHVs and the MOHP workers with some of the VDC representatives and found them open towards the idea of supporting refresher trainings for these providers. They recognize the ability of these empowered workers and appreciate the contribution they are making towards improving maternal and child health.

### **3.4 Sustainability Strategy**

Achievement of goals and objectives: The project employed the CSSA framework to identify stake holders and determine their roles and responsibilities in a collaborative manner. The project sought to sustain improved health outcomes through complementing the local system; bringing positive changes in community health practices; and improved technical and managerial capacities of the government, NGOs and health care providers. The project inputs to this effect have been adequately discussed in preceding sections of this report.

The project performed immensely well in strengthening FCHVs. The FCHV CCs are functioning independently, are advocating actively for health to be included as an agenda in all forums; and are supporting the community based child survival activities. The MGs are extending their activities to the community, actively identifying gaps in the health delivery system and demanding quality of services. The local governments have included health as an agenda for development; monitoring and supporting community based child survival activities. The support to HFOMCs and the CDP program addressed supply issues to a large extent.

The project enrolled the participation of the MOHP and built their capacity to provide adequate supervision. The intensity of MOHP's participation may suffer following project closure. Frequent transfers of MOHP (HF) staff mean that the new officer who takes over will not receive this support following project closure.

Phase out plans: The project has discussed phase out plans with each DHO. DHO Dadeldhura has planned for continuing activities through support of other agencies, whereas the other DHOs are awaiting guidelines from the regional office. In depth interview with the Regional Director revealed the presence of phasing out plans in the current year's agenda.

The regional and district level officers expressed a need for continued supervision support for CB-IMCI activities. CARE will phase in their next child survival project 'CRADLE' in one of the CSP districts and another district in the same region; and therefore will continue to have a presence in the region. CARE plans to continue

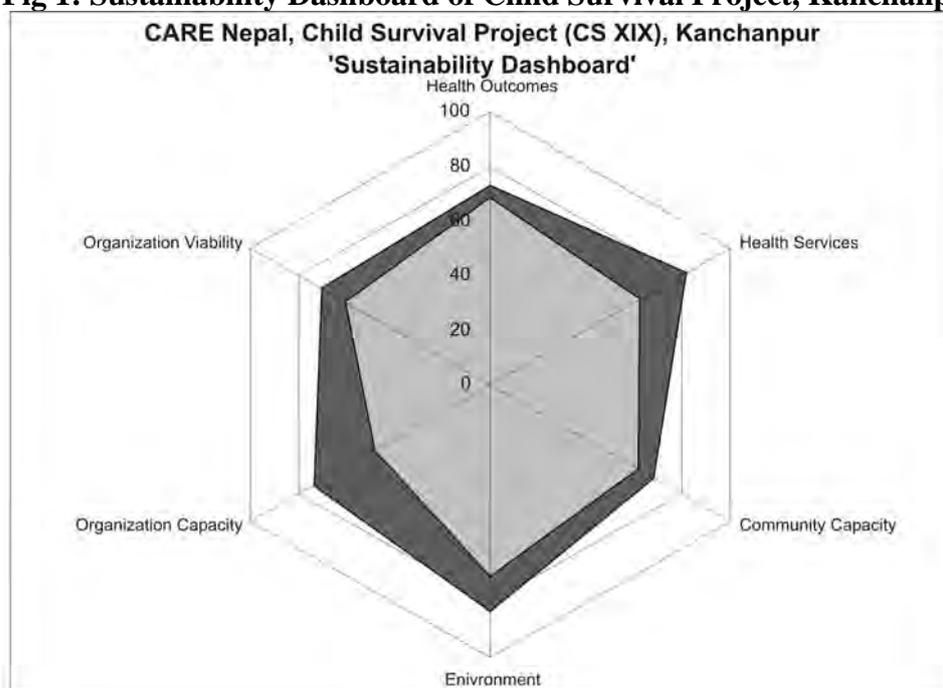
collaborative activities at district and regional levels to support planning and supervisory capacity of MOHP to sustain the outcomes.

Financial sustainability: FE team met with four of the eight NGO partners. All the NGOs met had financial sustainability plans and were found to have expanded their project profiles in the last four years. Many HFOMCs had sufficient quantity of funds circulating and the financial capacity to continue their activities. Further more the funds available in the MGs (especially in Kanchanpur) make the groups cohesive, they can meet regularly use the funds to help continue their activities. It is recommended strongly that CARE explore avenues for supporting financial management and leadership training to FCHV CCs to ensure appropriate investment of this fund.

Sustainability in the community: The project achieved an immense increase in demand for services and this has tremendously influenced the quality of services. This has been explained in the previous sections.

CSSA Framework: In order to assess whether the project was on the road to attaining sustainability, an attempt was made to apply the CSSA framework in Kanchanpur, in the first quarter of 2006, with the technical support of CSTS and the local USAID mission. This was carried out once again at the end of the final evaluation and the dashboard of sustainability is depicted in Figure 1.

**Fig 1: Sustainability Dashboard of Child Survival Project, Kanchanpur**



The light gray spider is for the assessment done in the first quarter of 2006 for Kanchanpur district and the dark gray spider for assessment carried out at the end of FE for the same district. In the first round of assessment (2006) the project found that:

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

The Project's strategies improved the capacity of community based structures like FCHV CCs, VDCs and HFOMCs and the resultant increase in sustainability is reflected in the dark gray section of the chart.

## **C Program Management**

### **1 Planning**

The DIP was developed with the participation of all key stake holders and built upon the lessons learned from the first phase of CSP in Kanchanpur district. The development of the DIP document has been adequately discussed in the MTE report. The project team inclusive of local NGO partners met once a month at the district level and once a quarter at regional level to plan activities and monitor progress. Review meetings with counterparts were held through Project Advisory Committees (PAC) both at district and regional level biannually. In addition to the PAC, the project staff participated in district level Reproductive and Child Health Committees and Health Sector coordination Committees. These committees met once every two months to discuss implementation plans for the district, operational and progress reviews and identify problems for joint solutions. The mid-term evaluation recommended formation of a national level PAC, which was not carried out by the project. It was felt that since CARE is a participant in many relevant national level forums, any issues needing national attention could be addressed through these forums. CARE did utilize its excellent national relationships to trouble shoot some supply related issues in Dadeldhura.

