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MCHIP Maternal and Child Health Integrated Program

Summary of Rapid CATCH Indicators from Child Survival and Health Grants Program (CSHGP) Projects Ending in October 2011

A mother with her infant (Population Services International / Malawi)

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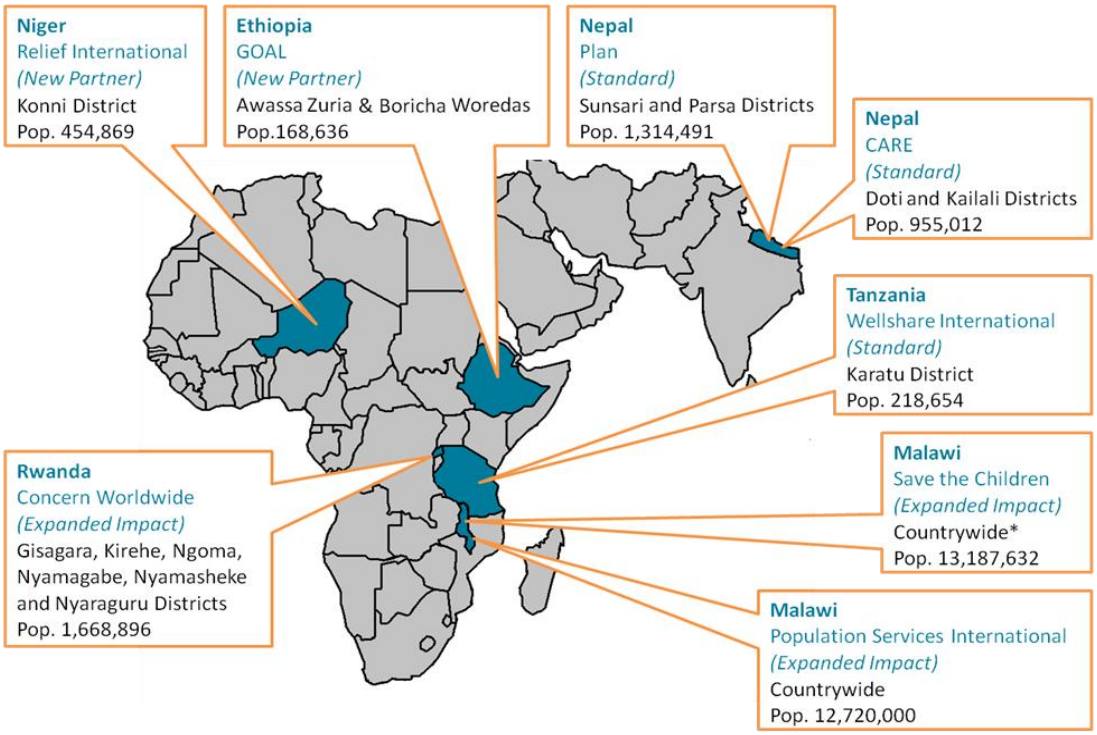
Introduction

This report is intended to share Rapid CATCH and other select project data generated by USAID's Child Survival and Health Grants Program (CSHGP) projects that ended between October and December 2011. Eight of the nine projects focused on maternal, newborn and child health (MNCH), while one focused on tuberculosis (TB) control[1]. The projects all aimed to improve the health of communities by implementing innovative community-oriented delivery strategies and addressing key operational barriers to scaling up delivery of high-impact MNCH interventions to ensure sustained health outcomes.

The Rapid CATCH is a tool that contains questionnaires, tabulation plans and indicator definitions for a set of standard indicators that all grantees collect at baseline and endline, regardless of their intervention mix, to understand the overall MNCH situation in their project area before and after implementation. These indicators are a subset of those found in Knowledge, Practice, Coverage (KPC) survey modules. There are different versions of the Rapid CATCH, which are designated by the year in which they were developed or modified (i.e., 2000, 2006, 2007, and 2008). Grantees are required to use the same version for both their baseline and end-of-project assessments. For more information on the Rapid CATCH and for KPC survey implementation references, please visit the monitoring and evaluation page of the Maternal and Child Health Integrated Program (MCHIP) Private Voluntary Organization (PVO)/ Nongovernmental Organization (NGO) Support Team's Web site.

