

SEMI-ANNUAL REPORT SUPPLEMENT

1 April – 30 September 2008

SUBMITTED TO

USAID/Nepal



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Background

JSI Research & Training Institute, Inc. was awarded a Cooperative Agreement to implement the Nepal Family Health Program II starting on 19 December 2007 and ending on 30 September 2012. NFHP-II is being implemented by JSI Research & Training Institute, Inc. and its partners – Save the Children, EngenderHealth, JHPIEGO, World Education, Nepal Technical Assistance Group, Nepal Fertility Care Center, Management Support Services and the Nepal Red Cross Society.

Objective

The goal of the project is to improve provision and use of public sector Family Planning/ Maternal, Neonatal and Child Health (FP/MNCH) and related social services supporting the Government of Nepal's intention to reduce fertility and mortality, as expressed in the Health Sector Strategy (2004); the Nepal Health Sector Program – Implementation Plan (2004-2009), particularly program outputs 1-4, and 6; and the Second Long Term Health Plan (1997-2017).

Report Organization

This report is organized following the content of the year 1 NFHP II Annual Workplan. Numbering of sections follows that of the workplan.

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1.0 HEALTH SYSTEMS, POLICY, LEADERSHIP/ MANAGEMENT

1.1. Policy

1.1.1 Quarterly meetings of Health Sector Decentralization Policy Forum:

The 2nd Health Sector Decentralization Policy forum meeting was held on April 25, 2008 followed by a supplementary meeting on May 13, 2008, at which it was decided to form a Task Force to develop Health Sector Decentralization Policy Perspective (guidelines) under the coordination of Dr. Babu Ram Marasini (with NFHP representation). The Task force is in process of developing the guidelines.

1.1.3 Social Inclusion Policy Advisory Group & Planning Framework:

To follow through on ideas discussed during the December 17, 2007 workshop, the Health Sector Reform Support Program (HSRSP) /RTI has hired a consultant to give final shape to the SI workplan framework.

1.1.5 National Standards & Procedures:

As part of the national strategy, MoHP is in process of switching from the current HMIS to a Health Sector Information System (HSIS) which would use only 83 indicators (vs. the current ~900) indicators; this is intended to produce only usable information and to reduce work burden. The proposed tools are at near-to-final final stage in development and will be tested in 3 districts. NFHP is supporting the Management Division in HMIS data analysis and report verification and will continue to work with new tools.

MoHP (Secretary level decision) has formed a **'Working Group'** to review the HRH Policy and work on Master Plan (with NFHP representation). 3 distinct tasks have been identified; 1) HRH Policy review, 2) Strategy for Retaining HR in Remote Areas, and 3) HRH Master Plan.

1.2 National Level Leadership/ Management Capacity

1.2.1 Procurement Act and Rules and MoHP Procurement Capacity:

NFHP has reviewed the new Procurement Act 2007 and presented its recommendations to USAID. NFHP has also assisted MoHP in developing "Procurement Guideline for Central Level" covering procurement of commodities, works and services. Officials from the Public Procurement Monitoring Office under the Prime Minister's Office participated.

1.2.3 GoN Funding Commitments for Procurement of Contraceptives:

This has been an area of some disappointment: the MoF has cut Rs. 40 m. from the level of funding for contraceptive procurement proposed by MoHP. This will be discussed with donors in the forthcoming Contraceptive Forecasting Meeting. A collective advocacy strategy will be developed for future efforts.

1.2.4 MoHP PPICD Annual Workplan & Budgeting Process:

MoHP is trying to shift from input-based to output-based in planning line with Nepal Health Sector Program Implementation Plan. A Task Force was formed chaired by Kapil Ghimire, Joint Secretary, MoHP with NFHP representation. Under this scheme with technical support from HSRSP/RTI, a new template is in development which will automatically generate data tables. Those tables will present information organized by output, donor, level, etc..

As in previous years, NFHP II supported FHD to prepare annual FP, SMN, CB-IMCI, Vitamin A, FCHV and Institutional Support Supplemental and Red Book workplans for FY 2008/09.

NFHP played key role in coordination and preparation of the annual CB-IMCI workplan (which is a multi-donor workplan).

Secretariat support continues to be provided, through MASS, with 2 persons in CB-IMCI and 1 person in Nutrition Section to assist in data entry/analysis and secretarial works. In addition, office supplies were also provided.

CHD with support from NFHP II conducted 3 CB-IMCI working group meetings within this reporting period. Program implementation status, problems, and constraints were discussed and commitments sought to expand and maintain the CB-IMCI program for the year 2008-2009.

1.2.6 Human Resource Development Policy:

Under MoHP leadership and in partnership with HSRSP/RTI, best practices in peripheral health facilities are being documented from all districts. One of the indicators is availability/retention of HR. Once the data collection is completed, follow up visits will determine the underlying factors contributing to good practices which will be shared among policy level managers in a national workshop.

1.2.7 Development & Revision of Policies, Protocols and Standards:

CHD organized a workshop in Pokhara to develop guidelines for integrated micro planning of MCH activities during which an outline was developed covering EPI, CB-IMCI, Nutrition, FP and SM. After completing the guidelines, micro planning will be carried out in several low HDI districts, notably Mugu, Manang and Ramechhap.

GoN is planning to implement the Community-Based Neonatal Care Package (CB-NCP) in 8 districts with the support of GAVI, UNICEF, PLAN, SCF/US and CARE. NFHP has provided supported to GoN in the development of many aspects of implementation (training, M&E, logistics systems, etc.).

1.2.9 & 1.2.10 INGO/DHO Focal Person Review Meeting

NFHP provided technical and financial support to CHD to carry out CB-IMCI focal person meetings in Hetauda and Nepalgunj. This provided an opportunity to bring together CHD/RHD, DHO, CB-IMCI focal persons and partner organizations in one place to discuss program successes and challenges, and lessons learned to improve the quality of CB-IMCI program. The meeting was inaugurated by the CHD director and chaired by respective regional health directors with participation of 59 focal persons.



CHD, Regional Director & CB-IMCI program chief in FP meeting

Responding to concerns about untrained staff, CHD director and program chief indicated that untrained staff will be gradually trained in co-ordination with EDPs, and emphasized the importance of supportive supervision. The director also recognized the contribution of HWs and FCHV in reducing U5 mortality, and indicated that CB-IMCI focal person will also serve as focal points for CB-NCP. Partner organizations (UNICEF, USAID, PLAN, CARE and SCF) expressed their commitment to continue support CB-IMCI.

CB-IMCI in Dang

CB-IMCI in Dang was not functioning well. There were frequent shortages of CB-IMCI materials and very poor recording/reporting. So NFHP II started to work in identifying the appropriate support on technical and logistic supply to reactivate the program in Dang. The need identification was done through VHSP/TSV. On request by DHO, NFHP gave technical and logistic support on CB-IMCI. Now most CHW and HFs have started reporting and the quality of case management is improving.

1.2.11 CB-IMCI Materials:

Printing of CB-IMCI training materials and their resupply continues for new and old program districts from Supplemental Workplan funds. The supply is being ensured by NFHP through regular TSVs and through GoN channels.

1.2.14 ORT Corner Sets & Weighing Scales:

NFHP procured 100 sets of ORT /Corners and weighing scales. Procurement of 50 more sets is in process for Salrahi, Dhanusha and Mahottari.

1.2.15 Support for CB IMCI and Other Child Health Program Implementation:

During this period CB-IMCI has been expanded to community level in Kalikot and to HF level in Salyan with financial support from UNICEF and GoN, and technical support from NFHP.

NFHP monitored March/ April round of polio NIDs, working closely with district public health offices. Similarly, we helped support implementation of the measles campaign in mid and far western regions through district level orientations, meetings of HF staff, vaccinators' training, and monitored in 28 sites across 13 districts.

The US Ambassador visited the MINI program and observed neonates with PSBI who were being treated cotrim by FCHVs and receiving gentamycin from the VHW. She interacted with the FCHV, VHW and mothers of sick newborns. She also observed community based pneumonia treatment under CB-IMCI program.



Program briefing to US Ambassador

During this period, NFHP provided technical input on the PLAN Child Survival project in Parsa.

1.2.19 Biannual Vitamin A Supplementation (April 2008 round):

NFHP supported various functions related to the semi-annual vitamin A supplement distribution including re-packaging of capsules, supply from RMS to districts and HFs. We monitored 369 sites in 27 districts, and supplied necessary materials.

1.2.23 Training Database:

Technical support continued to NHTC for maintaining training data. During this reporting period training data on 93 participants of Basic Logistics Training for MCHW/VHWs and 60 participants of Family Planning (IUCD, Norplant, NSV, Minilap, COFP/Counseling) and PAC (MNH) training has been entered into the database.

1.3 District Level Leadership/Management Capacity

1.3.1 District-Level Use of Data for Program Management/ Decision-Making

Bara and Surkhet are being given support in establishing an M&E network as a common forum of government, NGOs, INGOs and private sector to enhance data quality and use. In Bara the network has been established. As per the recommendation at the first meeting, NFHP along with other district partners has helped set up a resource center in the Bara district public health office, and support is on-going to strengthen Ilaka level meetings and RHCC meetings focusing on data use. As a result there is regularization of ilaka level meetings with review of monthly monitoring worksheets. NFHP helped to develop a list of HMIS indicators for flex sheet to be posted in district public health offices and in some Ilaka level HFs. Furthermore, upon request of district public health office Surkhet, we provided

program-wise monitoring diary to all Supervisors in order to make them more responsible for their own program.

1.3.5 District-Level Human Resource Management:

NFHP has noted disruption of service at local level due to unavailability of HF staff. During this period MoHP/DoHS appointed Medical Officers to fill positions under contract. Likewise 718 paramedical staff were given extensions of their temporary appointments from the previous year, with permission from the Public Service Commission. Once VDC HSP data is available, we will have good picture of the HR situation across CPDs, which will help better direct our advocacy to minimize vacant positions.

1.3.6 District RHCC:

RHCC provides a platform to share and discuss RH-related issues and activities. This meeting helps to reduce duplication of work, understand each others programs and activities. NFHP II has played an important role in establishing and strengthening the capacity of district RHCCs. In the Central region, all 10 CPDs have functioning RHCCs that have conducted quarterly meetings with support from NFHP II. Similarly, in Mid and Far Western region new RHCCs have been formed in 6 districts, revitalized in 2 districts and strengthened in 2 old CPDs with NFHP's support.

Before NFHP-II support was introduced in **Rolpa**, an RHCC already existed but was non functional and meetings were irregular. NHFP II field officers took initiative coordinating with the DHO and different stakeholders working in the district to revitalize the RHCC. Since then RHCC is functional and 3 RHCC meetings have been conducted. I/NGOs support and chair the RHCC meeting in rotation. Revitalizing the RHCC has helped improve coordination among RHCC members and ensured better support to district public health office programs. Partner organizations have started to regularly submit their RH program reports to their district public health office.

NHFP II field staff in **Surkhet** helped to revitalize the non-functional RHCC. They coordinated with all the district stakeholders, initially volunteered to prepare meeting agenda, helped to oversee the RHCC meetings, and used RHCC meetings as an opportunity to share the USG FP legislation and Policy, and national RH strategies. Currently RHCC is functioning effectively, and all the stakeholders consider it as a good forum for sharing their programs and activities and to discuss RH issues.

1.3.7 District-Level Quality Assurance Working Groups:

Building on the success of Quality Assurance Working Groups (QAWG) during NFHP-I in enhancing the quality of FP-MNCH services, we have continued this activity. Management Division is incorporating QAWGs within the QA Policy (See also activity # 2.1.22). QAWG guidelines have been revised, and the QA Policy has been distributed to all 20 CPDs. QAWGs have been formed under the leadership of D(P)HO in 9 new districts (Surkhet, Dailekh, Kalikot, Jumla, Puthan, Salyan, Rolpa, Dang, Kanchanpur and Sindhuli). They meet periodically to discuss, identify and decide what actions should be taken per the need identified during TSVs and review meetings. The districts have started using the QA fund following priorities set by the QAWG (see detail in activity no 2.1.16).

Since its establishment in May 2008, QAWG **Sindhuli** has started looking into various performance and quality related issues pertaining to FP-MNCH. It has discussed, prioritized and prepared action plans. As a result, MCH services in the district clinic have been more regular. Additionally, D(P)HO has introduced Illaka level monthly meetings. QA fund has been utilized for ANC table, curtain, BP cuffs etc.

1.3.8 District Public Health Team Role in HFOMC Decentralization:

After development of training manual, the TOT and district level supervisors have been trained under NHTC. A preliminary meeting was held with NHTC Director and HFOMC focal person to discuss further decentralization of HFOMC training to the district.

1.3.9 Implementation of the Leadership Module:

A concept paper on a model decentralization district has been developed and shared with officials of NFHP, HSRSP/RTI and MoHP. It is to be shared with a larger group with interest in health sector decentralization and capacity building for HFOMC members. The Task Force created by Health Sector Decentralization Policy Forum will complete drafting the perspective guideline for health sector decentralization as a basis for developing a model decentralization district. Once these two activities are completed, actual program implementation will begin in coordination with NHTC.

1.3.10 Community Level Monitoring:

One day meetings were organized in Jumla and Sarlahi with the objective of orienting district public health office supervisors conduct of CHW review monitoring meeting. This has helped ensure consistency on content areas, and collection and review of performance data. For security reason this activity has not been conducted in Mahottari and Dhanusha, where similar meetings had been planned.

1.3.11 District Level Review Monitoring Meeting:

District level review monitoring meeting is an important activity for program maintenance as recommended by CB-IMCI implementation guidelines. These meetings were conducted in 6 districts (Saptari, Bara, Rautahat Doti, Pyuthan and Baitadi) and all HF in-charges (306) presented their HF and community level performance on CB-IMCI activities. Utilizing this opportunity, program-related management problems were discussed updates were given on correct assessment, classification and treatment of ARI, diarrhea, malaria, measles, ear infection, malnutrition and management of sick neonates. Participants practiced filling in the CB-IMCI OPD register and preparing the monthly report. As per the request of CHD, NFHP facilitated meetings in 2 non-CPDs (Saptari and Baitadi).

1.3.12 District Level Profiles:

NFHP II has completed District Profiles of all 20 CPDs. Some of the key findings include:

- In general staffing situation in the health facilities (D/PHO, PHC, HP and SHP) of NFHP II CPDs was good, with between 81% to 99% positions filled. When completed, the VDC-level profile will provide a more comprehensive picture of all rural health facilities in the districts.
- Availability of the 7 key commodities needs to be improved in CPDs.
- Generally Kalikot district has poorer performance in comparison to other CPDs, for example in TT2 among pregnant women, vitamin A to postpartum mothers, and contraceptive use.
- Among 20 CPDs, 5 districts (Sarlahi, Sindhuli, Kalikot, Rolpa and Salyan) lack blood transfusion services.
- Delivery conducted by health workers as percentage of expected pregnancy, was highest in Dhanusa (75%) and lowest in Salyan (12%).
- LMIS reporting seems to be very good in CPDs, with at least 89% reporting in 19/20 CPDs. Similarly, timeliness and completeness of HMIS reporting is also good among the CPDs but there is lot of improvement needed in *quality* of recording.