Detailed annual work plans were developed and shared with the district health office and through annual reviews project progress and need for support was shared with a wider district audience. The issue of training FCHVs who had not undergone basic FCHV training (funding shortage in the government) in CB-IMCI was sorted through the above mentioned interagency forums. Sub-proposals were written to various agencies seeking funds for basic training and thereafter CB-IMCI trainings were carried out. However, this unforeseen hitch and subsequent trouble shooting cost the project time.

Conflict did however influence adherence to plan and at the time of MTE the project had been able to carry out 65% of planned activities. Trainings were delayed for the same reason and the project was conducting trainings (pending and for drop out FCHVs) even in the fourth year of project. This ultimately influenced the time frame for which community level workers received supervision following training. The conflict also affected planned supervisory activities which may be the reason for

smaller improvements in some of the key indicators. Project field staff felt that had the project been able to carry out all planned field supervision (technical and managerial), the results would have been amplified.

## **2 Staff training**

All staff stated that they had received adequate technical and managerial training opportunities. They were oriented to some of CARE's key strategies and policies (Right Based Approach, Partnerships, Equity, and Policy on Sexual Harassment etc). All field staff received training in CB-IMCI. It helped CARE that all field staff were either staff nurses or were trained health workers. Most project staff felt that they received most of the training that they needed to perform their duties. Health Supervisors felt that training in proposal development would have been useful. Discussions with some of the District Health Coordinators revealed that in addition to training they were mentoring the field supervisors in report writing as well.

## **3 Supervision of Program Staff**

As reported earlier, one of the casualties of working in a conflict environment was supervision in general. Staff supervision was also constrained by lack of mobility. Mobility was hampered more in remote areas especially during field visits. Yet, monthly and quarterly meetings were held in each district headquarters to enable staff to plan under supervision for the coming month/quarter and capacities to deliver addressed as much as could be done. To circumvent the staff and NGO mobility a volunteer position from amongst the FCHVs of a Local Resource Person was designed and supported, an innovation that helped the project gets its BCC and administrative initiatives smoothened.

## **4 Human Resources and Staff Management**

Staff retention and maintaining staffs' morale at consistent level in remote districts has always been a challenge. Furthermore, staff transition have also been high in this project, although these positions were filled in when possible, it is likely that these did affect the project working. Between the third annual report and the FE, one district coordinator left the project.

As this was an Expanded Impact Category project and employed experienced CARE staff, as the project ends, CARE-Nepal will have to lay off some positions, which is an element of expected anxiety in the project staff.

## **5 Financial Management**

CARE-Nepal had problems expending the money allocated to them as the capacity building activities could not be done due to lack of mobility of trainers and trainees. Towards the end of third year, when the cease fire was called and peace process started in the country, the project activities gained momentum, and the project expenditure was brought in line with the time line. At the time of the FE, the burn rates were acceptable.

## **6 Logistics Management**

Project staff did not face any problems pertaining to logistics. Supplies and vehicles were made available in a timely manner. However, some field staff mentioned that they were not allowed to use the motorcycles at times though they were authorized to do so. This however was neither expressed during MTE nor taken up with someone above their supervisor leading to the problem remaining unresolved. Communication through email was cited as a problem due to the remote location and poor infrastructure of the districts. However, teams were able to communicate through phones easily.

## **7 Information Management**

Information for capturing progress was gathered through monitoring forms filled by the FCHVs monthly, three Lot Quality Assurance Sampling Technique (LQAS) through the project period and Project Information Management System (PIMS) which detailed output level indicators and qualitative inputs from the field. These systems are per say adequate to monitor progress and guide project team toward their goal.

PIMS has been under revision owing to CARE's need to gather information pertaining to renewed strategies. This resulted in the need to reorient and train project staff. Consequently the project faced minor problems in data management. Health Supervisors expressed that they faced some difficulties dealing with revised forms and could have received more field support regarding the new procedures.

The forms being filled the FCHVs received a review by a joint technical team (NFHP and CARE) and were found to be lacking in technical accuracy. This issue was resolved through detailed discussions with FCHVs during monthly meetings and field supervision. Most forms (samples) reviewed during final evaluation were found to be fairly accurate. To assure future quality of care provided by FCHVs, NFHP representative suggested that focused quality indicators should be included in the project log frame. Primary concern in terms of quality of services provided is that of continued capacity building (refresher training, adequate supervision) of FCHVs; and their access by the community. It is for government and partner organizations to commit to build strategies based on practical realities of the country.

## **8 Technical and Administrative Support**

Technical and administrative support received by the project has been adequately discussed in the MTE report and in some of the above sections.

## **9 Mission Support**

The consultant met with local mission representatives who gave positive feedback regarding project activities. They appreciated the immense community mobilization the project has been able to achieve and were appreciative of the successes with the FCHV capacity building outcomes. The work done by the project with *Dabi* groups was highlighted as a good example of reaching PVSM groups. They were keen for the team to identify causes for some of the indicators which did not improve.

Representative from the USAID local mission could not join the evaluation team though they had expressed their interest to join. However, key program personnel from local mission participated actively in the dissemination meeting in Kathmandu.

The general environment of conflict has made it difficult for the local mission to make focused visits to project districts. However, CARE CSP maintains good coordination with USAID Nepal, with regular updates on the project progress and annual report. In addition, sharing and discussions are done with mission's health personnel on various occasions, when there is any request by the mission, or when CARE has some information to share. Moreover interactions are also held with the mission personnel through telephone, email, and meeting in various forums.

The project received ample support from the local mission to organize the CSSA workshop. The Mission participated in this process actively and encouraged the final evaluation team to develop the dash board of sustainability, time permitting.

The project was able to raise funds for malaria control activities through active coordination with Nepal Family Health Program (which is also funded by USAID local mission). CARE's application to CSHGP this year (maternal and neonatal health project called 'Cradle') was strengthened, owing to the financial support it received from the local mission another reflection of CARE being recognized as a valuable partner in Nepal.

CARE- Nepal has been participating in the mission led initiative on the Child Survival Sustainability Framework. Some of the CSP approaches of working in partnership with FCHVs, HFOMCs and Mothers' Groups have been identified as means to gear the programs towards sustainability. The 'do no harm' strategy developed by CARE as a *modality* to work in conflict situation has been appreciated by local mission.