Projects by country and grant category

Figure 1. Map of projects, including organization, grant category, project location, and target population



* Save the Children implemented a national level program but had five focus districts (Chitipa, Dowa, Thyolo, Mchinji, and Mzimba). The KPC surveys were conducted only in Mzimba District (population 724,873).

[1] Data from Project Hope's TB control project in Malawi is not included in this report as grantees implementing TB projects are not required to collect Rapid CATCH indicators.

Through CSHGP's "standard" category of grants, Plan, CARE, Wellshare International and their local partners took innovative approaches to improving information and service delivery at the community-level meant to contribute to improved quality and sustainability of interventions, and increased efficiency and expansion of coverage.

Through the "expanded impact" category of grants, Population Services International (PSI), Concern Worldwide, and Save the Children contributed to widespread child survival and health impact by collaborating closely with Ministries of Health and their key donor and implementation partners. The CSHGP defines scale as widespread achievement of impact at affordable cost[2], and seeks to expand proven child survival and health interventions and approaches at the national or significant sub-national level[3].

Through the "new partner" category, Relief International, GOAL and their local partners implemented projects focusing on child health (nutrition, malaria, diarrhea) and maternal and newborn care. This award category contributes to USAID's priority of engaging new partners in community-oriented health programming. Specifically, it enables USAID to partner with organizations that may not otherwise compete against more established organizations, providing opportunities for technical capacity building and collaboration through the CSHGP program structure.

Technical intervention areas and levels of effort (LOE)

Grantees all designate a certain percentage of grant funds or level of effort (LOE) towards intervention areas. These percentages are an estimate designated at the beginning of the project.

Table 1. Project start year and LOE

PVO	Country	Start Year	NUT	PCM	CDD	IMM	MAL	MNC	CS	HIV
CARE	Nepal	2007	5%	2.5%	2.5%	5%		75%		10%
Concern	Rwanda	2006		30%	35%		35%			
GOAL	Ethiopia	2007	25%		25%		25%	25%		
Wellshare	Tanzania	2006		15%	15%		20%	35%	15%	
Plan	Nepal	2007						100%		
PSI	Malawi	2006			100%					
Relief	Niger	2007	30%		20%		20%	30%		
Save	Malawi	2006						100%		

NUT: Nutrition; ARI: PCM: Pneumonia case management; CDD: Control of diarrheal diseases; MAL: Prevention and treatment of malaria; MNC: Maternal and newborn care; CS: Child spacing; HIV: HIV/AIDS

Sampling methods

Three of the eight grantees who implemented projects ending in 2011 used Lot Quality Assurance Sampling (LQAS) methodology to conduct their baseline and endline KPC surveys. The other five grantees used 30-cluster sampling methodology. (See annex for project-specific survey details.)

[2] Mary Taylor, *Achieving Impact on Child Health at Scale*, Basics II, November 2001
[3] CSHGP Fiscal Year 2006 Request for Application (RFA)

More information about KPC sampling methods can be found in the KPC Field Guide, and additional information about LQAS vs. 30-cluster sampling can be found in lecture 6 of the LQAS series online workshop and also in *LQAS frequently asked questions* on CORE Group's Web site.

Surveyor collecting information from a mother (Plan / Nepal)

Analysis methodology and notes

The data used in the analysis were submitted to CSHGP through the program's web-based project database and/or in each grantee's final evaluation report. The data in the database were verified against the data submitted in each grantee's final evaluation report. If discrepancies were found, MCHIP contacted the grantee to clarify the issues, and where appropriate, revisions to the online data form and/or FE report were requested. The data were analyzed using Microsoft Excel and Access. A 95% confidence level was used to determine statistically significant changes when comparing endline to baseline estimates. Two grantees, CARE and Plan, performed separate KPC surveys in each of their project districts; thus their sub-areas data were used to calculate population-weighted averages for this analysis.

Although grantees are required to collect all Rapid CATCH indicators, only those relevant to a project's technical intervention areas were included in this analysis. CATCH indicators not relevant to a project's technical intervention areas can be found in the last section of this report.

Endline KPC reports are included as an annex to grantees' final evaluation (FE) reports, which are publically available through the document search function on the MCHIP PVO/NGO Support Team's Web site. Additionally, another FE report annex is a printout of data entered into the CSHGP web-based database by grantees, including both baseline and endline CATCH indicator values. Baseline KPC reports, however, are not publically available because grantees' Detailed Implementation Plans (DIPs) are maintained as internal documents by the CSHGP Team at USAID; however, grantees often reference the baseline in their final KPC reports.