1.4 Logistics

NFHP-II has been successful in meeting its 4 logistics OP indicators. Moreover, as a result of our efforts, national LMIS reporting from health facilities has improved (90%) in year 2007/08. Reporting has improved dramatically in one of the most difficult districts, Kalikot.

A number of new initiatives were taken in logistics notably moving towards the web-based LMIS and Inventory Management System. For the first time, LMD organized forecast exercise of essential drugs so that adequate and accurate quantity can be procured. With the KfW's support and NFHP II management oversight, 9 new district storerooms were built in the reporting period totaling to 45 district storerooms. The HIV/AIDS and Essential Drugs Logistics System Assessment has been carried out. These and other important logistics activities are explained in detail below.

1.4.1 LMD Monitoring, Forecasting, Procurement, Distribution & Transportation:

NFHP II assisted in distribution of vitamin A capsules and aendazole tablets to all 75 districts for the April and October national bi-annual supplemental day, and monitored supply availability. We provided TA to LMD in coordination with FHD and CHD for estimation and distribution of supplies (FP commodities, ORS, Cotrim P, iron tablets), zinc sulphate to RMS and District Stores. We ensured supply of 1,100,000 pkts of ORS, 500,000 tabs Cotrim P, 275,000 tabs zinc sulphate, and 50,000,000 iron tabs. And we assisted in re-packaging and distribution of LMIS forms, stock books, HMIS forms and monitoring sheets throughout the country.

Annual Commodities Distribution Program (ACDP) was conducted with funds from LMD's transportation budget and with TA from NFHP II in two phases, first phase in first week of April, 2008 for 17 districts, 5 RMSs, and 2nd phase in 2nd week of May, 2008 in the remaining 58 districts.

1.4.2 Commodity Security Forecasting:

National pipeline review meeting has taken place in LMD in every quarter to review the national pipeline status of contraceptives and other key commodities including vaccines. In July 2008, NFHP II in coordination with FHD and LMD, requested USAID to supply 10,000 sets of implants of which 5,000 have been received by LMD.

In September, due to late approval of procurement from World Bank, LMD could not procure its planned 25 million of condoms and 17,000 sets of IUDs for FY 2007/08. The Bank stipulated a special clause of bid security from the manufacturer, disallowing bid security from the local agents. This made all bids non-responsive and LMD had to cancel all tenders. Also there is a reduction of MoHP's budget in contraceptive procurement by Rs. 4 crore (about US\$ 0.6 million) which will affect procurement of IUDs and Implants. In the meeting LMD director said that LMD will procure 5,000 sets of IUD as an emergency measure to address shortfall in IUDs, and FHD will also explore other possible funding.

To address the increased demand resulting from the "free drug policy", a 2-day workshop was held (July 24-25, 2008) to draft the consensus forecast of essential drugs, chaired by LMD with technical and financial support from NFHP II and USAID | DELIVER Project. The workshop was attended by DoHS, FHD, LMD, Management Division, CHD, EDCD, RMS, DHOs, NFHP-II, SSMP, and KfW (report is available). The proposed budget for Essential Drugs for FY 2065/66 was approximately Rs. 690 million (Center Rs. 250 million, region Rs. 50 million, and districts Rs. 390 million (excluding District Hospitals) (Budget to procure essential drugs to districts proposed through Management Division).

Discussions and Outcomes:

- The technical group did forecasts for 53 essential drugs and supplies for the coming year, including all the EDs listed as 'free drugs' by MoHP and cotton, gauze, bandages etc.
- The group agreed to quantify the need of essential drugs based district population.
- 45% of the needed supply is to be procured by the center (LMD) and 55% by districts. Regions (RHD/RMS) will procure essential drugs as buffer stocks. The group also categorized the essential drugs as jointly procured by district and Center; only procured by Districts and only procured by Center.
- The total projected cost of essential drugs needed for coming year is about Rs. 634.3 million of which 24.3 m for Center (LMD), 48.8 m for regions (RD/RMS) and 342.6 m for 75 districts. This is lower than the proposed budget (Rs 690 m).
- Essential drugs procured by the central/regional/district will be stored in the districts and supplied to health facilities as per demand (Pull System).
- Management Division in coordination with LMD will send to districts the list of essential drugs and estimated quantities to be procured from each district.
- LMD will send the list of essential drugs and quantities to be procured to each RHD/RMS to facilitate regional procurement.
- LMD will initiate procurement of the essential drugs as per the quantity identified by the consensus forecast and arrange delivery to district stores through RMS.
- The forecast will be reviewed next year.

Semi-Annual Security Forecast Review for FP and Other Key Commodities:

NFHP II assisted FHD in organizing a semi-annual Commodity Security Forecast Meeting for the period 2008-2012 in July 2008, during which the funding and quantities needed of FP and other key commodities were presented and reviewed. These meeting have helped improve coordination between program divisions and donor partners and contributed in enhancing MoHP capacity for long term forecasting of commodities and required funds.

This year (FY 2008/09) there has been a budget cut of 4 crore rupees in contraceptive procurement from MoHP fund, but about 90% of the total requirement for the public sector is covered by GoN. Last year MoHP's contribution in contraceptive procurement was about 78% of total public sector's need. FHD has already initiated a process and dialog to meet the shortfall for contraceptives for this year. NHFP-II is supporting FHD and LMD in this process. The annual contraceptive and key commodities forecast meeting is planned in Nov. 2008.

1.4.3 Logistics Training in Peripheral HFs, DPHOs & District Stores:

Basic Logistics Training for MCHWs and VHWs was conducted in Solukhumbu and Terathum during in April and May. With NFHP's technical and financial support, sub district level meetings were held in Sindhuli in May to address logistics problems such as stock out of commodities, low LMIS reporting, misinterpretation of stock-outs. Similar input was provided in Sarlahi in June 2008 in 14 Ilakas. These districts were selected for logistics inputs based on high rate of key commodity stock out, and district request.



Shiv Dutta Bhatta, Sr PHA , LMD Teku at logistics orientation program in Sindhuli.

Kalikot - Improved Logistics

Before our logistics intervention in Kalikot, LMIS reporting was poor. Upon request of DHO Kalikot, LMD with technical support from NFHP II conducted a 1 day logistics intervention to improve LMIS reporting, improve district supply system and reduce stock-outs; this targeted district manager, district supervisors, storekeeper and HFs in-charges. HFs In-charges committed to improve LMIS reporting and reduce stock-outs. Similarly, the storekeeper committed to supplying key items to HFs on a timely basis. As a result, LMIS reporting dramatically increased- from 42% in the 3rd quarter to 100% in the 4th quarter in year 2064/65. Furthermore the district store is now being managed more effectively (see below)



Before



After

Over this period, NFHP II supported district public health offices in organizing logistics interventions in 5 CPDs.* A total of 141 persons participated.

During TSVs, NFHP II regional and district based staff gave support to HFs on management of health commodities and drugs following FEFO system, recording/reporting, update of stock book, supply of commodities to CHWs etc.

Logistics Training: Procurement Training

NHTC/MoHP initiated District-Level Public Procurement Training in 33 districts based on the revised Procurement Act 2063 and Regulations 2064. NFHP provided technical support in revising the training manual, overseeing the trainers preparation workshop (TOT) and training implementation. TOT, training implementation and printing including training aids and materials were paid for by GoN. Training was held in all the five RHTC and Sub RHTC Sapahi.

1.4.4 Store Equipment and Repair & Maintenance:

Improving management of health facility stores helps ensure good storage practices, minimizing loss and damage to health commodities. Steel racks (8), cupboards (3) and pallets (8) have been supplied to 3 health facilities in Sindhuli. Information is being collected on needs for storage equipment in the remaining HFs in Sindhuli and in Sarlahi. Reorganization, management and cleaning of district store in Sindhuli was done with financial and technical assistance from NFHP II.

With financial support from NFHP II, at the Pathalaiya Transit Warehouse clean up was done in and around the complex, particularly addressing fire hazards. Bushes, grass and junk were cleared out.

Over this reporting period, DELIVER and NFHP II provided technical and financial assistance to Kanti Children Hospital, Maharajgunj for auctioning unusable commodities and equipment; this generated NRs. 617,500.00, and about 10,000 sq. of space were freed up

* Dailekh, Kalikot, Surkhet, Jumla and Salyan

for storage. Later store is to be renovated and painted. Similarly, one of the store rooms in RMS Nepalgunj was renovated, with the financial support from NFHP II and USAID| DELIVER Project. Since the renovation, a storage area of about 1,650 sq. ft. can now be fully used for safe storage of commodities.

NFHP Nepalgunj Field Office has collected a list of storage equipment like racks and pallets for health facilities in mid-west region CPDs, and is in the process of procurement. This will help to ensure adequate standard standards. Cleaning and reorganization of Central Warehouse, Teku was also done over this period.

1.4.5 LMIS Strengthening:

With TA from NFHP and funds from SSMP, LMD organized a Web-based LMIS Training for 16 districts from Eastern and 2 districts from Central region. We also provided a 3 days web-based training for government staff from 15 districts in Mid-Western region with technical and financial support from USAID | DELIVER project. During the training, computer equipment (computer, printer, UPS, LCD monitor, CDMA Ruim card and USB card holder for Internet access) was provided to all 15 districts. The participants were DHOs, storekeepers and cold chain assistant/computer assistants. It is expected that the new information technology will be actively used and will contribute to strengthening MoHP capacity.

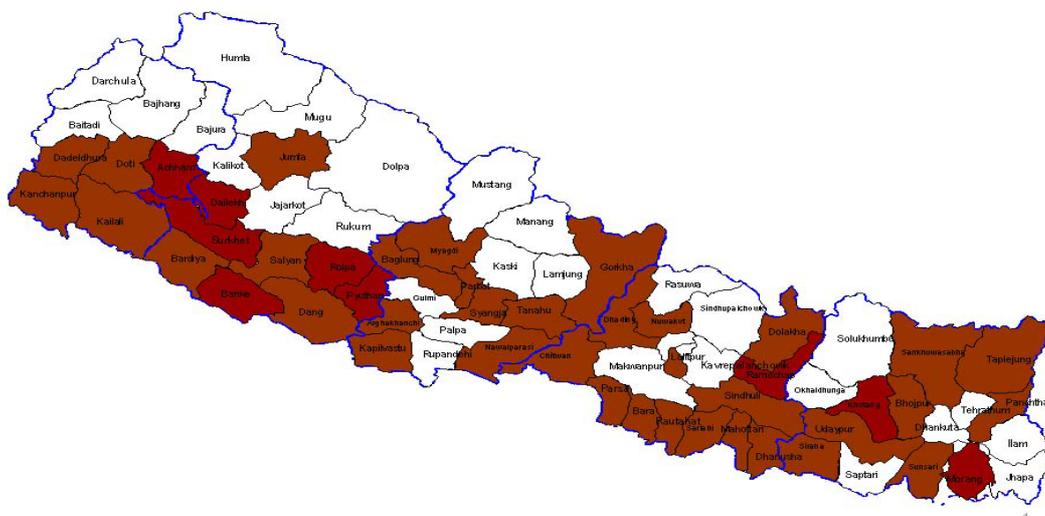


Web-based LMIS - Nepalgunj

1.4.6 Management Support for District Store Construction:

During this reporting period, 9 more district stores were completed with KfW funds and NFHP II/ USAID-funded management support. To date, storerooms have been constructed in 45 districts and one national cold chain room in Patalaiya. All the newly constructed stores are equipped with store equipment (Rack, Cupboard, Pallets etc) except Morang, Ramechhap and Khotang. Furniture has been providing to 5 CPDs (Banke, Surkhet, Rolpa, Salyan & Pyuthan). Now these districts are well equipped, well functioning with FEFO system and have adequate space for safe storage of health commodities.

Figure 2: Districts with new District Storerooms



A meeting of the district store construction committee was held under the chairmanship of the DG and approved new designs for district storerooms. The new designs include a 2-storey store for sloped land and 2-storey store for areas where land available is very limited.



Newly completed, equipped and reorganized District Storeroom in Pyuthan

1.4.7 Logistics Support to RMS & Districts:

NFHP II provided TA in maintaining and updating the software at RMS, Hetauda and Biratnagar for the management of health commodities and drugs, and regular supply and distribution of commodities from the center to RMS to districts. TSVs were conducted in Parsa, Bara, Rautahaut, Sarlahi, Sindhuli, and Siraha to determine the procurement needs and budget, distribution of calendar, rational supply and concept /need of Pull system.

RMSs of Far-Western and Mid-Western regions were assisted in determining needs for re-supply of health commodities based on district LMIS reports, and store keepers were coached on use of distribution calendar to ensure timely supply of health commodities.

LMD was given support to conduct: a Regional Review Meeting in Nepalgunj in September; Regional Logistics Review Meetings in Biratnagar and in Dadeldhura. These Regional Logistics Review meetings focused on timely LMIS reporting, availability of key commodity at SDPs and other key areas of logistics management. All DHOs and storekeepers from the eastern and far-western region including representatives from LMD, RHD, and RMS attended these workshops.

1.4.8 Logistical and Other Support in Emergency Situations:

NFHP II formed a Rapid Response Team (RRT) in order to respond for the flood victims in eastern districts, and supported flood victims with 10 drums and 25 litres of phenyl for proper management of wastes, financial support in transporting health commodities and helped in prevention of water born disease. Assistance was given to Sunsari district public health office in distributing drugs and medicines to flood victims in time and preventing loss of lives. NFHP II supported DHO Sindhuli in managing a diarrhea outbreak in the district, helping in preparation of health education materials and emergency drugs management. Similarly, we supported RMS Dhangadi for transportation of measles vaccine from Dhangadi to Bajhang DHO using emergency drug supply funds, and helped ensure supply of commodities to Kalikot district. This helped ensure successful and timely implementation of measles campaign in Bajhang and minimized the impact of a stock out situation in Kalikot.

1.4.9 Technical Support to LMIS Unit:

NFHP II gave support to ensure timely and accurate submission of reports from the districts, RMS, TWH and Pathlaiya to the central LMIS unit, and helped LMD in providing quarterly feedback on key commodities stock situation at the health facilities to all district public health offices. With technical and financial support from USAID | DELIVER PROJECT /NFHP II, we were able to arrange for power back-up system for the LMIS unit to ensure functioning during times of load shedding. With the power backup system, the LMIS Unit can now process LMIS data without any disruption.

1.4.10 TA to NCASC, LMD and MoHP on HIV/AIDS Logistics:

USAID | DELIVER Project Senior Policy Advisors, Dr. Dragana Veskov and Erika Ronnow conducted an assessment of the HIV/AIDS commodities and Essential Drugs logistics systems. An important objective was to determine where there is scope to effectively integrate HIV/AIDS commodity logistics within the general logistics systems.