## **10 Management Lessons Learned**

- Improve technical on-the-job field supervision: define what constitutes 'field time'; and develop performance supervision checklists for supervisors visiting field.
- Develop stronger negotiating techniques and platforms to influence issues like government staff transfers. Explore possibility of including these commitments in the formal agreements. Alternatively lobby through continuous dialogue at National level for achieving control. This has been tried with fair amount of success in India where INGOs negotiate not only for retention of trained government staff but also for transfer of nonperforming staff.
- Be more realistic in staffing patterns in difficult geographical areas. Negotiate with the donor through presentation of geographical constraints.
- Develop guidelines for receiving structured and regular feedback regarding HR issues from staff

## **D Other Topics Specified under USAID FE Guidelines**

Other issues identified: All issues identified have been adequately addressed in the above sections.

Contribution to scaling: Again has been discussed under various sections

Increased governance capacity: Has been discussed under the capacity building section

Equity: Has been discussed under the community mobilization section and across the report.

## **E Conclusions and Recommendations**

### **1. Project Achievements**

Analysis of baseline and end line data shows that not only did the project achieve its objectives, it demonstrated some promising methodologies in community mobilization and development of local capacities. The project improved access to services by bringing health care closer to the communities through FCHVs. It improved access to supplies through effective advocacy at local government level and district level, directly and through FCHV CCs. The quality of care was improved through improved capacities of health workers and enhanced participation of the community in the management of facilities and the ensuing demand. Behaviors were changed for most key practices and are being sustained through the participation of able community structures. Local governments and NGOs are more confident in addressing child survival issues and are committed to carrying the activities forward.

#### *Successful CB-IMCI Strategy*

CB-IMCI has increased access, free availability of life saving medicines for children at large and some preventive and promotive services for women. It has greatly changed the behavior of the community resulting in increased utilization of health services.

#### *Improved Demand for Services*

Project generated an immense demand for services through its robust community mobilization strategy which was complemented by capacity building of community level providers.

#### *Community Ownership*

Communities through the MGs own this project. The MGs demand that their monthly meetings be held, that they receive information and they created pressure for improvement of service quality. The VDCs and DDCs recognize FCHV as the 'pillar' of the CB-IMCI program and have supported her and community activities in a progressively increasing manner.

#### *Creation of sustainable community based resources*

The project promoted FCHV CCs and LRPs as community based structures which have proven to be a source of continued support to the community level child survival activities.

#### *Inclusion of PVSE-Rights Based Approach*

The project addressed the needs of the most marginalized through the *Dabi* groups and through increased focus of FCHV activities in *dalit* areas. The use of RBA as a tool to help the community identify and address issues ailing them has generated a lot of visibility for needs of equitable service provision. The *Dabi* movement started by the project has great potential to mainstream the marginalized groups in Nepal. Through the life of the project, the *Dabi* groups expanded the issues addressed from health to development. However, the movement requires to be guidance within the developmental agenda.

#### *Improved Local Capacities*

The FCHVs and MOHP workers are technically skilled to implement CB-IMCI activities; the health facilities are addressing improvement of health delivery through HFOMCs; and the VDCs/DDCs are monitoring/supporting community level child survival activities

#### *Achieved Project Targets*

Barring behaviors pertaining to hand washing and consumption of iodized salt, the project achieved most of its targets which will continue to receive support from CARE through its active participation in the Far Western Region

#### *Child to Community*

The child-to-child approach, applied in only a small proportion of VDCs within the project, has great potential and is being employed by other agencies as well in Nepal. As CARE implements its future projects it could well employ this approach to expand its community outreach.

## **2. Constraints**

The difficult geographical terrain of the project area and coinciding period of conflict formed the major barriers in amplifying the project outcomes.

## **3. Lessons Learned**

- The messages pertaining to offering a sick child more food and fluids/breast milk should be complemented with development of support system for the caregiver.
- The basic message of splitting the intake of the child to 6-8 small meals (as appropriate for age) should be reinforced to improve feeding practices during sickness.
- The adequate supplies of ORS through the government and its availability close to the community have made mothers reliant on ORS for managing dehydration. This needs to be complemented with the knowledge of home based rehydration as well.
- There is a need to address hand washing practices through a renewed communication strategy. The fact that mothers wash hands when they perceive them to be dirty should be central to the development of a behavior change message. Perhaps there is a need to inform mothers about what can be invisible and still be dirty in an emphatic manner.

- It is important to ensure that breast feeding is initiated within the first hour of birth to ensure the mother also benefits from the improved hormonal secretions. BCC messages need to incorporate this aspect adequately.
- It is important to link nutritional activities with other interventions which ensure food availability to ensure that the most marginalized are able to practice the learnt behaviors.
- The existing strategy for promoting consumption of iodized salt needs to be revisited to ensure that availability of salt and adoption of positive behaviors can be achieved.
- MOHP needs to strengthen systems to ensure timely and regular availability of essential life saving supplies to complement the improved health seeking behaviors of the community.
- Retention of immunization and growth monitoring cards needs attention to enable quantification of outcomes effectively. In the absence of immunization/growth monitoring cards, especially among highly aware populations, the rapid catch indicators do not necessarily capture the true nature of achievements.
- A Rights based approach to development transfers the implementation of the interventions to the community to a great extent and is an excellent tool to sustain outcomes beyond any project life. It should be applied in future project to achieve amplified outcomes.
- The rights based approach to community mobilization has a huge potential for sustainability. It throws up unexpected results, given that the local needs and solutions are best anticipated by the communities and cannot be foreseen by the best of project designing efforts. RBA tool was effectively utilized to include the most marginalized.
- There is a need for developing specific indicators which will reflect the nature of participation of the community. The process and quality of participation needs to be documented regularly to understand the attribution out outcomes.
- Organization of FCHVs into coordinating committees has ensured that the developed capacity sustains.
- An important lesson learned cited by the evaluation team was the need to provide financial management capacity to FCHV CCs to help investment of the MG funds.
- There is a need for community providers in urban marginalized pockets.

#### Management lessons

- Improve technical on-the-job field supervision: define what constitutes 'field time'; and develop performance supervision checklists for supervisors visiting field.
- Develop stronger negotiating techniques and platforms to influence issues like government staff transfers. Explore possibility of including these commitments in the formal agreements. Alternatively lobby through continuous dialogue at National level for achieving control. This has been tried with fair amount of success in India where INGOs negotiate not only for retention of trained government staff but also for transfer of nonperforming staff.
- Be more realistic in staffing pattern in difficult geographical areas. Negotiate with donor through presentation of geographical constraints.