When possible, grantees' coverage estimates were compared to national values obtained through Demographic and Health Surveys (DHS). DHS conducted within two years of baseline KPC surveys and within one year of endline KPC surveys were available for five of the six countries (all except Niger) in which projects ending in 2011 were implemented. If a DHS was not conducted in the same year as a KPC survey, a linear interpolation was done using the country's two most recent DHS points to generate a DHS estimate for the year of the KPC survey. These interpolated estimates are included throughout this document for comparison in both graphs and the narrative.

Table 2. DHS survey years

Country	DHS year 1	DHS year 2
Ethiopia	2005	2011
Malawi	2004	2010
Nepal	2006	2011
Niger	2006	N/A
Rwanda	2005	2010
Tanzania	2004-05	2010

Finally, most narrative descriptions of project approaches and results were taken directly or summarized from project reports. Project information in this report is limited to that included in project reports; however, this report just provides an overview. More information may be available in midterm and final evaluation reports, all of which can be found on the Maternal and Child Health Integrated Program (MCHIP) PVO/NGO Support Team's website, www.mchipngo.net.

Cross-cutting project strategies

Care Group meeting (Relief / Niger)

While certain CATCH indicators may map directly to specific project activities (e.g., bednet distributions, immunization campaigns, targeted counseling during antenatal care to encourage facility-based deliveries, etc.), grantees also employ cross-cutting strategies that may affect multiple CATCH indicators – within one technical area, and sometimes even across technical areas. Such cross-cutting approaches are introduced in this section and will be referred to where applicable throughout the remainder of the document as individual CATCH indicators are discussed.

In Konni District, Niger, **Relief International** used women's health groups (WHGs), a modified Care Group[4] approach, as the "main driving force" behind their behavior change strategy. Relief International established 284 WHGs and trained participants to educate and support their neighbors in healthy maternal and child care and nutrition practices in 61 villages. A series of short messages was developed for each technical intervention. These messages were phased in gradually and communicated primarily through interpersonal communication during home visits made by volunteers. Relief International also trained and supported health facility and community health workers (CHWs) in household and community integrated management of childhood illness (HH/C-IMCI) to improve the quality of services offered at health posts and health centers.

In six districts in Rwanda, **Concern Worldwide International** worked with World Relief and the International Rescue Committee to organize CHWs into peer-support and collaboration groups. These groups were established to organize health promotion activities through outreach and home visits but also became collaborative structures for CHWs. CHWs "coordinated systematic home visits during which individual counseling, mostly of mothers, would take place." (Concern FE34) A community mobilization database was used to monitor the four main project areas (malaria, pneumonia, diarrhea and child nutrition), as well as the existence of kitchen gardens, appropriate latrines, hand-washing stations (tippy-tap), rubbish pits, and long-lasting insecticidal nets (LLINs). According to the FE report, because the project successfully aligned with national and district priorities, it was difficult "to attribute exclusive responsibility to the project for any achievement. The six project districts, for instance, achieved results where the project had little, or no, initial mandate – for example, in maternal health. On the other hand, the human and social infrastructure, which the project had a central role in developing, certainly played a role in these results." (Concern FE47)

Peer support group members meet in Gasambu village to receive training and exchange ideas on how to improve their work as CHWs (Concern / Rwanda)

[4] The Care Group Difference: A guide to mobilizing community-based volunteer health educators (2004), http://www.coregroup.org/storage/documents/Resources/Tools/Care_Group_Manual_Final__Oct_2010.pdf

There were no community-based organizations engaged in health activities in Karatu District, Tanzania, when **Wellshare**'s project started; however, by the end of the project, every village had a functioning village health committee (VHC) or health-related management committee. Additionally, Wellshare worked with 22 long distance drivers to provide emergency transport and health education to their passengers. The project's BCC strategy, *AFYA 1-2-3* (AFYA means *health* in Swahili), was a multi-media campaign including print materials, videos, live drama performances, songs and special events. A focus on three key messages for each intervention area allowed for retention of important information. Messages were shared/reinforced through home visits, as well as community activities implemented by TBAs and community-owned resource persons (CORPs) during market days and events such as the Malaria Marathon, Day of the African Child, World Malaria Day, and World AIDS Day. Project-trained TBAs also led Survive and Thrive Groups (STGs), which targeted more than 320 young pregnant women and new mothers. STGs met twice a month and provided members with emotional support, health education and income-generating opportunities.