TA to NCASCE/ MoHP on HIV/AIDS Logistics:

USAID | DELIVER assisted NCASC in revising HIV/AIDS logistics curriculum to standardize with other logistics training packages of the GoN. After the revision, *Trainers Guide*, *Reference Manual*, and *Participants Hand Book* were developed. A trainer preparation workshop was organized for participants from NCASC, NHTC, LMD, RHTS, NPHL, TUTH, FHI, UNDP, USAID | DELIVER and NFHP II. With this, a pool of manpower has been developed to conduct HIV/AIDS logistics roll-out training in future. We also assisted in conduct of HIV/AIDS logistics management training for 36 ART clinical nurses, PMTCT ward nurses, lab personnel and storekeepers from different ARV sites in April and September and expect this to result in improved reporting and uninterrupted supply of ARV drugs and HIV test kits at the SDPs. We assisted NCASC in conduct of training on the ARV Drug Dispensing Tool in June for personnel of TUTH, TEKU, BPKIHS; this should help dispensers to more systematically track history of drug dispensed on patient profile on an individual basis. The drug handling and dispensing by stores should be improved. We also provided financial and technical support to NCASC for the development of LMIS software for HIV/AIDS commodities at central store with the purpose of strengthening recording & reporting of HIV/AIDS logistics. In this reporting period, 9 joint visits were made with government counterpart to ARV sites.

2.0 SERVICE DELIVERY

2.1 Health Facility Level Service Delivery (PI + RH)

2.1.1 Situation Analysis:

All NFHP II staff were oriented on approach and tools developed for VDC health system profile (VHSP) together with technical support visits. Field based staff in turn oriented district public health office staff in their respective districts. At this point data collection is completed in 56% (640) of VDCs. VHSP data is being entered in field offices in a database system developed using a free software EPI-Info. A model district report has been prepared Kanchanpur and the plan is to initiate use of HSP data by the district.

2.1.4 Standards and Accreditation of Pre-Service Institutions:

NFHP II participated in a strategic discussion meeting held by FHD and WHO, discussing options for ANM/SBA training (both pre-service and in-service).

2.1.6 TA to NHTC for FP/RH and Health Logistics Training:

Training Working Group: NFHP II has been involved in planning discussions with NHTC on the possibility of establishing Training Working Group (TWG) in order to improve planning and coordination of training. NFHP is providing technical support to NHTC to prepare a concept paper (which includes scope of work and members).

Participant Selection: During this reporting period, NFHP II supported NHTC in selection of appropriate participants for FP-RH (60 participants) and Health Logistics (93 participants). We also helped several CPD D(P)HOs to identify training needs and select appropriate participants for IUCD/Norplant training (during VHSP/TSV) viz. Bankutwa PHC, Banke; Tharmare PHC, Salyan; Naumule PHC, Dailekh; Tulsipur PHC, Dang; Batchkot HP, Salyan).

Public Procurement Training Package for District Level Managers: The Public Procurement Act 2063 aims to make the government's expenditure more transparent, competitive, honesty, responsive, reliability, and more useful with equal opportunity in public procurement. In order to ensure effective implementation of the Act, the government also introduced Public Procurement Regulations 2064. NFHP II provided support to NHTC in conducting a 4-day Instructional Design Workshop to revise the Public Procurement Training Package. Participants included a representative of Financial Section of Department of Health Services (MoHP), Public Procurement Monitoring Office under the Office of Prime Minister, District Treasury Controller Office, Office of Auditor General and National center for AIDS and STD Control.

Procurement Guidelines for Central Level Managers (Activity# 1.2.1): NFHP II supported MoHP in organizing a 2-day Instructional Designed Workshop for developing Procurement Guidelines focusing on goods and services as per the newly published Public Procurement Act and Regulation, in coordination with PPMO*, DoHS, NHTC, DTCO†, LMD and FCGN‡. The guidelines will help orient central level policy level personnel such as Centre and division directors on goods and service procurement.

CB-NCP training package: NFHP II provided technical assistance to NHTC in developing training manuals (trainer notebook, participant handbook and reference) for both health facility service providers and community level (FCHVs, MCHWs and VHWs).

2.1.7 Training Management Guidelines Revision:

Training Management Guidelines (TMG, 2004) for FP/PAC were developed by NHTC with NFHP support and found to be useful in managing training effectively. NHTC has agreed to revise it to include management of other training such as Health Logistics, SBA, HFOMC and work is in progress.

2.1.10 Alternative Learning Approaches:

NFHP II has assisted NHTC to design a self-paced learning course on NSV in order to meet high demand without causing unnecessary absenteeism. During this period, 2 doctors (Simara PHC and Gaur Hospital) have been identified and enrolled as participants for the first batch. NFHP II supported development of course outline and guidelines. Under this course the doctors will complete the knowledge component at their own work place and will be brought in for short practicums at the training site and will be certified after they are competent in skills. In addition to reducing absenteeism at work site, it is expected that this will reduce training costs.

2.1.12 Tailored Whole-Site IP Strengthening:

Building on success of on-site coaching for infection prevention (IP), we are further refining and expanding this approach. During this reporting period, we conducted tailored IP strengthening at Haripur PHC (Sep 23, 08) and Lalbandi PHC (Sep 25, 08) of Sarlahi district. During this process, NFHP II introduced IP performance standards and analyzed gaps based on those standards. The major gaps found were unsterilized dressings, deficiencies in waste management and hand-washing practices, and decontamination process not being practiced at both sites. We coached 23 health facility staff (9 Haripur and 14 Lalbandi) as per gaps identified. Additionally, self-assessment of IP practices against standards was initiated in both PHCs and acceptance was good. Quality Improvement (QI) committees were formed in both PHCs; PHC in-charges will monitor progress and NFHP II will provide ongoing follow up.

* Public Procurement Monitoring Office

† District Treasury Controller Office

‡ Financial Comptroller General Office, Nepal

2.1.13 HF TSVs:

Over this period NFHP II provided support to 664 health facilities on FP/MCH through Technical Support Visits (TSVs) using a performance improvement (PI) approach. During these visits action plans have been developed together with service providers. Actions requiring support from district level were discussed during district QAWG meetings and support was provided accordingly (See activity 1.3.7 & 2.1.16).

Example of how TSVs are used: Bankatwa PHC, Banke

IUCD service was being provided in the labour room, which was also not properly set-up and IP practices were poor. During a regular TSV with district public health office Public Health Nurse (PHN) various aspects of service quality were addressed. Based on findings during this visit, NFHP II helped with modifications in the clinic, setting up the labour room and IUCD/Norplant service room separately with essential equipment and education materials. On-site coaching was done, reviewing IP practices. As per the need identified during TSV, NFHP II supported Norplant training for one ANM.

There were similar experiences of on-site coaching with service providers on IP practices during TSV in 7 other service sites viz, Rolpa District Hospital, Salyan District Hospital, Naumule PHC Dailekh, Bhingri PHC Pyuthan, Suija and Lamahi PHC Dang and Jumla District Hospital. Similarly, service providers of Haripur PHC of Sarlahi and FP/MCH clinic of Sindhuli were coached at their sites on IUCD/implant services

Now Bankatwa PHC IP practice (decontamination, sterilization, proper collection and disposing daily waste materials) as well as FP counseling and Norplant services have been improved. ANC and delivery services procedures are now being done as per standards with proper recording and reporting. The Bankatwa experience also illustrates that joint TSVs, together with district public health office staff, can be very effective in bringing positive changes.

2.1.15 Client Exit Interviews:

NFHP use of client exit interview questionnaires was reviewed and revised to better capture quality of the services. Because of our emphasis on VHSP/TSV, limited client exit interviews have been completed during this period. About 80 interviews were conducted and clients responses were considered while developing action plans.

2.1.16 District-Level Quality Funds:

In context of NFHP II having new districts with different geographic conditions, the criteria for budget allocation and QA district fund use were reviewed and revised. Based on this, QA district funds have been allocated to all 20 CPDs considering population, geographical situation and number of health facilities. NFHP II has begun supporting various interventions with district funds as prioritized by QAWG and based on information from technical support visits. So far NRs 50,250 has been used to purchase and provide supplies, equipment and other materials needed to improve quality of services. Examples of materials and support provided through QA funds during this period include: thermometers, water tank and well maintenance, gas cylinders, stove Mackintosh, gloves, plastic apron for ANC/PNC checkup, curtains, toilet repair, benches, stools for clients, chairs, cement ring for waste disposal pit, foot step, ANC examination table, furniture for RH service, and baby wrappers.

2.1.18 National FP Training Centers CFWC, Kathmandu and ICTC, Nepalgunj:

NFHP II is continuing its financial and technical support to FP training sites CFWC and ICTC, Nepalgunj. New Director/Physician trainer was trained on CTS and NSV training. 24 newly trained service providers from 10 service sites including 3 new sites have started providing IUCD services. Similarly 14 service providers, trained in Norplant from 4 service sites including one 1 new site have started Norplant services.

2.1.20 Management Plan for CFWC and ICTC:

NFHP II is continuing discussion with FHD, NHTC and NFCC on best modalities.

2.1.22 TA to National CH, SMNSC, FPSC and Quality Assurance Working Groups:

Quality Assurance Working Group:

MoHP has formulated 'Policy on Quality Health Services-2007' and a 'Quality Assurance Steering Committee' has been formed at MoHP under the Chairpersonship of Chief Specialist (Curative Division, MoHP) and a section for quality assurance has been established in Management Division. It has begun developing a quality monitoring system across the health delivery system in collaboration with program divisions, centers and partner organizations. NFHP II has been providing technical support to Management Division to develop the quality monitoring system and is a member of the Technical Working Group (TWG) formed by Management Division. Since the first stakeholder's meeting in May, NFHP II has been providing inputs to the division on various occasions. Key inputs were finalizing TOR for the TWG; drafting of operational definition of the health facility level of QI system; collection of FP/MNCH standards, norms, protocols, manuals and guidelines; preparing format to collect QA activities and approaches and provided inputs; preparing 6-month work-plan; and organizing Health Quality Management Workshop. (See also activity #1.3.7)

NFHP II has provided technical assistance to FHD in determining specifications for instruments needed for MNH services such as delivery, CS set, PAC set, episiotomy set, delivery bed etc. Similarly NFHP II has supported FHD in developing specifications for FP commodities and equipment.

Family Planning Sub-Committee:

NFHP II has supported FHD to conduct 15th FP Sub-Committee meeting in July. At that meeting, recommendations were presented from the National FP review workshop. The meeting identified stakeholders that would implement these recommendations in their respective districts.

Safe-motherhood and neonatal Sub-committee

(See activity no 2.1.46)

Support to MoHP and UNICEF in Bottleneck Analysis:

Marginal Budgeting for Bottlenecks (MBB) is a tool for performance based programming and budgeting of health system's contribution to MDGs. GoN and UNICEF have been moving forward using the investment case modeling software to determine where the best investment for child health should be for Nepal to achieve MDGs. The NFHP II M&E team provided technical support by reviewing indicators of 12 interventions areas of bottleneck analysis, data collection and validation for each indicator of all bottleneck determinants.

2.1.31 Mobile and Static VSC Services:

NFHP II conducted TSVs to mobile and static VSC service delivery sites in 13 districts to assist D(P)HO to provide quality VSC services.

2.1.34 COFP Counseling Training Curriculum and Package:

Based on recommendations from an assessment of COFP/Counseling (2006) and inputs from other review meetings, during this period NFHP II supported NHTC to organize a workshop to review the COFP/Counseling training package. The duration of package has been reduced to 8(+1) days.

2.1.37 Support to Strength IUCD/implant Services:

During this reporting period, NFHP II provided technical support to 18 long term contractive service (IUCD/Implant) sites (see table # for detail) most of the sites are providing services.

We also assessed 8 potential IUCD/Implant sites (Kapilkot, Sirthauli, Belghari PHCCs in Sindhuli and Acchagadh, Jamunia, Haripur, Barhathwa, Lalbandhi in Sarlahi). Together with health facility staff, we developed strategy for starting IUCD/implant services in these sites. Of the 8 sites, NFHP II has already been successful in starting IUCD/Implant services in 2 (Haripur and Lalbandi PHCCs) and an additional 3 (Kapilakot, Sirthauli and Barhathwa PHCCs) are now ready to start services.

NFHP II provided technical support to strengthen and regularize implant services in Bankatuwa PHC in Banke and Shreepur PHC in Kanchanpur. Similarly, Surkhet Regional Hospital, Khalanga PHC in Pyuthan and Tulsipur PHC in Dang were strengthened for IUCD service.

Table# TSV to IUCD/Implant service sites	
District	Service Sites
Bara	Simara, Nijgadh
Dhanusa	Mahendranagar, Dhanusha Dham, Dhalkebar
Jhapa	Baniyani, Dhulabari, Surunga
Mahottari	Gaushala, Samsi, Pipara HP
Morang	Mangalbare, Jhurkiya, Bahune
Rautahat	Chandranigahpur
Siraha	Mirchaiya
Banke	Bankatuwa
Dang	Tulsipur, Manpur**
Kanchanpur	Shreepur
Pyuthan	Khalanga
Salyan	Tharmare*, Bajkot*
Surkhet	Regional Hospital
*Established IUCD services; **Established implant services	

2.1.45 Further Develop CB-MNC Interventions/ Approaches:

PE/Eclampsia with Calcium:

NFHP II supported FHD to form a Technical Advisory Group (TAG) for prevention of Pre-eclampsia/ Eclampsia consisting of representatives of LMD, NHTC, CHD, NHEICC, NESOG, Maternity Hospital, SSMP, WHO, UNICEF, USAID, NSI, GTZ, SMN and UNFPA.

We supported conduct of the first TAG meeting (3rd June 2008) with international expert (Dr. Harshad Sanghvi, Medical Director, JHPIEGO) presented "Bridging the Gap between knowing the right thing to do and doing it right; Eclampsia" highlighted the important role of calcium in reducing pre-eclampsia / eclapmsia hence maternal and neonatal morbidity and mortality. Members of the TAG endorsed moving forward with calcium intervention but await further evidence on aspirin before taking any decision.

NFHP II has explored different formulations, cost and possibility of manufacturing calcium in Nepal. One of the major constrains is availability of calcium at appropriate cost therefore NFHP II and ACCESS are exploring various options.

Chlorhexidine

NFHP II has been partnering with the NMARC project and PATH. A local pharmaceutical firm, Lomus, using product specifications from PATH, has provided suitable aqueous and lotion formulations. Arrangements are being made with the maternity hospital to conduct an equivalence study. FHD has assigned a focal point person for broader CHX issues and initiated a tippani for formation of a technical advisory group. Once the TAG has been formed and met, the next expected step is submission of a proposal to NHRC for approval for a field based acceptability and ease-of-use study.

2.1.46 Support National Safe-Motherhood/Neonatal Sub-Committee (SMNSC):

NFHP II has continued its support to SMNSC and, over this period, assisted in coordination of 4 meetings (6th April, 27th June, 15th August and 3rd September 2008). Important issues

discussed were: sharing of findings of CBMNC program of Banke and recommendation for formation of new TAG, approval of overall and infrastructure criteria for birthing center, BEOC, CEOC centers and placenta pits and provided technical input to uterine prolapse implementation guidelines. ADRA Nepal also shared its new program for 3 districts namely Rolpa, Salyan and Rukum. NFHP II supported printing and distribution of 11th issue of SM newsletter to all health facilities in 75 districts and all MNH stakeholders.

2.1.47 National SMN Review and Planning Workshop:

NFHP II is to support FHD and SSMP with the National SM Workplan Review and Planning workshop in November together with UNFPA, SAVE/US, ADRA and other SMN stakeholders. NFHP II helped prepare a joint MNH work-plan for FHD.