- Develop guidelines for receiving structured and regular feedback regarding HR issues from staff

#### **4. Recommendations**

- CARE with other PVOs should look at revised BCC strategies for influencing hand washing behaviors in the community.
- National level efforts should be made to streamline the supply of iodized salt. Efforts should be made to address the issue of salt bitterness and an appropriate BCC strategy needs to be developed to improve consumption of iodized salt.
- The Chaupadi tradition prevalent in the FWR requires national attention. This can be addressed in a focused manner through the maternal neonatal strategy being formulated at the central level. CARE's active participation in this forum and wider dissemination can ensure that this detrimental community behavior is abolished and outlawed in the country.
- MOHP needs to support the improved capacities of FCHVs and MOHP workers by planning for new and refresher trainings. The regional and central level officials may explore the possibility of support to the CB-IMCI program from within the community. There are excellent examples of VDCs supporting trainings of community level provider. Development of this linkage can mean faster expansion of IMCI activities in the entire country.
- There is a need for continued monitoring and supervision of HFOMC activities and the CDP. This has to be included in district level plans and actively implemented.
- The issue of urban marginalized population needs to be studied scientifically to support policy makers arrive at an appropriate solution.
- There is a need to develop process indicators to measure the participation of *dalits* in development. This will complement the measurement of amount of participation. Suggested indicators include: number of agenda items proposed by *dalits*; number of issues identified by *dalits* addressed; number of issues identified in *dalit* communities resolved; and number of *dalits* in key decision making positions.
- There is a need for PVOs to be more realistic in staffing patterns especially in difficult geographical terrains. Negotiate with the donor by presenting the geographical constraints.
- The Social Welfare Council may consider participation in project development phase of various PVOs to ensure that activity duplication in same geographical areas can be prevented.

#### **F. Results Highlight**

The impact of rights based approach to child survival and the effectiveness of organizing FCHVs into coordinating committees are some of the highlights of this project and have been discussed under appropriate sections.

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

**A: The Problem**

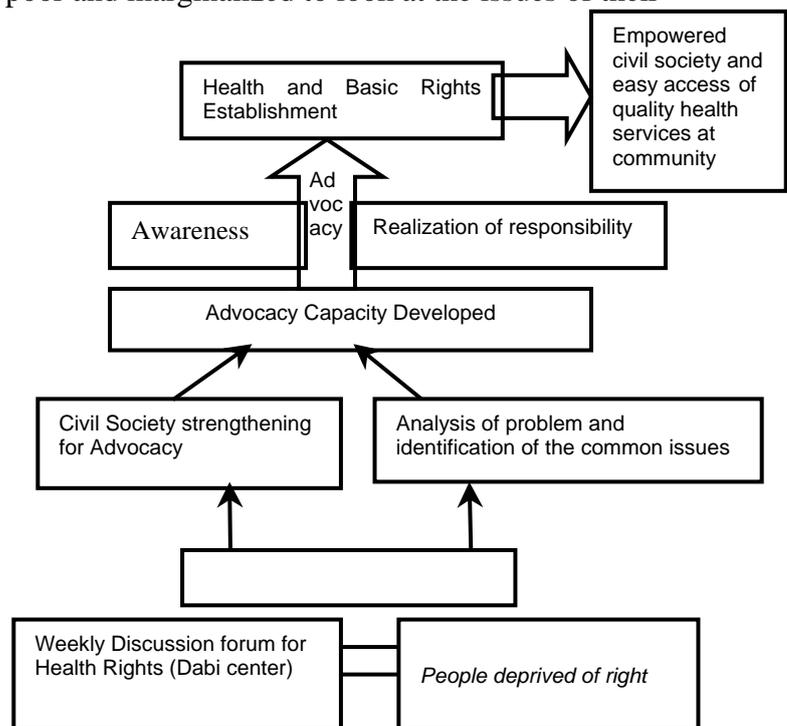
Access over basic need and services has been declared as basic civil rights by the government of Nepal in its tenth five-year plan. Nepal Health Policy 1992, Long-term Health Policy (1998-2017) and Mid-term Health Policy have specifically mentioned that basic health services are civil rights. The poor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

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

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

resources and enabled the communities to claim for their rights that are denied from the state and from contextual interpretation of statutory, religious and customary laws. What is "Dabi" ?

The "Dabi is used as a RBA tool which was tested first in 2004 in Child Survival, Kanchanpur. The project adapted the original concept of "REFLECT" (Regenerated Frerian Literacy through Empowering Community Technique) to address community health issues through social analysis and



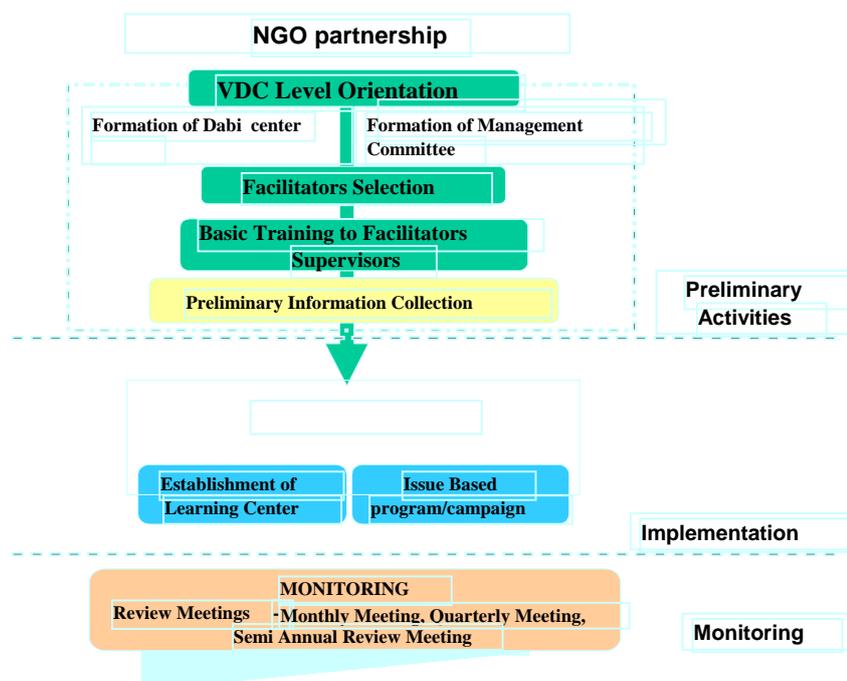
advocacy actions. The “REFLECT” is a new approach to adult literacy which fuses the theory of Paulo Freire and the practice of Participatory Rural Appraisal (PRA). It starts with probing historical and philosophical analysis of literacy, and the weaknesses of current practices. In a REFLECT programme there is no textbook, no literacy ‘primer’ – no pre printed materials except a manual for the literacy facilitators. The project has adopted REFLECT to integrate right based approach in the child survival program by CARE Nepal.

