

Nepal Child Survival Case Study

Technical Report



 **BASICS II**



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Abstract

Nepal has a long history of successful child survival and reproductive health programs that were implemented at scale and at the community level. The *Nepal Child Survival Case Study: Technical Report* reviews the processes and events that influenced expansion of the programs and achievement of results in several technical areas, including pneumonia treatment, control of diarrheal diseases, vitamin A supplementation, immunization, malaria control, and family planning. This report provides an overview of the context and evolution of programs; trends in mortality and malnutrition in Nepal; a description of intervention programs; a discussion of cross-cutting components such as the use of female community health volunteers, behavior change communications, information systems, and logistics and supplies; and lessons learned. The report is part of a package of materials intended for adaptation and replication in other countries.

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Photo credit: Nepal. A Traditional Birth Attendant (TBA) with her two children in an extremely remote area. Photographer: Caroline Jacoby.

BASICS II

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Executive Summary

The report first summarizes the program context and evolution of health activities; mortality trends and associations based on analyses of DHS data; descriptions of selected programs by intervention—family planning, malaria control, immunization, diarrheal disease control/oral rehydration therapy (ORT), vitamin A, and pneumonia treatment; and cross-cutting components. It finally describes the lessons learned about major program influences that determined how programs evolved. The documentation team also produced a more detailed report on program evolution, an annotated bibliography, and a CD-ROM containing selected tools and various reports.

This review of child survival programs in Nepal was conducted for the following reasons:

- Nepal has a long history of successful child survival and family planning program implementation;
- Programs have succeeded at national scale despite significant economic and geographic challenges;
- Interventions have strong community-based components;
- The Demographic and Health Surveys (DHSs) offered a parallel opportunity to review factors affecting mortality; and
- The United States Agency for International Development (USAID) was reviewing similar programs in other countries, thereby providing the opportunity to compare and contrast experiences.

Processes and events that influenced the expansion of the program and achievement of results were reviewed. The scope covered acute respiratory infection (ARI), vitamin A, immunization, family planning, diarrheal disease control, malaria, water and sanitation, infant feeding, polio eradication, control of iodine deficiency disorders, and maternal health interventions—all over a period of 40 years. A series of study questions (Sanghvi et al., 2002) developed for multi-country documentation and adapted for Nepal established the framework. A structure was developed with and for the team in Nepal to ensure consistency in the review of each program. The methodology involved developing timelines and identifying turning points and factors that led up to milestones. Conclusions were drawn on the basis of common factors across programs that presented as barriers or as facilitators. A special effort was made to clearly identify experiences that had relevance to other countries.

Pneumonia Treatment

This intervention program was also initiated following research and pilot projects done in Nepal. The community component was found to be critical but required a comprehensive approach requiring integrated training, close monitoring of quality of care, and good logistic support. The program proceeded with permission from the Government of Nepal (GON), but without an explicit policy for community workers to treat pneumonia cases with antibiotics. This program benefited from a strong national task force. Now, it is synergistic with the vitamin A program in empowering Female Community Health Volunteers (FCHVs) and gaining community support. The proportion of pneumonia cases treated improved substantially, with health facilities (HFs) and community health workers (CHWs) playing important roles.

Vitamin A

Nationwide vitamin A supplementation was initiated as a result of two key studies on child mortality in Nepal. The program was implemented for the GON by a local Nepal non-governmental organization (NGO), the National Technical Assistance Group (NTAG). The strategy, which focused on training and support, resulted in significant empowerment and community ownership for a pre-existing but weak cadre (FCHVs). The program was scaled up in phases that covered groups of new districts. Each district was given intense support for the first two distribution rounds and continuing oversight for capsule logistics. One unique characteristic of this program was the use of monitoring data for program advocacy; use of data in this way helped obtain resources and motivated staff to maintain high coverage.

Immunization

The national immunization program implemented global recommendations early. By 1988, all districts, with strong donor support, were engaged in the Expanded Program on Immunization (EPI). Initially, the program received its primary support from donors; as the program evolved, its primary supporter became the government. The program developed vertically and achieved good rural outreach. It involved extensive training and logistics to manage the cold chain and outreach, with coverage—except that for measles and tetanus toxoid (TT)—reaching greater than 80% by 1990. However, following a major push to achieve global targets under Universal Childhood Immunization (UCI), and because of structural changes at the Ministry of Health (MOH), coverage later declined. The program is reportedly self-sufficient for diphtheria, pertussis, and tetanus vaccine (DPT), TT, and measles vaccines and supplies.

Control of Diarrheal Diseases

The MOH in Nepal adopted World Health Organization (WHO) guidelines early (1982) and moved from case management to prevention of dehydration deaths. The national program needed early logistic support for oral rehydration solution (ORS) packets, in addition to behavior change communications (BCC) activities for the use of home fluids. The program used a standard training approach with limited (and late) development of a community component. Two control of diarrheal diseases (CDD) components were implemented—ORT corners and salt-sugar-water or *nun-chini-pani* (NCP). These were not well received in that the degree of community acceptance did not seem to be high; this may have been due to inability to address incidence. ORT use levels did not increase beyond approximately 50%.

Malaria

Comprising one of the earliest health programs, malaria interventions were expanded as part of the global malaria control effort, and they achieved rapid success. The program engaged a large cadre of vertical workers (slide readers and sprayers) but was not sustained. Resources and political commitment declined as malaria indicators rose following a change from attempts at eradication to less ambitious goals. Recently, there have been renewed malaria control efforts and a change in focus.

Family Planning

The family planning program in Nepal was large and well-supported. It began in the 1950s, initially with the aid of NGOs, but was later operationalized through the government health

system. It had the full support of the royal family and government, with charismatic leadership in early years and throughout its evolution. The program involved a gradual shift in policy from sterilization camps to integrated reproductive health services, and later to a focus on birth spacing. More recently, the program moved toward greater community involvement. Over 25 years, contraceptive prevalence steadily increased.

Main Lessons Learned Across Programs

Community Level

Enabling factors at the community level included having simple and focused guidelines for the community and community-based workers to follow; participatory training and emphasis given to improving quality of care at the community level; “visible” success in the eyes of communities and providers; application of broad, resource-intensive social mobilization strategies using media, partnerships with other sectors, volunteers, and celebrity spokespeople; and mobilization of thousands from many sectors, building ownership to support and monitor activities.

National Level

Enabling factors at the national level were research in-country, often followed by pilot implementation; global priorities, leadership, and sustained flow of external resources for the introduction and expansion of programs; strong national leadership with access to resources and ability to get permission for technical innovations; and effective donor coordination.

Systems Level

Enabling factors at the systems level included the development of logistics management and information systems; good monitoring, based on routine data and on specialized systems; use of mechanisms that reliably got resources through to programs outside the main government channels; and the ability of some programs to influence or drive change in other programs.

In Nepal, there remains a sizable unfinished agenda—to maintain gains already made, to raise coverage with ORT and ARI treatment, and to address malnutrition and neonatal health.