National Family Planning Review Workshop

NFHP II assisted FHD with the National FP review workshop at the end of June, where all key stakeholders working on family planning participated including NHTC, LMD, NHEICC, CEDPA, UNFPA, UNFPA, ADRA, SSMP, AED/N-MARC, FPAN, PSI. This workshop came up with practical recommendations to strengthen FP services such as:

- Conducting specific activities based on level of CPR-CYP achievement giving emphasis on districts with low CPR (e.g. FP micro-planning)
- Strategies to meet 'unmet need' and strengthen accessibility to long acting methods and initiate post-partum family planning including capacity building of FCHVs

NFHP II has incorporated key recommendations into annual FP work-plan. In addition, NFHP II has integrated family planning activities within its literacy and community and health facility as partners programs in selected districts and areas where these programs are being implemented. (*Note: a separate workshop report has been prepared*).

2.1.48 TA to National BPP Program:

NFHP II helped FHD to revise the Birth Preparedness Package (BPP). In an initial workshop stakeholders concluded that the contents and tools needed to be further simplified. During a second workshop they incorporated suggestions from partners and drafted the revised BPP (which included fliers to replace key chains, a revised version of the BPP flip chart and revised facilitators' guide). The developed draft materials will be shared among a larger group of stakeholders (including FCHVs) for finalization. The materials will be finalized and printed in the next reporting period.

2.1.51 Support for PAC Services:

NFHP II provided technical support to 15 PAC service sites in CPDs. The service sites* are providing regular service and have good linkages with family planning. In these sites, PAC facilities are separate (as per USG population policies) and are meeting the standard for services. US Population Policy and regulations have been shared with PAC providers. Trained service providers are now available in Tharmare PHC Salyan and Naumule PHC Dailekh, so we have provided logistical and other support to start PAC services.

NFHP II supported FHD to conduct PAC orientation at 2 sites viz. Salyan and Jiri District Hospitals for social mobilizers (FCHVs, teachers and representatives of HFOMC, NGOs, and political parties). The participants expressed commitment to creating awareness in their community about the availability of PAC services. The NGOs and the political party members expressed that this was the first time they were involved in health orientation and requested DHO to involve them in the future too.

Repair and Maintenance Services:

* Mirchaiya, Dhulabari PHCC, Surunga PHCC, Chandanigahapur PHCC, Simara PHCC, Mechi Zonal Hospital, Kalaiya District Hospital, Morang Zonal Hospital, Mangalbare PHCC, Parsa sub-regional hospital, Jhuirkiya PHCC and Jumla Hospital and Dailekh Hospital

Based on findings of the TSV, NFHP II field officers identified the need of repair and maintenance of equipment and instrument for continuous improvement of quality service delivery. During this reporting period, NFHP supported repair and maintenance of a variety of instrument and equipments (such as BP instruments, autoclaves, fridges, suction machines and weighing machines) in 32 health facilities from 8 districts.*

2.2 Community Based Service Delivery (CBSD)

Community-Based Integrated Management of Childhood Illness

2.2.1 CHW Review Monitoring Meetings:

CHW review monitoring meetings were carried out in Jumla and Sarlahi. 2389 FCHVs, VHW and MCHWs attended these meetings. Performance of CHWs was reviewed, problems discussed, knowledge and skills re-enforced and logistic supply ensured. Review monitoring meeting, an important component of CB-IMCI maintenance activities, helped

improve quality of CB-IMCI program in the two districts.



Review Monitoring Meeting, Morang

Over this period, in Morang the MINI review monitoring meetings were integrated into the D district public health office regular monitoring review meeting system. This was part of a process of mainstreaming MINI activities in the district and the results were positive. Henceforth all MINI review monitoring meetings will be included in the district public health office regular program review meetings.

2.2.2 Expansion of Community Level CB-IMCI:

As a part of expansion of community level CB-IMCI, HF level program management training was carried out for 111 HF and DHO supervisors in Dailekh. The training was facilitated by SUDIN Nepal and DHO staff members. NFHP central and field team members provided monitoring support. At the end of the training participants were capable of facilitating FCHV level training and implementing the monitoring system for CB-IMCI. A 2-day TOT was then conducted. The trained facilitators with support from SUDIN Nepal facilitated the next level of training for VHW/MCHW in Dailekh. A 7 day training was then conducted for 96 VHW/MCHW and both clinical and program management skills were taught.

Trained DHO & HF facilitators thereafter conducted 5 day training for 801 FCHVs in 5 batches. The training provided FCHVs with clinical skills to identify and manage children with pneumonia. Following the training, 625 influentials such as members of mothers' groups, community members were oriented on CB-IMCI activities and support for FCHVs was garnered. Traditional healers (218) were also oriented on diagnosis and timely referral of sick children.



Phase I Training in Dailekh

NFHP central, field office and district based field officers monitored the training and MASS provided excellent logistic support throughout the process. Since the above activities, nearly 6000 under 5 sick children have been assessed, over 350 of them have been diagnosed and treated with antibiotics for pneumonia and 121 severe cases have been referred.

Following the completion of the first phase of training in Dailekh, the second phase of FCHV training was completed for 55 batches through the support of SUDIN and DHO facilitators.

* Rolpa, Banke, Salyan, Dang, Sindhuli, Bara, Sarlahi and Siraha districts

During this phase of training the contents of the first phase were reviewed, issues discussed and new topics such as essential newborn care, management of diarrhea with ORS and zinc, nutrition and EPI were added. FCHVs were also provided necessary supplies. Performance of CHWs was again assessed and the results have been encouraging. Over 85% of ARI cases were correctly diagnosed and 87% of treated cases received a third day follow up.

CB-IMCI activity was also initiated in Salyan from September 18, 2008 with the district level planning and DDC orientation for community level training and orientation activities. A detailed implementation plan was prepared under the active leadership and participation of DHO, supervisors, NFHP and MASS staff. The first phase CB-IMCI training and orientation activities will be started from November 9, 2008 and the second phase from May 2009.

2.2.3 CB-IMCI Training for Transfer-in and New Staff:

Frequent transfer of CB-IMCI trained health workers within the government health system can have a negative impact on program quality. To support quality CB-IMCI program implementation, NFHP/USAID trained 14 VHW/MCHWs in Parbat district.

2.2.4 CB-IMCI Training for Replacements of Drop-Out FCHVs:

Every year 4-5 % of FCHVs drop out and this again could affect program implementation and quality. A four day CB-IMCI training was hence organized by NFHP / USAID for 91 new FCHVs in 5 districts (Shankhuwasabha, Siraha, Sindhuli, Sarlahi and Surkhet).

2.2.5 Community Based Neonatal Sepsis Management:

This activity is pending approval from Child Health Division. Draft training materials, monitoring forms and formats are all ready and awaiting final approval.

2.2.7 Provide TA support to Maintain CB-IMCI:

Technical and logistic support to strengthen CB-IMCI program is being provided to Sankhuwasabha, Parbat, Syangja, Doti, Dadeldhura and Bajhang. The support includes regular TSV, TA during community and district level review monitoring meetings, coaching at Ilaka level monthly meetings and any other opportunities that come up. For this purpose, consistent with GoN CB IMCI strategic guidelines, NFHP II has deployed one staff in each of these districts. In Sankhusabha where the program has been implemented over 2 years, staff has now been withdrawn.

CB-IMCI in Far-Western

TA support helps re-activate the program. Some HFs and CHWs had not submitted reports over the last 2 years in Doti, Dadeldhura & Bajhang. NFHP field officers coordinated with the DHO to send out circulars to all HFs and CHWs to make the CB IMCI program function better. NFHP field officers conducted TSV and supported case management and reporting. Since then reporting status has improved and the quality of case management by HF and CHWs is improving.

Community-Based Maternal Neonatal Care:

In NHFP II, we are now referring to what we previously called 'Community Based Maternal and Neonatal Care' *community-level maternal neonatal health activities*. The new nomenclature was required to address the various new elements that are now being included under the previous program and to enable the program to loosely fit under the various divisions within the Department of Health Services. This change in terminology is also reflected in Safe Motherhood Neonatal Supplemental Sork plan for 2065/66 (2008/09).

2.2.9 New Districts for Community Level MNH Activities:

Sindhuli has been agreed upon as a new district to implement both tested (BPP/PNC home visits, distribution of misoprostol for PPH prevention, management of low birth weight, hypothermia and possible severe bacterial infection) and new MNH program elements (e.g. neonatal vitamin A).

2.2.10 Refine CB-MNH Package and Revise Training Curriculum/ Approach:

Draft IEC/BCC materials have been prepared and are in process of FHD approval. The materials will be finalized and printed by next reporting period. IEC/BCC materials for prevention of PSBI will be uniform and in line with CB-NCP.

Learning from the implementation of community based maternal and neonatal care elements in 4 districts (Jhapa, Morang, Banke and Kanchanpur) have been reviewed to design a more integrated set of interventions ready for scale. Training and M&E materials are in the process of being finalized and will thereafter be approved through a meeting of a larger group of stakeholders.

The Misoprostol Technical Working Group (TWG) formed under the chairmanship of DG at DoHS approved the continuation of the FCHV dispensing model in Banke and the testing of health worker ANC dispensing model in another district. Comparison between the 2 models would thereafter determine the design of the national scale up program for postpartum hemorrhage prevention. We will continue in discussion with DoHS counterparts to explore the possibility of limited expansion of the Banke approach.

2.2.11 Pilot New Community-Level MNH Activities::

Newborn Vitamin A Dosing:

Four districts have been identified for piloting - Banke, Sindhuli, Nawalparasi and Udayapur. Every possible dispensing mechanism will be used to maximize early post natal coverage of neonatal vitamin A dosing. Data will be analyzed to interpret results for the various channels of dosing. A joint work plan is being developed for Child Health Division to implement this pilot program in which UNICEF, USAID and Micronutrient Initiative will jointly contribute to implement the program. The training materials and monitoring tools are being developed with a plan to begin program implementation by mid December 2008. Once pilot tested, the results will be taken to scale rapidly.

Gentamicin in Uniject Design Stage Trial:

This small-scale feasibility study has been approved by Ministry of Health and Population through the secretary level decision on 15th July 2008. The study has already been approved by Nepal Health Research Council on 24th June 2008. This design stage trial will be implemented in five village development committees for a period of 5 months in Morang district where MINI is already in place. In the uniject study, FCHVs along with other community health workers will treat neonatal sepsis cases at the community level with a combination of oral cotrimoxazole and gentamicin in a uniject device. The VDCs selected for this purpose are Dianiya, Sorabhag, Hatimuda, Govindapur and Madhumalla. The work plan and draft training materials have been developed. The uniject devices with drug were produced in Argentina during this reporting period. The devices are expected to reach Nepal by the end of November with field implementation expected to begin in January 2009.

2.2.12 Revise Counseling/ Health Education Materials:

All IEC/BCC and training materials for MNH activities at community level are under review. The materials will be finalized during the BPP workshop to be held in December 2008.

2.2.13 Community-Level MNH Policy, Standards and Guidelines:

No significant activities carried out during reporting period.

2.2.14 Dissemination of CB-MNH Lessons Learned:

During this reporting period CBMNH and MINI activities have been presented in different forums and abstracts have been submitted for future presentations.

MIRA / ESD Project: Regional Workshop on "Facilitating Synergies to Scale-up Maternal and Newborn Care Best Practices in Nepal."

This workshop was organized by Mother and Infant Research Activities (MIRA) in 5 different developmental regions to disseminate the best practices in maternal and newborn health. This was organized in Hetauda, Pokhara, Biratnagar, and Nepalgunj (and in Kanchanpur after the end of this reporting period). In each region, both CBMNH interventions specifically “Use of Misoprostol for prevention of postpartum hemorrhage in Banke” and “Newborn sepsis management at community level by FCHVs and community health workers” have been presented.

Abstract Submission:

Two abstracts were submitted for presentation in international forums during this reporting period. The first abstract was “Community-based prevention of post-partum haemorrhage with Misoprostol in the absence of skilled care providers”. This abstract was submitted for presentation in ANHE, Bangladesh under the leadership of Family Health Division. A second abstract “Lessons learned from early implementation of neonatal vitamin A dosing in Nepal” was submitted to the Micronutrient Forum to be presented on 12-15 May 2009 in Beijing, China.

Publication in peer reviewed journal:

During this reporting period a manuscript on the study of “Use of misoprostol for prevention of postpartum haemorrhage in Banke” is being developed. This manuscript is now in an advanced stage and it is intended that it be submitted to the Lancet in the next reporting period. A manuscript on MINI is also in an advanced stage of development and should also be submitted during the upcoming reporting period. Other manuscripts are under development including a general paper on CB-MNC, another on the CB-MNC process evaluation and 2 more on the FCHV program. One or more of these is also likely to be ready for submission over the upcoming reporting period.

Presentation in International forum:

“Lessons learned from Morang Innovative neonatal intervention (MINI) program” was presented as a panel discussion at the Global Health Council Conference in Washington DC from May 27 to 31st 2008.

Presentation in National forum:

“Lessons learned from Morang Innovative Neonatal Intervention (MINI) program” was presented in the Eastern Regional Annual Review meeting held at Biratnagar from 3rd Sept 2008 to 6th Sept 2008. The participants for this meeting were district managers of Eastern Developmental Region, Eastern Regional Health Directorate, FHD, CHD, LMD, NHTC, NHEICC and other stake holders.

Observation and supervision visit:

A team from Pakistan comprising government officials and PRIDE project members visited Banke district to observe CB-MNH interventions carried out through NFHP. This observation visit was conducted from 25 to 29 August 2008.

The MINI project was visited by Family Health Division team under the leadership of the Director of Family Health Division on 4th September 2008.

The Technical Advisory Group for the misoprostol intervention visited Banke district for the evaluation of the project from 6th September to 7th September 2008.

2.2.15 Technical assistance on Community-Level MNH activities:

Technical support was provided to ACCESS project for the district-wide expansion of its low birth weight intervention in Kanchanpur district. TA was provided for the following activities: revision of intervention forms and formats; integration of the monitoring forms with CBMNC forms; and district planning of the program implementation. The ACCESS funded LBW program is now completely integrated into the NFHP CB-MNH activities.

Technical support was provided to MINI project during the project evaluation by Social Welfare Council. The project evaluation was performed under the leadership of Social Welfare Council from 9 to 12 August 2008. The purpose of this evaluation was the renewal of project agreement and general agreement with SWC.

2.2.16 Maternal Deaths-Verbal Autopsy

Maternal deaths are continually monitored in Banke. A maternal death reporting system has been established linking the community to district health office: the FCHV reports the death to the health facility; the HF, in turn, reports the death to the district health office. For any reported deaths, a verbal autopsy is administered with the family or key informants of the deceased person by a trained staff using a verbal autopsy interview guide/ instrument. Results are reviewed to determine the cause of maternal deaths. In total, 49 maternal deaths have been reported over 33 months. In addition to the verbal autopsy, a motherhood process method was also applied in order to verify the maternal deaths and compare the mortality impact with the pre-intervention period. The motherhood process method was performed in each ward of 13 low performing VDCs over this reporting period. Through this process, two additional maternal deaths were identified. NFHP II has also provided assistance to the DfID/ USAID-funded maternal mortality study, focusing on quality of the verbal autopsy. NFHP II is in preparatory phase for expanding maternal death surveillance in Sindhuli, over the upcoming reporting period.

2.2.17 Expansion of Established Community-Level MNH Activities:

In Banke, BPP, early post-natal home visit and misoprostol distribution activities have already been implemented; LBW management will be added in this year. In Banke and Kanchanpur – subject to CHD clarification – PSBI activities may also be expanded.