The framework given aside explain the process of “Dabi” process. The "Dabi" is a community-level interaction forum of common interest groups basically of vulnerable communities; dalit, women, and children. The community people used it as a critical tool to open the culture of silence. The "Dabi" facilitates a critical analysis of social conditions and positions among the community and enable them to be aware about their rights and responsibility. The "Dabi" be critical while facilitating the empowerment process in micro level to get changed in our traditional practices (believes, behaviors, values) and to accelerate social transformation process in a totality.

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

#### B: Project inputs

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



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

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

Establishment of Dabi Centers: A total of 84 Dabi Centers have been formed in different four project districts; eleven advocacy centers respectively in Bajhang and Doti district, 45 in Kanchanpur, 5 Child Club in Dadeldhura. In addition to this, around 20 community representatives (two from each Community Support Groups (CSGs of PLHAs and non PLHAs) have been trained in Dabi concept to work on the issues of PLWHA. Members of these centers meet regularly, discuss on various issues and implement the plan of action that includes advocacy in organized manner at different level through interaction, rally, press meet, and dialogue with different authorities, political leaders and so forth.

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

The project has developed a Dabi Center *Operational Guidelines* incorporating experiences of different advocacy centers and disseminated it throughout the project for wider application/implementation.

The project has prepared 2 edition of *Dabi Samachar*, as wall paper news of ongoing advocacy activities, and shared it throughout project districts and other projects. This *Dabi Samachar* contributed to motivate other dalit and marginalized to participate in Dabi activities and for constituency building on common issues.

The project has documented *Paribartit Aabajharu*; case studies and its publication. All together 60 cases of success stories of Dabi centers have been documented and disseminated, as it is being used as a resource material in other Dabi Centers for constituency building on the issues.

The project has prepared *Agadi Badheka Pailaharu*, an audiovisual documentary (of 26 minutes) of Dabi learning of Kanchapur district and shared in 11<sup>th</sup> Annual Child Survival Meeting, held at Atlanta on 26-31 July, 2006.

The project published a *Bal Bachau*, CSP News Bulletin, as a special edition on RBA experience of CSP and disseminated widely within and outside CARE, partners, INGOs and GOs.

Institutional networking: For constituency building on common issues, the project has facilitated the process of institutional networking with common interest group/organizations. With this support, different community-based groups/advocacy center, local campaigners, Dalit member-based NGOs worked together to identify and prioritize their demands (claim) and come up with advocacy plan with alternatives.

These networks have been strengthened with the capacities to pressurize the district planning process to allocate adequate resources to address the issues of marginalized

#### C: Result/change observed

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

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

**Stop Chaupadi practice:** Chaupadi is traditional practice that isolates women during the menstruation period and during the child deliveries period. This is one of most harmful cultural practices that directly affects new borne and maternal health. Dabi worked to sensitize community people and also pressurized to traditional believers to stop such practices. In Kanchanpur, 200 Chaukudi (*a small hut to stay during chau*) are destroyed and approx. 70% household have stopped such harmful practices, ongoing the same process in other project district.

**Registration of vital events, such as birth registration, at community:** Many of VDC level secretarial office in project districts, have been closed due to the conflict situation of the country that are suppose to provide registration services at community. At present, VDCs are providing services from district head quarter and this has resulted to be delay for registration, but the local government is charging penalty to community people that actually is happening due to the absent of government service. Child Club of Dadeldhura district, organised with support from CSP, pressurized local government body to reduce delay-penalty and to regularize service at community and succeed to reduce penalty from Rs 50 to Rs 15. Now, almost all VDC secretaries in Dadeldhura, are providing this services at the community level.

**Regularise outreach health clinic service throughout the district:** Outreach health clinic was one of the weakest performance areas of government health services, which plays a vital role to improve basic health care services such as immunization, ANC/PN. Dabi initiatives have pressurized to regularize the clinics. As a result, in Kanchanpur district, almost all ORC are functioning regularly. Other CSP districts have also started the same process.

Quality health service delivery: Dabi Center raised voice to HFOMC and DPHO to make the HF services a full time, Filling of vacant position in the HF, regularizing the supply of medicine and maintaining the adequate stock and succeed to resolve in most of HFs of Kanchanpur district, the same process is going on into other district, as well.

Other social issues (alcoholism, gambling, domestic violence, etc): Apart from health issues, Dabi is also working on addressing other social issues which have negative impact on community's health. Dabi centers also introduced various beneficial practices. These practices include declaring alcohol free zone, compulsory social audit of local level construction works, organising through saving credit program, no practice caste-based discrimination. Following two issues have been identified for regional level constituency building and for "micro-macro" policy advocacy that includes;

Implement the recent decision of Supreme Court to stop chaupadi pratha effectively with clear implementing strategy and action plan of government,

Pressurising the district planning process to approve development activities only after ensuring access of Dalit in the services and suspend development project if dalit have no access because of caste based discriminations.