CARE implemented the Government of Nepal's (GoN) Community-Based Newborn Care Program (CB-NCP) technical package in Doti, one of two project districts. In both project districts, CARE implemented the GoN's Birth Preparedness Package (BPP), an integrated safe motherhood intervention, and also supported the national community-based integrated management of childhood illness (C-IMCI) strategy. The project trained 289 female community health volunteers (FCHVs) in primary health care, including components of nutrition, acute respiratory infection and diarrhea, and 655 facility and community-based workers in zinc supplementation for diarrhea control. FCHVs were also trained to lead mothers' group meetings. The project made a point of involving key decision makers in the household – men and mothers-in-law – to accelerate improvements in positive maternal behavior and also applied the Self Applied Technique for Quality Health (SATH) strategy in marginalized communities to enhance knowledge and understanding within those communities. The project leveraged resources of other CARE projects in the project districts and also built on their complementary BCC activities.

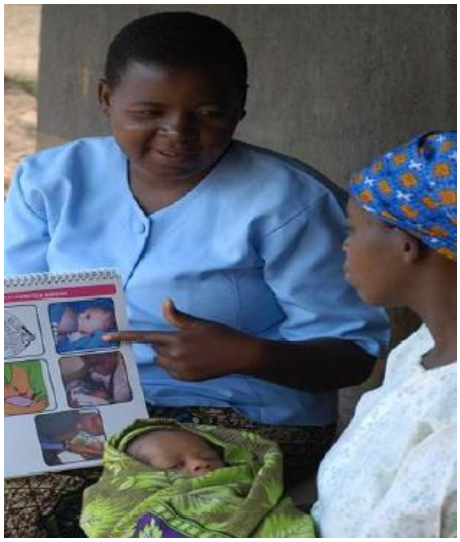
FCHV counsels a mother during a home visit (CARE / Nepal)

Mothers' cards explained to FCHVs (Plan / Nepal)

The central feature of **Plan**'s project in three Nepal districts was to support the maternal and child health activities of the GoN, particularly the CB-NCP program, through the Pregnant Women's Group (PWG) approach. PWGs are facilitated and supported by FCHVs and are a sub-group of the larger mothers' groups. There were 260 PWGs and 123 PWGs formed in Sunsari and Parsa districts, respectively. PWGs were a critical entry point to increase access to health education and services, particularly for the marginalized population. The project strategy also included "strong Ministry of Health and Population (MOHP) partnerships; intensive training and orientation programs; health education sessions on MNH services at the VDC level; public commitments by pregnant women, their mothers-in-law and husbands (decision makers), service providers (health workers and FCHVs) who aid utilization of maternal and newborn health care practices; strong local support from VDCs and other stakeholders; community expansion of birthing centers; and regular review meetings." (Plan FE vi)

In Awassa Zuria and Boricha woredas in Ethiopia, **GOAL** focused on strengthening the health system at the household and community levels through social and behavioral change communication (SBCC) methodologies. GOAL adapted the Care Group approach, which has been used in several other African countries, to the Ethiopian context. Care Group Volunteers (CGVs) made regular visits to a small number of households where pregnant women or small children resided to promote specific hygiene, nutrition and health prevention and care-seeking behaviors. CGVs also made referrals to health posts when necessary and followed up patients who sought services from health extension workers (HEWs), the government's CHW cadre. The project worked with existing public health structures, especially first level facilities (health posts), by building the capacity of HEWs and providing support to the Ministry of Health in supportive supervision and quality of care improvement.

In Malawi, **Save the Children** focused their efforts intensively on the newborn by working "at the national level to institutionalize newborn health into the government system, improve technical quality and increase coordination between partners." (Save FE 24) Through Save's expanded impact project, the national *Integrated Maternal and Newborn Care (IMNC) Training Manual* for facility-based health workers was developed and implemented countrywide; a community-based maternal and newborn care (CBMNC) package was developed and implemented; Kangaroo Mother Care (KMC) was expanded; and community-based approaches to promoting the use of essential newborn care (ENC) were tested. The project and the MOH/RHU coordinated the development and testing of the CBMNC package, including training materials on how to conduct home visits and community mobilization, counseling cards and job aids, and the community-based surveillance system. One of the ENC approaches tested was the *Agogo* Approach in Mzimba District. The approach used trained *agogo* (grandparents), who were over 50 years old, had at least one grandchild, were good communicators, knew the traditions and were respected in their community, for community mobilization and behavior change.