2.2.18 Maintenance Support for Community-Level MNH Activities:

TSVs continue to be an important tool for strengthening MNH activities in CBMNC districts*, ensuring availability of key commodities, assessment and strengthening of FCHV knowledge and skills for supporting women during pregnancy, delivery and postpartum period. Findings of TSVs have been shared with district public health offices. Issues identified through TSVs include need for joint visits with district public health office, proper maintenance of registers, and provision of quality services from health facilities. Various forums have been used for sharing TSV achievements, lesson learned and constraints, and advocacy for the program including RHCC, QoCMC, HFOMC, annual district performance review meeting and district monthly meetings.

Based on TSVs with pregnant women in **Jhapa**, more than 76% (121 of 159) made at least three birth preparations (money, transport and SBA) as recommended by the intervention. Of the 68 recently delivered women who received a TSV, 79% reported having delayed newborn bathing (53 of 68) and 65% (44 of 68) received a post-natal home visit from an FCHV and 49% were counseled on FP.

Technical assistance was provided to regularize FCHV and Ilaka level monthly meetings. During this reporting period, staff monitored 36 FCHV monthly meetings and 12 Ilaka level meetings in Banke and 20 FCHV monthly meetings and 11 mothers' group meeting in Kanchanpur.

FCHVs register pregnant women and record major outcomes. Monitoring data as shown in the table below indicates that coverage and outcomes have been well maintained in all three districts. The data demonstrates the effective mobilization of community resources to increase MNH indicators.

* during this period the number of MNH-related in TSVs in CBMNC districts were 609 in Jhapa, 486 in Banke and 306 in Kanchanpur

Table 6: Monitoring data of CB-MNC interventions by districts (April – September 2008)

Indicators	Jhapa		Banke		Kanchanpur	
	N	%	N	%	N	%
PW register in CB-MNC register (as % of expected pregnancy)	4041	40	3965	65	2038	44
PW register in MSC register as % of expected pregnancy	-	-	3825	63	-	-
PW received 225 iron-folic during pregnancy and postpartum as % of registered pregnancy	3814	94	3700	93	-	-
PW received anti-helminthes as % of registered PW	3978	98	3732	94	1785	88
Birth attended by health workers as % of registered PW	3008	74	1422	36	605	30
Full course MSC taken as % of RDW who received MSC			2741	72		
MSC taken before baby born (as % of RDW taking complete course)			0	0	-	-
Newborn bathing delayed at least for 24 hours after birth (as % of registered women)	3849	95	3483	88	-	-
FCHV performed home visits within 3 days of delivery (as % of registered women)	3971	98	3725	94	1840	90
RDW received postnatal vitamin A as % of registered women	3947	98	3700	93	2002	98
NN visited by FCHV within 3 days, found to have extremely low weight and referred to HFs (as % of extremely low weight identified NN)					34	59

Source: CB-MNC monitoring data

2.2.19 Revision to CB-MNH Indicators & M&E Tools:

Indicators for MNH activities at community level were revised and shared with FHD officials and presented for final approval. Two of USAID OP indicators are now included in this list.

2.2.20 CBMNC Summative Report and Six-Survey Reports:

Over this period, hard copy and e-copy of CB-MNC summative report and baseline/follow-on survey report of Jhapa, Banke and Kanchanpur were printed and distributed to SMN stakeholders e.g. FHD, DPHOs, SSMP, UNICEF, NFCC, PSI, NHRC, DDA, etc.

Internships

NFHP is keen on building capacity of young interested public health professionals and one way to do so is to offer interested candidates an opportunity to work and learn with our highly competent technical team. In this regard, we are supporting 2 interns for skills in community based service delivery. *Dr Gurpreet Kaur* started her internship with community-based service delivery team at the end of July. She observed the MNH activities in Banke and Kanchanpur, collected case studies, which will be finalized over her tenure. Her scope of work includes:

- 1 Develop an outline of reporting document for the CBMNC program,
- 2 Including dummy tables and some preliminary write-ups
- 3 Develop a computer based program for regular entry of CBMNC data in line with the dummy tables and ready for easy analysis
- 4 Perform case study in Banke
- 5 Perform interview/focus group discussion about the program and health issues/behavior change of the community with FCHVs, mothers and health workers.
- 6 Need assessment of the program in urban slum

Dr. Agya Mahat has also been working with the community-based service delivery team and started her internship in September. She visited Salyan and Banke to learn about CB-IMCI and CB-MNC activities including health system at district and below level. *Dr. Mahat's* Scope of Work includes:

- 1 Assisting in development of MNH training materials, monitoring and evaluation tools and job aids.
- 2 Support for MNH training activities
- 3 Field visits to Banke, Kanchanpur and Morang to learn about Technical Support Visits with NFHP and MINI field teams.
- 4 Support to Gurpreet Kaur to develop case studies
- 5 Become oriented on CBIMCI implementation through interactive CD
- 6 Support district level planning and some community level review monitoring meetings
- 7 Support child health team in community level CBIMCI training
- 8 Observe National Vitamin A day, Measles Campaign with Child Health team.
- 9 Collect success stories from FCHVs, Health workers & program beneficiaries
- 10 Take "action oriented program photos"

2.2.22 Supply of Vitamin A IEC/Program Materials:

Pocket calendars for Nepali year 2065 containing information on vit A distribution dates and case treatment protocols were printed this year with financial support from AuSAID. They were widely distributed to FCHVs, health facility staffs, I/NGO personnel, donors and other stakeholders. The calendar helps promote NVAP, informing people about vitamin supplementation events and helps to update Health Facility Staff on case treatment.

Program materials are instrumental for the promotion of NVAP. As indicated in the table; FCHV registers, scissors, stickers, t-shirts and tika were produced and distributed for the April 2008 round of capsule supplementation. These materials aided FCHVs in carrying out supplementing activities smoothly and keeping records of dosed children.

Vitamin A Program Materials Produced over this Period for FCHVs

MATERIAL	QUANTITY
FCHV register	10,000
Scissors	12,000
Sticker	10,000
T-shirt	140
Tika	10,000

2.2.23 Program Promotion Prior to Vitamin A Distribution::

As a part of promotion for the April round of Vitamin A Capsule distribution leaflets, pamphlets, and posters were distributed at community level in various districts. These materials informed community members about the date of distribution and encouraged them to use vitamin A rich foods. Radio/TV spots and audio cassettes were developed and aired from various media channels in different languages. The radio spots were developed in Nepali, Bhojpuri, Maithali and Abadhi and broadcasted 487 times from different radio outlets (National, Regional and local FMs). Two TV spots were broadcast 101 times over four different television channels. Audio cassettes were used during miking prior to capsule distribution. The airing of messages was useful in reminding community people to take their children for the supplementation and maintaining high capsule coverage as indicated by the reports of districts. As a part of promotion, a 2-day vitamin A re-orientation program was conducted in Bardiya and Arghakhanchi with funding from AusAID. The re-orientation program refreshed old FCHVs and oriented new FCHVs on the National Vitamin A Program. A total number of 1,996 participants were oriented in the two districts.

2.2.24 Supervision of Capsule Supplementation:

Staff from the Logistic Management Division supervised vitamin A logistics at the Regional Medical Stores (RMS) and different districts and RMS supervised at district public health office, HF store to ensure proper quantities (as per the plan) prepositioned on a timely basis at health facility and FCHV levels. Personnel from eleven I/NGOs supervised the April vitamin A distribution. 774 sites were visited in 46 districts. The supervision team checked

whether the FCHVs dosed correctly and recorded the names of dosed children. FCHVs consistently provided feedback that the presence and support from supervisors was encouraging to them.

2.2.26 Logistical Support for Vitamin A capsules & De-Worming Tablets:

NFHP/ NTAG provided support in supply and re-packaging of vitamin A capsules required for the April 2008 round working with Logistic Management Division, district public health offices, Regional Medical Stores, health posts and sub-health posts, ensuring that FCHVs receive their materials at least two weeks prior to the event. To minimize wastage NTAG assisted the Logistic Management Division to repackage the capsules into smaller containers (200 per bottle) prior to dispatch to the regional stores for the April and October rounds. In order to provide de-worming tablets, NTAG assisted Logistic Management Division in procuring tablets for 3.1 million children aged 1 to 5 years, and subsequent dispatch to the D/PHOs through Regional Medical Store along with vitamin A capsules.

2.2.27 Emergency Logistics Support:

Vitamin A capsules and de-worming tablets were supplied on an emergency basis in 25 districts. In these districts the Regional Medical Stores were not able to ensure timely deliver the capsules/tablets for the April round of supplementation. Supplies were sent by plane in several districts* and by vehicle in several others.† Additional capsules were sent on emergency basis to Rautahat, Udyapur and Sindhuli. Similar emergency transport was required for the October round which occurred after the end of this reporting period.‡

2.2.28 Multi-Sectoral Mobilization:

To increase coverage in Kathmandu Municipality, a one-day coordination meeting was held to explore ideas on reaching the unreached, particularly children in slum areas. Participants included District Public Health Director, Department Chief, ANMs from Kathmandu Municipality Clinic and NTAG staffs. The Public Health Department of Kathmandu Municipality selected 51 new community volunteers from slum areas and NTAG trained them to distribute vitamin A capsules/de-worming tablets to targeted groups, educating mothers about vitamin A rich foods. Letters were sent to Nepal Red Cross Society, Family Planning Association, embassies, and I/NGOs requesting their support for the April round.

2.2.29 Coordination with GoN and I/NGOs:

We coordinated with MOLD, MOES, Women Development Department, and other I/NGOs to mobilizing their staff and line-agencies to support FCHVs during the April round. Promotion was also done through FCHV review meetings in selected districts where NTAG was involved in other program activities.

FCHVs

2.2.31 FCHV Trimesterly Review Meetings:

FCHV review meeting are held approximately every four months at health facility level. NFHP II field officers help facilitate and coordinate this activity to ensure the effectiveness of the meetings with regard data review, contents review and logistic supply.

Kalikot: During review meetings, FCHVs and HFOMCs were encouraged to seek support from VDCs and other local organizations. Accordingly, in Manama VDC, on request from FCHVs, the VDC provided dresses to all FCHVs. In other VDCs FCHVs have been making

* Solukhumbu, Khotang, Bhojpur, Okhaldhunga, Morang, Makwanpur, Kaski, Kailali and Nepalgunj

† Jhapa, Terahthum, Syangja, Tanahun, Doti, Dadeldhura, Baitadi, Parbat, Baglung, Myagdi, Lamjung, Bajhang and Gorkha

‡ by air to Solukhumbu, Okhaldhunga, Khotang and Sankhuwasabha districts and by vehicle to Udaypur, Siraha, Rasuwa, Dolakha, Sindhupalchowk and Kavre

similar requests. Most VDC have responded favorably, recognizing FCHVs and their contribution.

Jumla, FCHV meeting: FCHV monthly meetings were generally not being held. NFHP II staff coordinated through district to local level to revitalize FCHV monthly meetings. FCHV program guidelines were shared at all levels, with focus on coaching at local level. Thereafter FCHV funds were established in each VDC and health facilities started to regularize FCHV monthly meetings. Reports are now being collected on time and commodities are being resupplied regularly.

FCHV Program Advocacy meeting:

Due to delay in endorsement of the FCHV fund guidelines, this meeting could not be conducted as planned. The FCHV program advocacy meeting was planned to orient DDC, district supervisors and NGOs on FCHV funds.

2.2.33 Revision of FCHV Strategy:

MEH Consultant was tasked by FHD/NFHP and MASS to support the review of the Female Community Health Volunteers strategy. A number of meetings have been held and a literature review completed; an interim report has been drafted covering strengths, gaps and opportunities. FHD organized a preliminary workshop attended by FCHV representatives, focal persons from Kathmandu, Lalitpur and Bhaktapur, concerned officials from various divisions and centers, ministries (MOHP/DoHS, MOLD & MOES) and EDPs. Finalization of the strategy is expected over the next quarter.

2.2.34 FCHV Database:

FCHV data from all 75 districts have been entered, however some errors (for e.g. date of birth and ethnicity etc) were observed in raw data thus FHD has notified the districts, requesting that they update and correct the data as per the format provided. NFHP II district based staff are supporting their districts to update the database during HSP and TSV.

2.2.35 FCHV Fund Guidelines:

FCHV fund guidelines has been developed and endorsed by MoHP. 5000 copies have been printed and sent to NFHP II field offices. District based staff have assisted the districts in distribution to VDCs and have encouraged opening of bank accounts as per the guidelines. The guidelines have been shared with partners during various district level meetings. The guidelines have been translated into English and 200 English copies have been printed.

2.3 Strategic Information/ M & E

2.3.1 Draft M&E Plan:

NFHP II submitted final M&E plan which was approved by USAID CTO on July 16, 2008. The M&E plan includes 8 impact level indicators, 14 OP indicators and 12 program monitoring indicators, and expected values for each year. We also prepared and submitted performance indicator reference sheets (PIRS) for all of the above indicators using USAID format.

The first year (2007/08) expected and actual values for OP indicators were submitted to USAID. We have met expected results of 11/14 OP indicators. The achievement in CYP at national level was 81% of expected and in CPDs it was 77%, although the final figures have yet to come from HMIS section.

2.3.2 & 2.3.3 TSV Monitoring Checklists and Guidelines:

This reporting period, NFHP finalized general NFHP II TSV tools for health facility level and community level along with tools guidelines, and program specific monitoring tools such as

for CHFP and literacy/life skills, based on the NFHP II M&E plan. This was followed by orientation on tools after which implementation began. To manage general TSV data, we have developed integrated menu driven databases using MS Access 2007 with in-built controls to minimize errors in data entry.

2.3.4 Routine Monitoring Data Gathering and Processing:

District based staff gather data using routine TSV tools, VDC HSP tools and direct observation based on which monthly summary sheets and a field trip reports are prepared and forwarded to NFHP II field offices and district public health offices. In field offices, data from summary sheets are entered into the computer, data and field trip reports are reviewed and then program specific feedback reports prepared. So far, TSVs have been conducted in 62% (711) of all CPD health facilities, and – over this period – have included 993 CHWs, and 76 ilaka level meetings.

2.3.5 HMIS Capacity Building:

NFHP II has been supporting a staff person in the HMIS section, DoHS, to supervise data entry, data verification, and to support installation of computerized database and WAN system. During this reporting period a WAN system has been installed and orientation has been given to district public health office staff in 9 districts,^{*} computerized database installed and oriented in 4 districts,[†] and ilaka level data verification conducted in Dhankuta. In addition, we supported HMIS data dissemination to MoHP and program divisions, software development for revised HMIS data processing, HMIS data presentations, and analysis and dissemination of free health service data (by age, poor, destitute etc). After installation of WAN system, districts have been continuously accessing raw and analyzed data for their use.

2.3.6 Further Analysis of 2006 DHS Data as Baseline for NFHP-II:

During this reporting period we analyzed 2006 DHS data to establish NFHP II benchmark measures, compared 20 CPDs with data from non-CPDs. In order to make the comparison more meaningful, we have initiated a quasi experimental design where 20 CPDs will be compared with other selected districts, matching to the extent possible by geographical location, HDI, SES, caste/ethnicity, education. This should allow us to better interpret changes in both groups both for a midline household survey (planned for 2009) and once 2011 DHS data are available. This task, with technical support from us, is being carried out by one of our former M&E staff who is currently doing higher study in abroad.