## Attachment A: Team members and their titles

Name	Designations
Ranjani Gopinath	Consultant, external evaluator
Khrist Roy	CARE USA Headquarters; Technical Advisor, Child Health
<b>CARE Nepal Team</b>	
Nirmala Sharma	Health Sector Coordinator, Kathmandu
Lalu Maya Paudel	Research Monitoring and Documentation Manager, Kathmandu
Deepak Paudel	Community Health Specialist, Kathmandu
Ram Sharan Pyakurel	Program Manager, Regional Office, Doti
Khakindra Bhandari	Training Specialist, Regional Office, Doti
Min Raj Gyawali	RMD Specialist, Regional Office, Doti
Indra Adhikari	Partnership and Advocacy Specialist, Regional Office, Doti
Lava Raj Timsina	District Health Coordinator, Doti
Khim Bahadur Khadka	District Health Coordinator, Dadeldhura
Keshab Krishna Bhurtel	District Health Coordinator, Bajhang
Upendra Dhungel	AICBO, Kanchanpur
Rahamat Hussain	AICBO, Doti
Ram Narayan Shah	AICBO, Bajhang
Kamala Adhikari	Health Supervisor
Shanti Raut	Health Supervisor
Induka Karki	Health Supervisor
Urmila KC	Health Supervisor, Doti
Hira Shah	Health Supervisor, Doti
Lal Bahadur Khadaka	Health Supervisor, Doti
Shanti Thakali	Health Supervisor, Bajhang
Krishna Pal Bohara	Health Supervisor, Bajhang
Dan Bahadur Karki	Health Supervisor, Bajhang
Nar Bahadur BK	Health Supervisor, Bajhang
Durga Sapkota	Health Supervisor, Doti
<b>NGO Partners</b>	
Tek Bahadur Bam	SOURCE- Nepal
Chitra Kathayat	WDS- Dadeldhura
Dharma Singh Air	Project Coordinator, NNDSWO, Dadeldhura
Lal Bahadur Biswakarma	SOURCE Nepal, Doti
Bhagat Singh Biswakarma	Samajik Samanata Abhiyan, Kanchanpur
<b>Other Stakeholders</b>	
Shyam Sunder Mishra	RHD Regional Health Director, FW Regional Health Directorate
Satish Bishta	Public Health Inspector CHD
Surendra Bhandari	Social Welfare Council
Bal Bahadur Mahat	DPHO Kanchanpur
Dr. Md Nurul Hoda	DHO Bajhang
Pushker Bijucche	Assistant Statistician, DHO- Doti
Hikmat Bahadur Bogati	Sr. AHW, DHO-Doti
Kishor Shrestha	Medical Recorder, DHO-Doti
Ramesh Malasi	Health Assistant, DHO-Doti
Khagendra Shahi	Public Health Inspector, FW Regional Health Directorate
Laxmi Budha	Secretary FCHV CC, Kanchanpur
Goma Ghimire	FCHV, Doti



## **Attachment C: Assessment Methodology**

### Background

The final evaluation involved a) KPC survey; b) qualitative survey; and c) dissemination at National and district level (the latter conducted after the departure of the consultant).

To carry out the qualitative survey, CARE shared key documents with the consultant and provided clarifications for questions arising out of review of these documents. Consultant discussed and listed key stakeholders who were to be contacted for assessments.

CARE carried out a final KPC survey in January 2007 so that figures are not affected by varying seasonality of diseases. The baseline was carried out in the same month three years ago. The KPC was carried out with the support of a local consulting firm. The final report of the survey is being submitted as a separate document.

### Participation of key stakeholders and partners

While in Katmandu, consultant met with USAID local mission staff, Child Health staff, MOHP, Social Welfare Council staff and ex regional director FWR (currently posted in Katmandu, and INGOs implementing IMCI initiatives elsewhere in Nepal to understand the questions they needed answered through the evaluation process. Based on this listing draft tools for the community level FGDs/IDIs/meetings were drafted first and shared with CARE Nepal team for review and translation.

### FE workshop

The workshop was scheduled for two days where participants from partner NGOs, MOH, Social Welfare Council, FCHVs and others came together to understand the project, its objectives and the process and the tools to be used in the FE. Small group activities were done based on geographical and technical area of expertise to work on all the tools. The participants were informed about the differences between the questions asked during a quantitative and a qualitative survey. They were also oriented to various final evaluation methodologies like FGDs, IDIs and Key informant interview. In order to make the situation more real, on the second day role plays were done. Suggestions from participants were incorporated in the tools to finalize them.

Most of the team members had prior experience in survey methodology, however, each district team leader was asked to spend time with their teams to review the tools further. Each team was given a synthesis format so as to maintain consistency on district reports. List of various tools used is at the end of this section. Some members of the team (CARE Health Sector Coordinator and Senior Health officials) were available as temporary members of the team. Though their participation lasted anywhere between two to four days, it was found valuable in terms of understanding and disseminating findings first hand. The consultant was meant to join the Kanchanpur team after observing special initiatives in Dadeldhura, could not do so owing to restricted mobility consequent to the ongoing conflict in the area. Kanchanpur district team faced difficulties in mobility as well.

### Sampling

Purposive sampling was carried out to identify field areas. Some far/near, new/old, those with special initiatives were selected. However, this could not be done for Bajhang district. Bajhang is an extremely difficult area geographically, with very few motor able roads. The team walked for two days, selected VDCs on the way to the district office and completed the allotted tasks.

### Survey and post survey Synthesis

Over the next eight days, four teams with 10 members each formed sub teams and carried visited 28 VDCs and one municipality in the four project districts and met a total of 587 people. As mentioned earlier, consultant visited communities in Dadeldhura and Kanchanpur and details of tasks carried out are listed in the evaluation schedule. The full list of communities and health facilities visited, and list of persons interviewed by the consultant is included in the annex “Interviews, Contacts and Participants”. Some CARE staff meanwhile tabulated from the project MIS and gathered district HMIS for use during evaluation.

Each district team synthesized the findings in a participatory manner and listed the key findings and lessons learnt. The teams also came up with recommendations or consideration at national, district, VDC and community level. Team leaders brought the synthesized reports and the filled tools back to Dadeldhura where district presentations were made. The district reports were further synthesized into a project report on key findings and lessons learnt. Although a regional level dissemination had been planned earlier, that was cancelled owing to mobility restrictions. It was decided that instead, district level disseminations would be conducted. Consultant shared a district dissemination format with CARE project staff. These district disseminations were conducted after the departure of the consultant.

Dissemination meeting included the participation of key stakeholders (listed in annexure). Presentations on project achievements, strategies, special initiatives, sustainability assessment and findings were made by CARE staff, FCHV CC representative, CB IMCI point person Kanchanpur, NGO partner and the consultant. The dissemination was well received and had active participation from the government and other INGOs.