A mother is counseled on breastfeeding (Save / Malawi)

Hand washing station (PSI / Malawi)

Population Services International (PSI) also implemented an expanded impact project in Malawi, but PSI focused on the prevention and management of diarrheal disease using a social marketing approach that combined marketing techniques with public health approaches to behavior change. PSI's multi-channeled BCC approach targeted key opportunities, abilities and motivations to adopt key behaviors, such as water treatment, clean water storage, appropriate hand washing, and correct ORS preparation and use. PSI developed materials appropriate to the community context and implemented targeted outreach communications (TOC) activities at prenatal, antenatal, and under-five clinics as well as among the general community to effectively to raise awareness of the importance of drinking safe water, treating dehydration caused by diarrhea with ORS and hand washing with soap at key times.

Rapid CATCH indicators

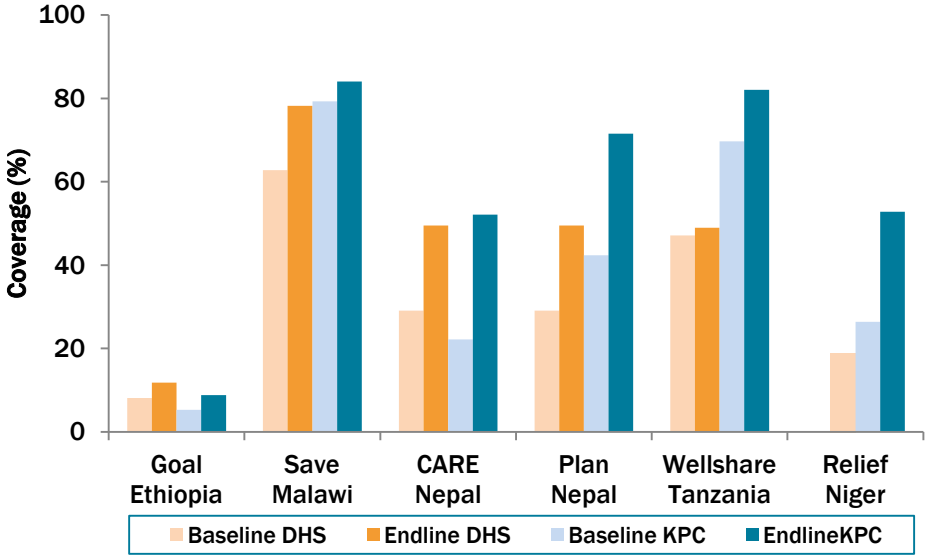
The following sections shift the focus from broader project strategies to changes in specific indicators by technical intervention area. CATCH indicators and a few select key indicators reported by multiple grantees are presented, and coverage changes are briefly discussed. If grantees offered possible explanations for changes reported, they are included. Indicator results are reported from cross-sectional surveys conducted among the project's target population before and after a CSHGP project was implemented. It should be noted that other projects/organizations were often working in same areas and that any changes reported cannot be solely attributed to a grantee. Furthermore, seasonality should be kept in mind; often baseline and endline surveys were not conducted during the same time of year (see annex for survey implementation dates).

Maternal and Newborn Care

1. Skilled Birth Assistance

The percentage of children age 0-23 months whose births were attended by skilled personnel (i.e., doctor, nurse, midwife, or auxiliary midwife)

Figure 2. Skilled Birth Attendance: A comparison of KPC and DHS data (2006/7–2011)



Many CSHGP projects put effort into both promoting the importance of having a trained health worker present at delivery and creating/strengthening links between communities and health facilities, and skilled birth assistance showed positive trends across projects. **CARE**, **Plan**, and **Relief** all reported a statistically significant difference between baseline and endline. DHS trend data from Niger was not available for comparison, but CARE and Plan both reported gains in SBA coverage greater than gains shown by Nepal's DHS data. Most notably, at baseline, CARE's project area was below the national average, but by endline, they had surpassed the national average.