2.3.8 Technical Support for FCHV Survey:

NFHP II provided technical support in reviewing and finalizing the data tables of 2008 FCHV survey.

3.0 COMMUNITY

3.1. Community Participation in Governance of Local Health Services

Based on lesson learned from NFHP I, the Community and Health Facility as Partner (CHFP) program has been revised and implemented in four districts; Banke, Dang, Kanchanpur and Surkhet. The main focus has been given to improve the capacity of HFOMC members to plan, implement and monitor basic health services within their community. During this period, CHFP focused more on the redesign of concept and refinement of training manuals, guidelines and M&E manuals. NFHP II provided technical assistance to International Rescue Committee to implement the CHFP in Surkhet. Similarly,

^{*} Jhapa, Morang, Sunsari, Dhankuta, Saptari, Sarlahi, Bara, Parsa and Rautahat

[†] Jhapa, Morang, Sunsari and Dhankuta

support has been given to UNFPA in its program districts. The details of these activities and achievements are given below:

3.1.2 Orientation to D/PHOs and DDCs about CHFP:

We conducted 1-day orientation meetings on CHFP approach in Banke, Dang and Kanchanpur with key staff of stakeholders, notably district public health offices and DDCs. During these sessions we focused on vision, strategies, approaches and activities of CHFP to be implemented in the districts. After this orientation, DDC and district public health offices selected focal persons and incorporated CHFP into their regular workplans. Roles of stakeholders were also determined. Participants decided to continue to hold meetings at DDC and VDC secretary's offices to review progress and challenges. DDC Banke decided to devolve responsibility for 10 health facilities to local bodies. Participants found the orientation helpful to improve coordination and linkages among different stakeholders working in health sector decentralization at district level.

3.1.4 3-Day Interaction Meetings:

3-day interaction meetings were conducted for member of 41 HOMCs across the 4 districts (Banke=8, Kanchanpur=15, Surkhet=13 and Dang=5). Altogether 377 HOMC members* participated. District public health office and DDC focal persons also participated in some meetings. As a result of these meetings HOMC members reported having a clearer sense of their roles and responsibilities in managing health facilities and were better informed about types of health services available from different levels of health facility. As one participant said, *"Before this training we mainly concentrated on curative health services but after this training we realized our roles to manage other preventive and promotive health services"*

3.1.7 TSVs with HFOMCs:

Altogether 107 technical support visits were conducted in 86 HFs in Banke, Kanchanpur, Surkhet and Dang districts. Of them, 48 were conducted in the 30 VDCs currently supported for CHFP. 20 out of the 30 were conducting meetings every month. The regularity and quality of meetings had improved markedly. HFOMC members included dalit and women who have started to attend regularly and bring issues to the meeting from their respective community. The committees are conducting community mobilization activities, writing their decisions on action plan format, mobilizing local resources etc.

Binauna SHP is located in a remote area in Banke district; it was selected for CHFP due to low service coverage and a high proportion of the population belonging to underprivileged groups. A three-day interaction meeting was held, during which HFOMC members developed an action plan to construct a training hall, toilet and separate room for MCH services inside the health facility. Similarly they planned activities to increase service utilization particularly by the marginalized. In their regular meeting, they began to plan for mobilization of local resources to help implement their action plan. They made requests to RRN (a national NGO), the Community Forest User's Group and other organizations for support. Within a few months, they were able to collect Rs 250,000 from RRN and furniture worth Rs. 56,000 from the Community Forest User's Group. Now, the training hall and two toilets are almost finished. They have also set up a separate examination room in the health facility to maintain privacy. HFOMC members have started to make visits in their community to inquire into public health problems/issues to be addressed by the committee. Similarly they have started to share decisions made in the meeting with other community members. They are now seeing an increase in utilization of services at the health facility by marginalized groups.

3.1.12 TA for Scale Up:

NFHP intention is to address scale-up of CHFP through leverage and diffusion. During the first year, our focus has been to develop, implement and refine the approach so that it could be scaled-up smoothly. Building networks, working, sharing and learning together with different stakeholders involved in capacity building are also important preparatory steps for scaling up.

* Male 212, Female 129 and Dalit 36

3.2 Community Efficacy-Literacy and Life Skills

3.2.1 & 3.2.40 Planning Meetings with District Stakeholders:

NFHP II staff have met with district stakeholders (DEO, LDO and Womens Development Officers) during district planning meeting visits and have discussed HEAL/LC and GATE activities. These stakeholders have recommended implementing activities primarily in communities with a high concentration of underprivileged, Dalit, Janjati and un-reached people. Planning meetings have contributed to ensuring coordination and avoiding duplication with the work of other organizations.

3.2.2, 3.2.23 & 3.2.44 Grants to Local NGOs:

GATE/HEAL/LC activities are designed to be implemented through local NGOs in selected districts. NFHP staff have met with senior staff of possible NGOs/CBO partners to explore their performance and interest. Subsequently, NGOs have been selected based on their legal status, experience in non-formal education and health, working in remote areas and with marginalized group, and track records coordinating with GoN line agencies.

HEAL/GATE Implementing NGOs

District	NGO
Banke	Mahila Upkar Munch
Dang	Samaj Kalyan Samittee
Surkhet	Women Association For Marginalized Women (WAM)
Rolpa	Development Concern Society
Sarlahi	Bagmati Sewa Samaj
Mahottari	Local Development Training Center (LDTC)

NGOs developed their proposal with information collected from the village orientation program and submitted it to World Education which, in turn – based on recommendations from concerned program officers and program specialist – approved the proposals and signed agreement with presidents of each NGO. NFHP II also oriented NGOs committee members and staff on the US Government Population Polices.

3.2.22 & 3.2.42 Village Orientation Program (HEAL/LC):

NGOs conducted Village Orientation Programs (VOP) in all recommended sites, in coordination with NFHP II. The purpose of VOP is to share program objectives and implementation strategies with the community members so that they could see the usefulness of the program and can speak about the program with other community members. Altogether 394 VOPs were conducted by local NGOs in program districts.* VOPs helped to identify participants, facilitators, local supervisors and to form the Class Management Committees.

Activities by District

Districts	HEAL	LC	GATE
Banke	10	48	-
Dang	10	53	-
Surkhet	10	48	-
Rolpa	10	45	11
Mahottari	10	54	10
Sarlahi	10	55	10
Total	60	303	31

* Banke, Dang, Surkhet, Rolpa, Mahottari and Sarlahi

3.2.5 HEAL/GATE Basic Class:

Altogether, over this period 40 HEAL classes started in 4 western districts (Banke, Dang, Surkhet and Rolpa) from 2nd week of August and 20 HEAL classes started in 2 central terai districts (Mahottari and Sarlahi) from the last week of August. 1431 women, aged 15-45 (including 205 from Dalit and 828 Janjati) are participating in this course. Nine GATE classes started from the last week of August in Rolpa, and 20 classes started in Mahottari and Sarlahi from the 3rd week of July. 679 adolescent girls aged 10-14 (including 158 Dalit and 251 Janjati) are participating in this course. Tr both HEAL and GATE classes run 9 months. After the HEAL class, participants should generally be able to read and write and will have been exposed to clear messages on healthy behaviors. It is also expect that they will share knowledge with their peers. GATE graduates should be able to read and write and will be referred into vocational activities aiming to improve economic status.

3.2.24 Master Trainers/ Facilitators and Local Supervisors:

One local supervisor is supposed to supervise a maximum of 10 HEAL or 10 GATE classes per month. The NGO focal person is responsible for monitoring and supervision of Learning Circles. A two day supervisors' training was organized at each NGO office for HEAL and GATE supervisors. For the western cluster the training was conducted in Nepalganj July 1 and for the central cluster the training was conducted in Hetauda in August. Through the training, the supervisors acquired knowledge and skills to do effective supervision.

3.2.45 Training of Trainers for LC:

Two TOTs for learning circles were conducted in Dang and Sarlahi. During TOT, participants were trained on facilitation, listening and questioning skills. After the TOT, participants were able to conduct the facilitator's training in their respective communities.

Training of Facilitators

NFHP II staff conducted HEAL Facilitator's training (9 days) in Dang and Banke districts in local languages. In Dang, we used the Dangel Tharu language curriculum "Soshan Se Sikshya Or" (from exploitation to education). Similarly, in Banke we used the "Muhtalihai" (beginning) curriculum. In other districts, GON's standard curriculum "Naya Goreto" was used. Similarly NFHP staff conducted training for 29 GATE facilitators and 3 local supervisors in two districts, Rolpa and Mahottari. After this training, facilitators are now able to conduct GATE and HEAL classes in their respective communities.

Learning Circle Facilitators' Training (LC/FT)

A three day LC/FT training was conducted in Rolpa, Dang, Surkhet Banke, Mahottari and Sarlahi districts. All the Learning Circle facilitators were Female Community Health Volunteers. A training package was developed enabling both literate and illiterate FCHVs to facilitate learning circles. The LC/FT training emphasized teaching/ learning skills (learning environment building, introducing new topics, practicing in small groups, games, discussions in a big group and summarizing the main theme) so that they will be more confident in facilitating the session.



GATE facilitators



Group work during GATE training

3.2.43 Explore Opportunities for Collaboration:

LLS program officers organized meetings with various local bodies including HP/SHP, VDC, community, NFE participants, and Class management committees (CMC) to find potential areas for collaboration. LLS program staff also initiated meetings with Winrok (EIGCM). A good relationship was established with the stakeholders after these meetings.

Other Activities

a) NGO Orientation

A 3-day NGO orientation program was organized in Nepalgunj for NGO chairpersons, program coordinators and accountants. The main objective was to inform participants about LLS implementation strategy and orient them on financial norms to be followed per World Education policy. Four NGOs (Dang, Banke, Surkhet & Rolpa) were provided computer workstations to maintain data and reporting. NGOs are now regularly submitting electronic reports.

3.3 Behavior

3.3.1 Work with Other FP/MNCH Partners:

A technical advisory group comprising members from FHD, NHEICC, NHTC, UNFPA and NFHP was formed to update family planning content. A workshop was conducted in April to finalize content on all modern contraceptive methods attended by FP/RH subcommittee members*. It was agreed to develop five areas of high priority message content in consultation with local service providers, considering the social, cultural and linguistic context.

3.3.2 MNH Behavior Change Plan:

NFHP II provided technical support to NHEICC to develop a CB-NCP communication strategy. This strategy clarifies content and approach for raising awareness and improving health seeking behavior to improve the health status of neonates in selected NFHP II CPDs and other districts. In addition, NFHP II supported NHEICC to conduct review meetings, and designing IEC BCC materials.

3.3.3 Review/ Revise/ Produce BCC Materials:

BCC materials (FP leaflets, posters) developed during NFHP I were reviewed and revised. These revised BCC materials have been distributed in all the NFHP II districts in sufficient quantity. Similarly, informed choice posters and safe motherhood related materials were also sent to districts where needed.

Audio copies of “Gyan Nai Sakti Ho” radio program II and III, (altogether 104 episodes) which was produced and aired during NFHP I, were handed over to T4Global (an INGO which is working in Nepal through their local partner “True Neighbor Nepal”). True Neighbor Nepal is working in 22 districts including NFHP II CPDs; namely Salyan, Surkhet, Dailekh, Kalikot, and Jumla. The radio programs have been loaded in 12,000 digital players which are distributed to local groups and aiming to reach 1.2 million people. It is estimated that at least 400,000 people in 5 NFHP II districts will be exposed to the radio programs through this partnership.

FP messages on IUD, Norplant, birth spacing and a well planned family were aired from 42 local FM radio stations. These radio spots were inserted in conjunction with national news in

* including staff from FHD, NHEICC, NFHP, FPAN, NFCC, UNFPA, MSI, CRS, PSI, CEDPA, ADRA, CFWC, MoHP, IOM, Kathmandu district public health office

the morning and evening prime time. This contributes to increased knowledge about the FP MNCH among the target audience.

Street Theater on FP focusing on IUD/Norplant was organized in 5 NFHP districts.* In each district, 25 shows were performed at main junctions, ordinary bazaar and haat bazaar. After each show, interviews were carried out with audience members to evaluate retention of message, audience perception and intentions. Audience members expressed willingness to share the message with friends and neighbors.

The "Hamro Kura" FCHV magazine was produced and distributed to all FCHVs, nationally, through district public health offices.

3.3.7 Interpersonal Communication::

On request from Kanti Children Hospital, Maharajgunj, NFHP II supported training on IPC for hospital staff. The objective was to help improve the quality of relations between service providers and parents of sick children. There were altogether 52 participants including senior and junior doctors working in the hospital.

4.0 CROSS CUTTING

4.1 Project Planning

4.1.1 District Planning:

District planning meetings were conducted in two remaining districts; Jhapa and Morang districts. The main objective of this activity was to familiarize the district public health office, DEO and LDO about NFHP II, assess the needs of the districts and prioritize possible future program interventions through NFHP II. Almost all senior staff of the district public health offices participated in the meeting. A formal MOU outlining the roles and responsibilities of both parties, namely district public health office and NFHP II, was signed in these districts.

4.3 Field Coordination

4.3.7 Meeting in Field Offices:

Over this period staff meetings were conducted twice in Nepalgunj and once in Hetauda. Progress and challenges were reviewed and staff were updated on various new topics, guidelines and policies in different technical areas. Orientation was done on US Government Population policies. This activity enhanced the knowledge of staff in technical areas, increased level of motivation of field staff and helped in developing synergy in implementation of program activities in CPDs.

4.3.8 Security Situation:

Among the 20 CPDs, there were some security problem in eastern and central *terai* districts[†] but the western *terai* and hilly districts were generally unaffected. In the eastern and central *terai* districts, there were blockages of transportation, closed district offices and health facilities, agitations and killings of government staff and other people in the community over this reporting period. An unidentified gang killed Mr. Suresh Kumar Yadav the health facility in-charge in Jayanagar SHP, Rautahaut on 7th Sept. After this event all health facilities including the district public health offices were closed for about one week in Bara, Rautahat, Sarlahi, Mahottari and Siraha. There was a transportation strike in Jhapa in August lasting about 15 days. Similarly there was a long transportation strike in Siraha over this period. Despite these difficulties, NFHP staff were generally able to continue their regular work

* Sindhuli, Sarlahi, Banke, Dang, and Surkhet

† Jhapa, Morang, Siraha, Dhanusha, Mahottari, Sarlahi, Rautahat, Bara and Parsa

especially at community level without any major disruption. With some exceptions, all program officers were able to do technical support visits at community level.

4.3.11 Local-Hire staff:

NFHP II hired 34 temporary staff through MASS in 17 CPDs (2 person in each district) to develop VDC Health System Profiles and conduct TSVs.

Other:

External Visitors in CPDs:

Over this reporting period, more than 6 national and international teams visited in Banke to observe the NFHP II program activities. They were; 6 members from USAID; 7 members from CBG; 10 members from PRIDE, Pakistan; 6 members from DDA/FHD and Ms Maria Francisco from USAID, Global Health Washington. NFHP II field office staff shared program activities with those visitors. Most visitors expressed keen interest to learn more about the PPH control program (misoprostol). These visits helped to share lesson learned with visitors.