### **Evaluation Schedule and Activities**

<b>Date</b>	<b>Activity</b>
Sunday 19 Aug 2007	Consultant arrival Katmandu Discussion with Nirmala Sharma and Deepak Paduel to finalize schedule, identify additional meetings, discuss logistics of the process and plan for forthcoming meetings. Utilized this opportunity to discuss perspective on some of the outcomes. Tabulation of quantitative survey data and comparison with NDHS
Monday 20 Aug 2007	Meeting with Quantitative Survey Agency Representatives Meeting with Director Child Health Division, MOHP, GoN and team members Meeting with CARE Nepal Program/Policy and technical staff Additional document review
Tuesday 21	Meeting with NFHP senior staff, Meeting with ex Regional Director for FWR

<b>Date</b>	<b>Activity</b>
Aug 2007	Health Directorate, Meeting with Chief of Social Welfare Council and team members, the nodal agency for all NGO activities in the country Arrival of Khrist Roy, CARE Atlanta, Meeting with local USAID Mission
Wednesday 22 Aug 2007	Travel to Doti
Thursday 23 Aug	Participatory tool design workshop with various stakeholders Orientation to qualitative techniques
Friday 24 Aug	Field team formation, training and familiarity towards tools, evaluation logistics. IDI with DHO Bajhang. Late evening: interviews with NGO partner members and FGD with project health supervisors
Saturday 25 Aug	District teams leave for districts. Interview with Regional Director, FWR Health Directorate Travel to Dadeldhura
Sunday 26 Aug	Visit to Ashigram VDC, Health post assessment, IDI with Health Assistant.
Monday 27 Aug	Visit to Navadurga VDC, FGD with FCHVs, Interview with Health facility in charge, facility assessment and in the evening: interviews with NGO partners
Tuesday 28 Aug	Travel from Dadeldhura to Kanchanpur, FCHV CC members FGD
Wednesday 29 Aug	Visit to Pipladi VDC, mothers group FGD, non-mothers group FGD, Health Facility In charge interview, facility assessment and Interview with DSC Doti
Thursday 30 Aug	Meeting with DDC members, Kanchanpur CBIMCI point person, Save the Children's Neonatal health staff, DPHO Kanchanpur
Friday 31 Aug	Meeting with Kanchanpur Municipality members and Dabi group members, analysis of sample FCHV forms
Saturday 1 Sep	District level synthesis for Kanchanpur, travel to Dadeldhura from Kanchanpur, district team leaders travel back to Dadeldhura with some members.
Sunday 2 Sep	District finding presentation and full team analysis
Mon 3 Sep	And travel to Kanchanpur
Tue 4 Sep	Orientation to district dissemination structure, Finalization of key findings and lessons learnt, debrief CARE project staff
Wed 5 Sep	Travel to Katmandu and individual preparation for dissemination
Thur 6 sep	Group preparation for the dissemination
Fri 7 Sep	National Dissemination Meeting
Sat 8 Sep	Consultant leaves Katmandu



## Attachment D: List of Persons Interviewed and Contacted

### Interviews, Contacts and Participants

Name	Designation
<b>CARE Nepal Kathmandu</b>	
Khrist Roy	Technical Advisor Child Health, CARE Atlanta
Alka Pathak	Country Director
Nirmala Sharma	Health Sector Coordinator
Deepak Paduel	Community Health Specialist
Karuna Onta	Program Development Coordinator
R. P. Lamichhane	Research Monitoring and Documentation Manager, Sagun Program
Lalu M Kandel	Research Monitoring and Documentation Manager, CD
Sandesh Singh Hamal	Program and Policy Coordinator, Kathmandu
Chahana Sinhh	Program Officer, Urban Poverty Program
All CSP staff	
<b>Central Ministry of Health Officials</b>	
Dr. Yashovardhan Pradhan	Director Child Health Division (CHD)
Dr. Bhim Acharya	Chief IMCI Section, CHD
Mr. Shankar Acharya	Public Health Inspector
Mr. Satish Bishta	Public Health Inspector
Mrs Mangala Magandar	Assistant Director and Senior Public Health Officer Family Health Division
Mr. Hari Tiwari	Assistant Director , Social Welfare Council
Mr. Surya Bahadur Thapa	Treasurer, Social Welfare Council
Mr. Madan Prasad Rimal	Director, Social Welfare Council
Dr. Shyam Sundar Mishra	Regional Director FWR
Mr. Amir Khati	Ex Regional Director FWR
Dr. Md Nurul Hoda	DHO Bajhang
Dr. Ganesh Joshi	District Health Inspector
Dr. Bal Bahadur Mahat	DPHO Kanchanpur
Dr. Shiva Datta Bhatta	DPHO Dadeldhura
<b>USAID Local Mission</b>	
Dr. Sitaram Devkota	RH Specialist
Dr. DP Raman	Program Management Specialist
<b>Other Stakeholders</b>	
Mr. Madhusudan Sharma Subedi	KPC Survey Team Leader
Mina Suwal	Maternal/Neonatal Project, Save the Children US, Kanchanpur
Stephen Hodgins	Project Director, NFHP
Dilip Poudel	Team Leader, Child Health
Gyanu Sijapati, Chitra Katayat, Bhuvanewari Joshi, Beena Katka and Rupa Mal	Woman Deliverance Society
Jit Bahadur Sarki, Sundar Jairu, Dharma Singh Air and Rajendra Jairu	Nepali National <i>Dalit</i> Social Welfare Organization
Lal Bahadur Bik	Source Nepal
Bhagat Singh BK	Samajik Kalyan Samanata Abhiyan

## Kanchanpur District

VDCs/Municipality visited: Chandani, Shreepur, Daiji, Kalika, Dodhara and Pipladi;  
Kanchanpur Municipality

Respondent	Tool	Number	Area
Mothers Group	FGD	5	Chandani, Shreepur, Daiji, Kalika and Pipladi
Non- MG members	FGD	2	Pipladi and Chandani
FCHV, including CC members	FGD	3	Kanchanpur Municipality, Chandani and Pipladi
Dabi group		2	Daiji and Shreepur
HF workers	IDI	3	VHW Shreepur PHC, ANM Kalika HP, MCHW Pipladi SHP
HF In charges	IDI	3	Dodhara PHC, Daiji HP, Pipladi HP
HFOMC	IDI	2	Shreepur & Daiji
VDCs	IDI	2	Shreepur & Daiji
DPHO	IDI	1	Kanchanpur
DDC	IDI	1	Kanchanpur
Municipality representative	IDI	1	Kanchanpur
CDP observation in HF	Check list		

## Doti District

VDCs visited: Khirsan, Latagada, Banlek, Warpata, Mudhegaun, Bhumirajmandu, Ranagaun, Durgamandu, Chhatiwan, Sarsawtinager and district line agencies

Respondent	Tool	Number	Area
Mothers Group	FGD	5	Khirsan, Chatiwan, Banlekh, Mudegaon and Ranagoan
Non- MG members	FGD	1	Bhumirajmandu
FCHV, including CC members	FGD	5	Banlekh, Bhumirajmandu and Chhatiwan
LRP	IDI	3	Khirsan, Bhumirajmandu and Chhatiwan
Dabi group	FGD		Bhumirajmandu
HF workers	IDI	5	Ladagda, Sarswatinagar, Banlekh, Mudegaon and Durgamandu
HF In charges	IDI	3	Durgamandu, Khirsan, Sarswatinagar
HFOMC	IDI		Ladagada and Ranagaon
VDC reps	IDI	2	Ranagaon and Warpata
DHO	IDI	1	Doti district head quarters
DDC	IDI	2	Doti district head quarters
NGO partners	IDI	1	FEDO, Doti
PAC members	IDI	2	Doti district head quarters
CDP observation in HF	Checklists		Ladagda, Sarswatinagar, Khirsan, Banlekh, Mudegaon and Durgamandu