In the final evaluation reports for both **CARE**'s and **Plan**'s projects, government incentives paid to FCHVs and pregnant women for institutional delivery were cited as key contributors to increases in both SBA and institutional delivery – both in the project areas and nationally. In project areas at endline, coverage was higher than the national average for both; however, there was a notable difference between CARE's two districts, one of which had hilly terrain (39%) and the other of which was primarily plains

(56%). During their project, CARE established and equipped over 50 birthing centers closer to communities (using both external funds and community contributions), trained SBAs and promoted the use of clean delivery kits. Plan reported that "the government policy for recruiting auxiliary nurse midwives (ANMs) and health workers locally appear[ed] to be the single most important contributor to the availability of skilled birth care and the expansion of birthing centers, which was undertaken with community support. [Additionally, performance-based] social recognition awards to FCHVs, ANMs, and other key staff were reported to be an important factor in keeping their motivation high." (Plan FE vi)

In **GOAL**'s project area, women traditionally deliver in privacy at home with little support, and while women received support and advice about safe delivery practices through Care Groups, the endline estimate was still extremely low (9%), although not far below the 2011 DHS estimate (12%). At endline, an additional 5% delivered with a trained TBA (TTBA) (n=1) or HEW (n=5), but the majority were still delivering with only friends and/or family members present (65%), and 21% were delivering alone (GOAL FE 83). GOAL found that, although underutilized and not considered skilled providers, HEWs and TTBAs can provide a valuable service in their communities by helping ensure clean deliveries. HEWs, for instance, are often placed at health posts and expected to perform deliveries. The project, therefore, supported the training of 56 HEWs from 28 health posts on safe and clean delivery in a hospital setting for one month and also on identification of emergency complications and referral in delivery. Prior to GOAL's CSHGP project, HEWs' one year of training included classroom content – but no hands-on delivery experience.

TBAs learn to use the village-level pregnancy register (Wellshare / Tanzania)

In Karatu District, Tanzania, **Wellshare** reported an increase in skilled birth attendance (70% to 82%) over the life of the project. The change was not statistically significant, but at both baseline and endline the indicator was much higher in the project area than nationally. In their project, Wellshare "reposition[ed] the role of TBAs as partners to promote maternal prevention behaviors and skilled delivery." Although Wellshare strongly encouraged that all babies be born in a health facility, they provided HBLSS training to TBAs for emergency deliveries with technical assistance from the American College of Nurse Midwives (ACNM) and project staff. Wellshare also developed village-level pregnancy and vital events registers that allowed for community-level data to be fed into the national health information system at the district level. Additionally, the Survive and Thrive groups, led by project-trained TBAs, provided opportunities to educate and counsel women on important maternal behaviors. Four of these STGs also received expanded training in micro-finance. During final evaluation interviews, TBAs "stated that they [were] empowered to advocate for mothers, and they were welcomed by skilled providers to assist deliveries in many health centers." (Wellshare FE 7) TBAs did not mind making referrals to health facilities because they were not losing out on potential income (they were not paid for home deliveries), and facility births also reduced their workload.

In **Relief International**'s project area, 53% of women were assisted by a skilled attendant at endline, while most other deliveries (40%) were attended by TBAs. More than half of deliveries assisted by TBAs occurred in health centers (75/142) even though the MOH does not consider TBAs to be skilled personnel. According to Relief International's endline KPC report, this is a well-known practice, particularly in integrated health centers and district hospitals where TBAs work night shifts under the supervision of a

midwife. Officially, TBAs are expected to only accompany women to the maternity ward and help mothers in the post-partum wards, but they do assist deliveries when midwives rest during night shifts. (Relief FE 23) That the health facility delivery indicator was slightly higher than the SBA indicator at both baseline and endline speaks to this trend. It was noted in the FE report that skilled birth attendance may have actually been higher than reported because although some health post workers are nurses, they may not have been known as such by survey respondents. Relief International worked with TBAs so that they understood the importance of a skilled birth attendant and their new role as 'companions to delivery.' Skilled delivery assistance was also promoted through Care Groups.

In Malawi, the SBA indicator did not increase in **Save the Children**'s surveyed project area, but it was high (and above the national average) at baseline (79%). Despite SBA being a common practice among women in Mzimba district, Save the Children reported that nationally there was a shortage of nurse midwives, leaving many facilities understaffed and also that the retention of midwives, particularly in rural areas, was a problem. Some of the solutions suggested in the final evaluation report included "encouraging district assemblies to support nurse midwives in their areas by providing accommodation, land and assistance with farming." (Save FE 29) It is noteworthy, however, to mention that the indicator did increase in a larger household survey that Save the Children conducted in three districts where they focused their CBMNC efforts (from 64% in 2008 to 91% in 2011)[5].