Support for Sunsari Flood victims:

NFHP II provided support for Sunsari flood victims in managing drugs (transportation, store and supply), providing health education in affected communities, managing waste disposal in shelter areas and monitoring the situation. In addition, NFHP staff contributed Nrs. 70,308.00 to provide support for the victims. This fund is using to set up a water tank in shelter areas.

Case Studies

Birth Preparedness Package: RAJU RHANA & MOTHER'S GROUP

Jhalari VDC, Ward 9
Kanchanpur District
Wednesday, September 17, 2008
CBMNC Field Officers & Translators: Renuka Rai & Krithika Josi
Interviewer: Gurpreet Kaur

Verbal Consent for pictures and voice recording obtained from FCHV Raju Rhana & her Mother's Group

FCHV Raju Rhana: *What is it? Look, what is it? Did everyone see?*

Mother: *Sutki (postpartum woman)...*

FCHV Raju Rhana: *Yes, it is a sutki...she has a very high fever. To lower fever at home... You should soak a cloth in water and place it on the forehead... And with the wet cloth to the forehead, where do you have to go?*

Mother: *Swaastha sanstha (health facility)*

FCHV Raju Rhana: *We have to go to the swaastha sanstha or hospital. For a sutki with a high fever... we should place a wet cloth to the forehead and immediately go to the swaastha sanstha. This is absolutely correct.*

Nine women have gathered together on this hot summer afternoon. Five of these women are pregnant; the remaining four either hold a baby or have a child playing nearby. Forming a half circle around a set of seven pictorial cards, this is Female Community Health Volunteer (FCHV) Raju Rhana's Mother's Group, a forum used to disseminate community-level maternal neonatal healthcare messages amongst women of reproductive age. The pictorial cards, locally called *chitra*, are a participatory game used to teach essential birth preparedness messages.

In Nepal, where the maternal mortality is nearly twenty-fold greater than that of developed nations, the Community Based Maternal Neonatal Care Program (CBMNC) has developed community-level initiatives that address the country's maternal and neonatal health. A vital component of the program is dissemination of birth preparedness messages through FCHVs like Raju Rhana. Covering topics of pregnancy, delivery and the neonate, these messages encourage pregnant women and their families to arrange for a skilled birth attendant, gather essential items for delivery and plan for emergencies; additionally, the FCHVs teach their community to recognize the danger signs related to pregnancy, delivery and the postpartum period.

CBMNC has created a set of pictorial tools to assist the FCHV in her counseling sessions. One of these tools is a key chain which is distributed to a pregnant woman and her family for their independent review. This keychain is distributed in all program districts except for one: Raju Rhana's Kanchanpur District. Located in Nepal's Far Western Region, the FCHVs in Kanchanpur District are trained to disseminate birth preparedness messages through participatory approaches not used elsewhere. Through the Kanchanpur experience, CBMNC wishes to see if the dissemination of birth preparedness messages via interactive games such as *chitra* is as effective as the keychain.

In today's mother's group, FCHV Raju Rhana uses *chitra* to review essential preparations for emergency situations and postpartum danger signs that require immediate health facility referral. With the pictorial cards laid face down, a mother is asked to select a card, show its picture to the group and share her insight. In this manner, five round-shaped cards depicting postpartum danger signs are reviewed: bleeding, severe abdominal pain, severe headache, high fever and convulsions. One triangle-shaped card bears the picture of an ambulance. Indicating the card's three corners, Raju Rhana teaches the necessity of three essential birth preparations: "one is the ambulance number, second is money and third is a matching

blood donor.” The last card is square-shaped and features the picture of a health facility; it serves as yet another method to review the five postpartum danger signs requiring health facility referral. After all cards have been individually examined, the FCHV arranges the *chitra* on the floor. To emphasize the point that emergency situations and danger signs require health facility referral, the picture of the health facility is placed in the center of a circle formed by the postpartum danger sign and emergency preparation cards.

Raju Rhana has been an FCHV in her village for eight years and has used *chitra* for the last two. The FCHV likes the card game because it enables a different method of explaining the birth preparedness messages. She says the cards are “*like a game... [The women] can hold them in their hand, understand for themselves...and I like it when they get the answer right.*” The women in Raju Rhana’s mother’s group also say they like learning from the *chitra* game. When asked what they learned from today’s *chitra*, the mothers say they have learned about danger signs that require immediate medical attention; because of the pictures on the cards, these women say they will be able to recognize the danger signs if encountered in the future.

The CBMNC program introduced its health initiatives in Kanchanpur in July 2006. A 2007 Birth Preparedness Index (BPI) measuring seven key indicators involving pregnancy care, delivery attendance and recognition of key danger signs suggests that birth preparation messages are effectively disseminated with and without the keychain: the BPI between baseline and follow-up in keychain-using Banke District increased from 45 to 56 versus non-keychain using Kanchanpur District 44 to 57. Though follow-up data such as the BPI indicate the participatory approach using *chitra* has been as successful in disseminating birth preparedness messages as the keychain, CBMNC is careful not to make any definitive conclusions based on Kanchanpur alone as programs are not uniformly incorporated amongst its districts. Kanchanpur, in point, has other unique elements of the CBMNC program that also support the dissemination of the birth preparedness messages and may thereby also enhance the participatory game’s influence. Regardless, the Kanchanpur experience does suggest that message dissemination can be effectively accomplished via interactive games such as *chitra* without the distribution of individual key chains.

FCHV Empowerment: SARSWATI GHARTI CHHETRI

Karkando VDC, Ward 7

Wed, Sept 10, 2009

CBMNC Field Officer and Translator: Basanti Chand

Interviewer: Gurpreet Kaur

Verbal Consent for pictures and voice recording obtained from CBMNC FCHV Sarswati Gharti Chetri

Ten years ago, Sarswati went against her husband’s wishes and joined the cadre of nearly 49,000 Female Community Health Volunteers (FCHVs) who form the backbone of Nepal’s community-level maternal and child health outreach initiatives.

A dynamic thirty-nine year old mother of three, Sarswati had completed eight years of school and was known for her readiness to help others. Friends encouraged her to apply when a FCHV position became available in her local community, a village located close to Banke’s urban center. Although Sarswati underwent the FCHV training, her husband was against the idea. A hardworking man whose employment as a car driver had enabled him to purchase land and build a house for his family, Sarswati’s husband was uncomfortable with his wife working outside of the home.

Sarswati recalls her first tasks as an FCHV: she taught families how to treat diarrhea, helped them immunize their children and provided information to couples on family planning methods (*parivar neojan*). Her FCHV responsibilities from those first few years have since evolved significantly. Now, Sarswati also teaches women and their families on issues regarding pregnancy, delivery and newborn care. Among older children, the FCHV is able to diagnose and treat pneumonia. Three years ago, the Nepal Family Health Program

included her in a pilot intervention aimed at reducing postpartum hemorrhage risk among home births. Following this training, Sarswati is actively involved in distributing misoprostol (maatri surakchya chakki) to pregnant women in her community as a means of providing protection against postpartum hemorrhage.

A conversation with Sarswati quickly reveals the FCHV's enthusiasm for her work and her excellent grasp of health knowledge. Sarswati understands the messages she must deliver and more importantly, has learned effective ways of communicating them to the women and families under her care: FCHV training has taught her to provide health education in an interactive manner. For instance, Sarswati finds that counseling about misoprostol via a question/answer format usually works best in helping families remember when to take the medication and its side effects. In these counseling sessions, the FCHV will ask questions such as "When will you eat the medicine?...What are its side effects?" Currently Sarswati has seven pregnant women under her care; two are past their eight month and have received misoprostol.

As Sarswati's responsibilities and her effectiveness as a FCHV have evolved, so too has her husband's opinion. When community members and health staff praised Sarswati's work to her husband, slowly his opinion began to change. Her husband began to listen to her counsel and little by little, his "mind began to change". The process took almost three years but now her husband no longer objects; in fact, he helps out with some of the housework so that his wife has time to do her FCHV work.

If Sarswati encountered this kind of resistance against her work at home, did she encounter any resistance within her community? At first, it was difficult to convince community members to take their children for immunization. When she would come to the house, the family would say there was too much work and they could not take the child. Refusing 'no' for an answer, Sarswati would ask for the immunization card and take the baby herself. If the child developed fever, families would get upset with the FCHV and exclaim "What did you do?!" Explaining that the fever was only a side effect, Sarswati would encourage them not to worry, that it would disappear in three days. "The fever is a small price to pay for an immunization...What if your child fell ill with polio? His entire life would be ruined. Then what would you do?" Now, when she makes her rounds, families greet her warmly and ask her to come by and make sure their child's immunizations are up-to-date. Because many are illiterate, they rely on Sarswati to look at the records and tell them when next to visit the immunization clinic.

Perhaps remembering the conflict with her husband, Sarswati is a dedicated advocate for other women in her community. She shared the story of a Muslim woman who had two children and wanted to undergo a tubal ligation. The mother-in-law was against the permanent family planning method. As a result, the daughter-in-law threatened to divorce her husband. Sarswati spent sixteen days going to the family's home, talking with the mother-in-law and encouraging her to support her daughter-in-law's wishes. Eventually the mother-in-law was won over and the FCHV accompanied the woman to the hospital for her tubal ligation.

As Sarswati's FCHV role has matured over the years, so too has the respect within her home and community. Her role as a primary health care provider and educator enabled Sarswati to legitimately step outside of her family unit and assume a leadership role within her community at large. And as we see, the FCHV training has been a stimulus for Sarswati's further empowerment and community participation: Sarswati has become an active member of various other community projects. Several local community clubs invite Sarswati to come voice her opinions on a myriad of social issues including forestry, safe drinking water and education. Currently, the FCHV is busy raising her community's awareness about women's trafficking and domestic violence.

Misoprostol

Herimenya VDC, Ward 2

Mon, Sept 8, 2008

CBMNC Field Officer and translator: Neima Gupta

Interviewer: Gurpreet Kaur

Verbal Consent for Pictures & Voice Recording Obtained:

- Lal Maya Thapa (FCHV)
- Suman Lata Singh (MCHW)
- Sabitry Thapa (TTBA)
- Pooja Bandari (PNC)

Twenty year old Pooja Bandari only received one antenatal check up till her sixth month of pregnancy. When she moved to her parents' village in Banke, her pregnancy fell under the care of the village's female community health volunteer (FCHV), Lal Maya Thapa. It was under Lal Maya's guidance that Pooja began to regularly visit the village's antenatal clinic. As the FCHV provided iron/folate tablets and albendazole, Lal Maya Thapa also provided antenatal counseling. The FCHV talked to Pooja about birth preparedness, teaching her about danger signs related to pregnancy, delivery and the postpartum period. Lal Maya encouraged Pooja and her family to make preparations for delivery; she encouraged the twenty year old mother-to-be to deliver at the hospital or at the very least, to arrange for someone to attend her delivery at home. Pooja's family decided she would only go to the hospital if complications arose and arranged for the traditional birth attendant (TBA), who lived next door, to attend the delivery.

When she was eight months pregnant, Lal Maya talked with Pooja and her family about misoprostol, locally known as "maatri surakchya chaki". She told them taking three tablets of misoprostol with hot water right after Pooja delivered the baby would help her uterus contract and decrease blood loss. If side effects like shivering, fever, diarrhea, headache and vomiting were to appear, they would be short lived and should not cause alarm. But, if Pooja lost more than two cloths worth of blood, she should immediately be taken to the hospital. Lal Maya told the family to keep the red packet with the three pills in a safe place. Because Pooja had no older female guardian in her house, the family asked the TBA to safe keep the medicine. Since she was attending the delivery anyways, placing the misoprostol with the TBA ensured Pooja would receive it at the proper time.

Twenty-two days ago, Pooja Bandari delivered her first child, a healthy baby girl named Asmita Bandari. Pooja says her labor pains began around six in the morning, the TBA was called at eight and her baby was born at ten. The young mother took the misoprostol immediately after the baby's delivery and experienced no side effects. According to the TBA, Pooja had light blood loss, about one cloth's worth. Lal Maya came to see Pooja and her newborn later that same day; at that time, the FCHV collected the empty misoprostol packet.

In November 2005, the Nepal Family Health Program's Community-Based Maternal/Neonatal Care team (CBMNC) launched a pilot initiative to provide postpartum hemorrhage protection through community-level misoprostol distribution to women like Pooja Bandari, who deliver at home. Though part of a broader set of CBMNC safe motherhood and neonatal interventions being implemented in Nepal, the misoprostol pilot initiative is limited to the Mid West Region of Banke District.

 initiative is implemented under the leadership of the Ministry of Health and Population, Family Health Division (FHD) and Banke District (Public) Health Office (D(P)HO). Implementing partners include Nepal Family Health Program (USAID), JHU/HARP-GRA (John Hopkins University), ACCESS Project (SC/US & JPHPIEGO), PLAN. Funding is provided by USAID.

Based on the 2006 Demographic Health Survey, nearly 281 pregnant women per every 100,000 die during delivery in Nepal. Putting these statistics in perspective, the maternal

mortality in Nepal is nearly twenty-fold greater than the maternal mortality in developed nations such as the United States.

More than half of delivery-related maternal deaths in Nepal are due to postpartum hemorrhage (PPH). The most common cause for PPH is uterine atony, i.e. ineffective contraction of the uterus after delivery of the infant. An injection of oxytocin, an uterotonic drug can significantly reduce the risk of PPH but it requires administration by a skilled birth attendant (SBA) such as a doctor, nurse or auxiliary nurse midwife. Traditional birth attendants, like the one used by Pooja Bandari, can not administer oxytocin. In Nepal, 81% of women deliver at home of whom only 19% use a SBA. Ultimately, more than half of Nepal's pregnant women deliver unprotected from PPH.

Misoprostol has been demonstrated as an effective alternative to oxytocin injection for the prevention of PPH at the community level. Also an uterotonic agent, misoprostol is taken orally immediately after delivery of the infant. The drug has a long shelf life, is inexpensive and does not require refrigeration.

At the frontline of the CBMNC misoprostol initiative in Banke are Female Community Health Volunteers (FCHVs) like Lal Maya Thapa, who provide primary health outreach and education to their local village communities. As Lal Maya did with Pooja during her antenatal period, FCHVs educate pregnant women and key household members about misoprostol's purpose and provide instructions on its use and management of possible side effects. The medication itself, the FCHV dispenses to the pregnant woman during her eighth month with strict instructions that it be consumed immediately after delivery of the infant. (Pooja Bandari's case is a little unique in that usually the medicine is stored within the pregnant woman's home.) Within a day or two of delivery, the FCHV makes a postpartum visit, assesses the mother and baby's condition, documents misoprostol use, and retrieves any unused medicine.

Thirty-seven year old Lal Maya Thapa has worked as an FCHV in her community for the past twelve years. For the past two years, she has distributed misoprostol to pregnant women under the CBMNC pilot initiative. Since she started distributing misoprostol in her community, Lal Maya has noticed a decrease in severe delivery-related bleeding cases. The FCHV says that most women in her village deliver at home given that labor is less than eight hours. These home deliveries are either attended by the TBA, maternal child health worker (MCHW) or family member. If the home delivery is attended by the MCHW, women may receive an oxytocin injection; otherwise, they are left unprotected against PPH. She says that most women under her care take misoprostol if they birth at home. Some women, who travel to their parents' home outside of Banke District after their eighth month, will take the misoprostol tablets with them to use at delivery. These women return the empty packet to Lal Maya upon their return to Banke.