## Bajhang District

VDCs visited: Deulekh, Rayal, Bhairabsthan, Syadi, Banjh and Sunkuda

Respondent	Tool	Number	Area
Mothers Group	FGD	5	Deulekh, Rayal, Bhairabsthan, Syadi and Sunkuda
Non- MG members	FGD	4	Deulekh, Syadi, Sunkuda and Banjh
FCHV, including CC members	FGD	4	Deulekh, Rayal, Syadi and Sunkuda
Dabi group	FGD	1	Sunkuda
HF workers	IDI	9	Deulekh, Rayal, Bhairabsthan, Syadi, Sunkuda, Banjh and Maulali
HF In charges	IDI	6	Deulekh, Rayal, Bhairabsthan, Syadi, Sunkuda and Banjh
HFOMC	IDI	4	Deulekh, Rayal and Syadi
VDC reps	IDI	2	Syadi and Sunkuda
DHO	IDI	1	District head quarters
DDC	IDI	-	District head quarters
CDP Observation in HF	Check Lists	3	Three facilities in the above VDCs

### Dadeldhura District

Respondent	Tool	Number	Area
Mothers Group	FGD	4	Nawadurga, Jogbuda, Bagarkot and Ugratara
Non- MG members	FGD	3	Nawadurga, Jogbuda and Bagarkot
FCHV, including CC members	FGD	3	Nawadurga, Jogbuda and Ugratara
LRP	IDI	2	Nawadurga and Rai
HF workers	IDI	5	Jogbuda, Bagarkot, Ugratara, Rai and Ashigram
HF In charges	IDI	3	Nawadurga, Jogbuda and Bagarkot
HFOMC	IDI	2	Bagarkot and Ugratara
VDC reps	IDI	2	Nawadurga and Bagarkot
DHO	IDI	1	District HQ
DDC	IDI	1	District HQ
NGO partners	IDI	2	WDS and NWSSDO
PAC Member	IDI	1	District HQ
CDP Observation in HF	checklist	5	Nawadurga, Jogbuda, Bagarkot, Ugratara, Rai and Ashigram
Child club	Meeting	1	Ashigram

## RESULTS PRESENTATION

7 September 2007, Kathmandu, Nepal

### List of Participants

Name	Designation	Organisation
Ranjani Gopinath	Consultant and Team Leader	
<b>CARE</b>		
Khrist Roy	Technical Advisor Childrens Health	CARE Atlanta
Indu Pant	Gender Advisor	CARE-Nepal

Pradeep Adhikari	Coordinator	CARE-Nepal
Pushkal Shrestha	Technical Coordinator	CARE-Nepal
Rajendra Lamichhane	RMD Manager / SAGUN	CARE-Nepal
Nur Pant	HIV/AIDS Specialist	CARE-Nepal
Rabin Bogati	Program Coordinator	CARE-Nepal
Sagar Man Sainju	Budget Officer	CARE-Nepal
Bimal Baral	Finance Officer	CARE-Nepal
Sudarshan Raj Sharma	PSL Officer	CARE-Nepal
Purna Bajracharya	IS Manager	CARE-Nepal
Moon Gurung	HR Manager	CARE-Nepal
Jay S Lal	Program Coordinator	CARE-Nepal
Lalu Kadel	RMD Manager	CARE-Nepal
Sandesh S Hamal	PPC	CARE-Nepal
Karuna Onta	Program Development Coordinator	CARE-Nepal
Chahana Singh	Project Officer	CARE-Nepal
Sama Shrestha	Peace Building Technical Coordinator	CARE-Nepal
R Sharan Pyakurel	Project Manager, CSP	CARE-Nepal
Indra Adhikari	Partnership and Advocacy Specialist	CARE-Nepal
Diawary Bouare	Assistant Country Director	CARE-Nepal
Deepak Poudel	Community Health Specialist	CARE-Nepal
<b>NGO Partners</b>		
Tek Bahadur Bora	Program Coordinator	SOURCE Nepal
Bharati Singh	FCHV	EHKU CC
Vivek R Singh	Social Inclusion Specialist	BNMT
<b>MOHP and SWC</b>		
Shiv Bhatt Bhatt	PHA Administrator	DHO Dadeldhura
MP Rimal	M&E Chief	SWC
Dr Bhim Acharya	Chief, CB IMCI	CHD
Dr. Shyam Sundar Mishra	Regional Director	FWRDH
Satya Deo Prasad Yadav	Officer	LMD, CSP Section
Ganesh Joshi	Public Health Inspector	DPHO, Kanchanpur
Satish Bista	Public Health Officer	CHD
Surendra Bhandari	Assistant Director	Social Welfare Council
Amir Khati	Director	NHTC
<b>USAID</b>		
Sitaram Devkota	RH Specialist	USAID
Sharon Arscort	Sr. Technical Advisor	USAID
DP Raman	Program Management Specialist	USAID
<b>Other INGOs and NGOs</b>		
Dilip Poudel	Team Leader	NFHP
Sujeeta Shakya	Program Office M&E	NFHP
Dev Bahadur Ale	Program Manager	Save the Children Norway
Ishwar Shrestha	Head, DCMFH	Institute of Medicine
Muriel Mac Seing	HPFO Officer	CECI
Anush Shrestha	Associate Officer	Action Aid Nepal
Laxmi Raman Ban	Director	NHEICC

Other CARE staff involved in the project, but not in the evaluation:

Mr. Bijay Bharati, Ex Monitoring and Documentation Specialist

Ms. Maya Belbase, Ex Training Specialist

Mr. Mahendra Bikram Shah, Ex District Health Coordinators

Mr. Dambar Singh Gurung, Ex District Health Coordinators

Raj Kumar Mahato, Ex District Health Coordinators



## **Attachment F: Special Reports**

F (i) Malaria Report

F (ii) CSSA Report



**Attachment G:**  
Project Data Form



# **Attachment H**

KPC and HFA Questionnaires