Why is it that most women in Lal Maya's village prefer to deliver at home given that Bheri Zonal Hospital is within a thirty minutes drive? Lal Maya thinks that many women would probably prefer to deliver at the hospital but their families can not afford the service fees. The Maternal Incentive Scheme which awards 500 NRPS (Nepali Rupees) for delivering at a qualified health facility is of no use. The villagers say it takes 500 NRPS just to hire a vehicle to the hospital. Many families can barely afford the transportation let alone afford the hospital's 3000 NRPS fee. Then there are some families who have money but either cannot or will not lose a few days work to accompany the woman to the hospital. Stories of community members' delivery experiences with unfriendly and neglectful hospital staff are yet another reason Lal Maya cites for the prevalence of home deliveries. So, why did Pooja Bandari, who followed all other CBMNC ANC messages, deliver at home? When asked, her response was "But, my baby came at home..." It is unknown if this decision was perhaps determined by an older family member as none was present at the time of interview.

A woman is considered protected against PPH if she delivers at a qualified health facility, uses a skilled birth attendant, receives oxytocin injection and/or takes oral misoprostol. A baseline survey conducted by CBMNC staff in Banke showed only 28% of women protected against PPH. A follow-up survey eighteen months after FCHVs like Lal Maya began

distributing misoprostol showed protection against PPH increased to almost 80%. Results at follow-up reveal the drug has significantly lowered the incidence of heavy bleeding and maternal mortality in Banke District. Reports of heavy bleeding among women who consumed misoprostol were significantly less than among those women who did not consume the drug (26% vs. 35% respectively). Monitoring data from the first eighteen months of the misoprostol initiative shows maternal mortality in Banke fell to 40% less than the national average.

Misoprostol distribution through Lal Maya Thapa and her sister FCHVs has equitably reached nearly three quarters of Banke's pregnant population. But, there is some concern about the drug being dispensed through the hands of non-medical persons, let alone semi-literate women. Monitoring data show almost universally correct usage of misoprostol with no instance of the drug being consumed prior to delivery. FCHVs distribution of misoprostol is regularly monitored by local health staff at the subhealth post (community clinic). The maternal child health worker (MCHW) and village health worker (VHW) at the subhealth post supply the drug to the FCHVs. At this point of contact, the health staff determines the number of pregnant women under the FCHV's care and accordingly dispenses the misoprostol packets.

FCHV Lal Maya Thapa will go to the subhealth post every one/two months and obtain her misoprostol medication from MCHW Suman Lata Singh. When Lal Maya comes to the subhealth post, Suman Lata asks the FCHV about her existing misoprostol stock and examines her register. Suman Lata then supplies misoprostol according to the number of eight month pregnant women under the FCHV's care plus one or two extra packets for emergencies.

In order to monitor its pilot intervention, CBMNC requires FCHVs to complete a misoprostol-specific form for each woman to whom the drug is dispensed. Though the format accounts for minimal literacy and is largely pictorial, some wonder if it's too much for FCHVs. Considering that Lal Maya only completed three years of school, is the misoprostol form difficult for her to complete? She says, no. Lal Maya completes what she can on her own and if she needs help, she gets it at the FCHVs' monthly meeting with their MCHW, Suman Lata.

But, what if misoprostol was dispensed through hands other than the FCHVs? What if someone at the subhealth post level dispensed the drug? Even though Suman Lata Singh provides ANC checks to local women at this level, she says she would be limited to distributing the drug during the clinic hours of operation; additionally she would miss those women who did not come in for checks. Suman Lata further elaborates...This is her [FCHV's] ward, she knows which house has a pregnant woman...that's why she can give the chaki [misoprostol]for delivery...Someone else who lives outside, he will not know every woman that is pregnant and he will not be able to give the chaki to every one of them."

Technical Support Visits

Manikapur VDC, Ward 8

Sept 13, 2008

CBMNC Field Officer and translator: Neima Gupta

Interviewer: Gurpreet Kaur

Verbal Consent for Pictures & Voice Recording obtained: Aaila Bohara (FCHV)

Verbal Consent for only Voice Recording obtained: Kavita Thaba (PNC)

The technical support visit with female community health volunteer (FCHV) Aaila Bohara was conducted at her home in Manikapur village, located close to the airport and less than fifteen minutes drive from Banke District's urban center. A large portion of Manikapur's population including Aaila is Pahadi, people originally from Nepal's northern mountain region. Like many in Manikapur, Aaila's family migrated south to the Mid West Terai (plains area) because her husband works for the Nepali Army.

When we came to see Aaila in the morning, she was still getting ready. Greeting each other warmly, Community Based Maternal Neonatal Care (CBMNC) Field Officer Neima Gupta asked after Aaila's family, explained she was here for a technical support visit (TSV) and assured the twenty-nine year old mother to take her time. We settled into the sitting room where Aaila's young daughter and son kept us company. The FCHV joined us ten minutes later with her counseling materials and medicine stock in hand.

Over the next one and half hours, Neima Gupta systematically evaluated Aaila's CBMNC-related knowledge and counseling skills. The field officer first ran through a checklist that probed the FCHV's knowledge regarding care of the pregnant and postpartum woman and child. Aaila was asked about essential neonatal care and birth preparedness issues including antenatal/ postnatal checks and danger signs of pregnancy, delivery and postpartum.

During this checklist assessment, Aaila's medicine stock was examined. Did she have enough condoms? How much vitamin A did she have with her? What was her iron/folate stock? Two iron/folate bottles in hand and noticing a difference in their amounts, Neima unscrewed the bottle appearing to hold less, dumped the contents in her hand and counted to make sure there were sixty pills.

Though Neima Gupta's checklist is used to evaluate FCHV performance in all CBMNC participating districts, the checklist used in Banke District includes a few unique assessment points. In Banke, the CBMNC program has launched a pilot initiative aimed at reducing postpartum hemorrhage associated with home deliveries. The majority of Banke's FCHVs, including Aaila Bohara, are trained to distribute misoprostol at the eighth month of pregnancy to women in their communities. A portion of the technical support checklist is therefore dedicated to evaluating a FCHV's knowledge regarding misoprostol's purpose, its usage and side effects. The field officer must also identify the number of pregnant women currently in their eighth month under the FCHV's care and of those, the number having received misoprostol counseling and/or the medicine itself. Aaila Bohara had eight pregnant women under her care but none were currently in their eighth month; therefore none had received misoprostol.

At the conclusion of the checklist assessment, Aaila's misoprostol and birth registers were examined. Most FCHVs are semi-literate and require some help with the register completion. This is not the case with Aaila Bohara. She has completed ten plus years of school and her records were well kept and up-to-date. Flipping through the pages and coming upon an unfilled delivery date, Neima enquired if the woman had yet delivered. Aaila replied no.

Based off the checklist assessment, Aaila's overall knowledge was very good but her knowledge with regards to misoprostol side effects required some review. FCHVs are taught to counsel on five misoprostol side effects: shivering, diarrhea, nausea, headache and fever. In listing the side effects, Aaila missed the last two. This weakness in side effect knowledge is consistent with Neima Gupta's experience with other TSVs. The field officer has found that FCHVs usually know everything about misoprostol but sometimes forget one/two side effects, usually fever and headache. As Neima explains, one reason for this "...gapping...Why they have this problem? On this we did some analysis....in the flip chart, the fever and headache, the pictures are not that clear."

The next step in the TSV is an evaluation of a FCHV's counseling skills on birth preparedness (BPP) and misoprostol. Each one of these issues is associated with its own counseling tool, a letter-sized pictorial flip chart. When asked to review the misoprostol counseling, Aaila mentioned she did not use the misoprostol flipchart but rather counseled off the BPP flipchart. The field officer strongly discouraged this practice and explained that "Side effects are written in here [misoprostol flip chart]. They are not in the...birth preparedness flipchart...If you won't read from this...There are five side effects. Whichever ones you remember, you'll say and then leave. If [the pregnant woman] experiences one of the side effects that were not mentioned, then her family will get worried. That is why this [misoprostol flip chart] needs to be used."

Nodding at the field officer's explanation, Aaila counseled off the misoprostol flip chart but her unfamiliarity with the tool was readily apparent as she talked in a quiet voice with uncomfortable pauses and little eye contact with her audience. Neima stepped in after noticing the FCHV's difficulty with the tool. Taking the flipchart from Aaila, she demonstrated how to properly hold the tool: over the elbow, in front of the chest, at eye level with the audience. As for proper presentation technique: don't lean over the flip chart, read from its back panels. The field officer emphasized the need to interact with your audience by maintaining eye contact and asking questions like "Sister, what do you see here?"

After Neima read through the misoprostol flip chart, she returned it to Aaila to re-read. Whereas before the FCHV had fumbled with the tool, this time Aaila looked directly at her audience and communicated misoprostol's purpose, use and side effects in a loud clear voice to her encouraging field officer's "Good job!"

So goes Neima Gupta's approach to conducting a technical support visit (TSV). Neima has worked within a technical support capacity for the last seven years, but this is her first year working for the CBMNC program. Focused on high impact, cost effective, community level interventions promoting safe motherhood and neonatal health, the FCHV is the key person through which all CBMNC messages are disseminated. Therefore, monitoring FCHV performance is essential towards maintaining the effectiveness of CBMNC interventions.

In essence, a TSV is a community-level "monitoring and evaluation" without the associated intimidation and formality. In this capacity, CBMNC field officers are considered facilitators rather than supervisors; persons whose purpose is to provide guidance and corrections rather than disapproval and reprimands for inaccuracies. When asked how she minimizes any intimidation associated with a TSV, Neima says "It doesn't happen. They know us, they know what this is for...And they're language, that's the language I talk to them in. They don't feel like this is someone from outside. I do it like a conversation...First when I go to their house, I ask about them, how they are, talk with them. They open up a bit. I don't give technical support from the start. I do some rapport building first."

Within the scope of the CBMNC program, field officers administer technical support at three different levels: peripheral health facility, FCHV and antenatal/postnatal woman. The peripheral health facility is itself comprised of three types: subhealth post, health post and primary health care center. The most basic health facility is the subhealth post. These local health facilities are primarily assessed for medicine stock levels and data accuracy. As demonstrated with the TSV with Aaila Bohara, technical support to FCHVs evaluate knowledge of health issues, counseling skills, stock levels and register accuracy. In order to properly assess a FCHV's effectiveness in disseminating health messages, field officers also visit antenatal and/or postnatal women under her care.

Neima performed a TSV with a postnatal woman under Aaila Bohara's care. The framework for a postnatal TSV is similar to the FCHV TSV: maternal and child health knowledge is first evaluated off a checklist followed by an assessment of birth preparedness issues. Information related to the delivery, i.e. its date, location, blood loss, and misoprostol usage is also collected amongst postnatal TSVs. Afterwards, an evaluation of postnatal counseling and care is undertaken: Has the mother received a postnatal check at the subhealth post? Has the FCHV supplied her with iron? And has she received family planning counseling?

When we came to see Kavita Thaba, she was seated on the front porch breastfeeding her eleven day old baby girl. Because she delivered in hospital, Kavita did not take the misoprostol FCHV Aaila Bohara gave to her at eight months. The mother of three reported an uneventful delivery with light blood loss. In the TSV with Kavita, Neima found good antenatal knowledge but poor postnatal knowledge specifically with regards to the postnatal check and family planning methods.

The CBMNC program counsels women to undergo a postnatal exam within the first seventy-two hours after delivery. Eleven days past her delivery, Kavita had yet to visit the subhealth post. Neima finds that many women in fact do not go for postnatal exams, "they say I didn't see any danger signs, I didn't go". The field officer's response to this is: "Danger sign, whether you saw it or not, you need to go for a [postnatal] visit."

Kavita's knowledge about family planning was also very low. The TSV revealed that her current pregnancy had been unplanned. Earlier, Kavita had used Depo Provera but the contraceptive had caused continual menstrual bleeding; therefore, she stopped the Depo injections when her husband went away for army duty. Unfortunately, when her husband returned, Kavita was not covered by a contraceptive and became pregnant. Neima suggested condoms as a subsequent family planning method but was informed the husband refuses to use them. Because of Kavita's interest in family planning and lack of knowledge, Neima spent the last portion of the TSV counseling on locally available long term family planning methods.

The question which begs asking then, is the TSV found helpful by its recipients? New mother, Kavita Thaba said the TSV taught her some things she did not know before such as other family planning methods. As for Kavita's FCHV, Aaila Bohara, she found the TSV to be a very helpful review. Additionally, she is now clearer about the misoprostol flipchart's use after the review with field officer Neima Gupta.

TSV site selection is partially determined by performance status; priority attention is assigned to underperforming communities. Aaila Bohara, for instance, resides in Manikapur village, a low coverage area with regards to childhood immunizations and misoprostol distribution. If a TSV assessment reveals a significant implementation error either at the level of the FCHV or program beneficiary (antenatal/postnatal woman), CBMNC field officers refer to the local subhealth post workers for assistance. Additionally, the field officers may address such errors by administering a review session at the community's monthly FCHV group and/or mother's group.

The limitation of the TSV is its lack of generalizability. Due to limited resources in both manpower and time, TSVs are not conducted in a systematic manner. But, CBMNC's intention with the TSV was never to systematically evaluate all of its program participants. The CBMNC program uses the TSV to gain qualitative insight into its interventions' implementation at the community level. Twenty to twenty-five TSVs each to health facilities, FCHVs and antenatal/postnatal women per month are generally sufficient to allow field officer's to capture an impression of the CBMNC program in action. In Banke District, this task is accomplished by three field officers with each one usually visiting between ten to fifteen health facilities, FCHVs and antenatal/postnatal women per month. Per CBMNC monitoring data from July 2007 thru June 2008, TSVs in Banke were conducted at 218 health facilities as well as with 267 FCHVs and 534 antenatal/postnatal women.

Though CBMNC intends TSVs at health facilities be conducted jointly with a government counterpart from the District Public Health Office, this rarely occurs. An opinion has been expressed that increased government-side involvement in TSVs would be beneficial. Given that CBMNC strives to create effective safe motherhood/neonatal interventions that can eventually be incorporated into the national health program, participation of district public health office staff in TSVs at all three levels (health facility, FCHV, beneficiary) would help increase government understanding and ownership of the program's activities.

The strength of the TSV lies in its ability to produce important qualitative information that is otherwise lost among standardized monitoring and evaluation. For instance, a standardized monitoring and evaluation might have revealed Aaila Bohara's weak knowledge of misoprostol side effects; but, it likely would have failed to identify its contributing cause, i.e. that the FCHV was providing misoprostol counseling off the BPP flip chart. An added benefit of the TSV is that it enables the FCHV to review information, clarify any confusion and receive immediate feedback from the field officer. This expressed interest in a FCHV's work may be very influential in maintaining her performance level. Given that FCHVs operate on a voluntary basis without monetary compensation, there is considerable concern about maintaining the cadre's motivation level. As FCHV Aaila Bohara's comment suggests, the individually-focused attention inherent to a TSV may help sustain FCHV motivation: "When people from the office come to visit my home...it feels very good...and to the village it looks like this is a very important person and that's why people keep coming to see [me]..."