Table 3. KPC skilled birth attendance CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	22.2	(4.5)	52.1	(5.4)	29.9	✓
GOAL	5.3	(4.1)	8.8	(5.2)	3.5	
Plan	42.5	(4.2)	77.6	(3.5)	35.1	✓
Relief	26.4	(6.7)	52.8	(7.3)	31.2	✓
Save	79.3	(6.5)	84.0	(4.8)	4.7	
Wellshare	69.7	(7.2)	82.0	(5.4)	12.3	

Health facility deliveries

The percentage of children age 0-23 months whose births took place at a health facility

Several projects that had an MNC focus also reported health facility deliveries and four or more antenatal care visits indicators even though they were not part of the Rapid CATCH. As seen in the table below, trends in health facility deliveries (percentage of children age 0-23 months whose births took place in a health facility) followed those of SBA.

Table 4. KPC health facility delivery non-CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	%Point Δ	Change Sig?
CARE *	22.8	(4.5)	48.9	(5.4)	26.1	✓

[5] Community Based Maternal and Newborn Care in Three Districts of Malawi: Household Survey Findings, Baseline and Endline. Save the Children. January 2012.

Plan **	33.0	(4.0)	63.9	(4.1)	30.9	✓
Relief	29	?	59.7	(7.2)	31	✓ (?)
Save	79	(6.5)	79	(7.6)	0	
Wellshare	57.0	(10.1)	73.3	(7.3)	16.3	

* assuming all non-home births were in health center in CARE's project area

** Plan only collected information from mothers of infants 0-5 months

The final evaluation consultant attributed the increase in facility births, from health posts to the district hospital, in Konni District, Niger, in part to a combination of community mobilization, training of health care providers and material support. Health personnel "appreciated the training they received from [**Relief International**] in clean delivery techniques, including the nurses, who described the training as very practical." (Relief FE 22) At the end of the training, the CSHGP project provided clean birthing kits to each health center. Use of clean delivery kits increased from 20% at baseline to 76% at endline among facility deliveries. Within communities, Care Group volunteers encouraged women to give birth at the health posts and with a skilled provider.

As stated above, in Nepal, the government offers incentives for facility births. At endline, 60% of mothers in **CARE**'s project area were aware of this, and facility deliveries did increase from 23% to 49% over the life of the project. However, availability of birthing centers that were consistently open was sub-optimal according to the final evaluation report. Project interventions that may have positively influenced the indicator include updating health facilities and encouraging VDCs to support birthing centers with trained ANMs. Of note, the proportion of newborn deaths occurring in the first 24 hours after birth significantly decreased (from 52 in the second year implementation to 20 in the fourth year), which "is attributed to the increase in institutional and SBA deliveries as well as increased availability of essential and emergency neonatal care in the district." (CARE FE 32)

According to **Plan**'s final evaluation, increased availability of trained personnel, increased awareness of beneficiaries at the community level and accessibility of birthing centers in the community appear to have had a synergistic effect on increased institutional delivery, which increased from 33% to 64%. Another crucial factor contributing to the availability of SBAs/ANMs in birthing centers was the "government's policy that allows Health Facility Operation and Management Committees (HFOMCs) and VDCs to hire required health personnel at the community level with their own resources." (Plan FE 20) Meanwhile, the primary barrier to institutional delivery was reported to be the unavailability, or high cost of transport when available.

In Malawi the health facility delivery indicator was 79% at both baseline and endline in Mzimba District where the KPC surveys were conducted. However, in Save the Children's larger three-district household survey, an increase was seen (from 70% in 2008 to 92% in 2011)5. The increase seen in the three focus districts may be in part due to a national policy, introduced in 2008, that prohibited TBAs from conducting deliveries, an increased availability of maternity waiting homes, and improved support for facility deliveries among communities. IMNC guidelines were rolled-out nationally (30% of facilities nationally had at least one health worker trained in IMNC in 2011) during the project, but still, it was noted that quality of MNC provided by facility-based staff remained an important challenge that must continue to be improved.

Four or more antenatal visits

The percentage of mothers of children age 0-23 months who attended four or more antenatal care visits during their most recent pregnancy

Antenatal care indicators were reported by five of the six grantees who implemented MNC interventions, of which three (CARE, Plan and Wellshare) reported statistically significant increases.

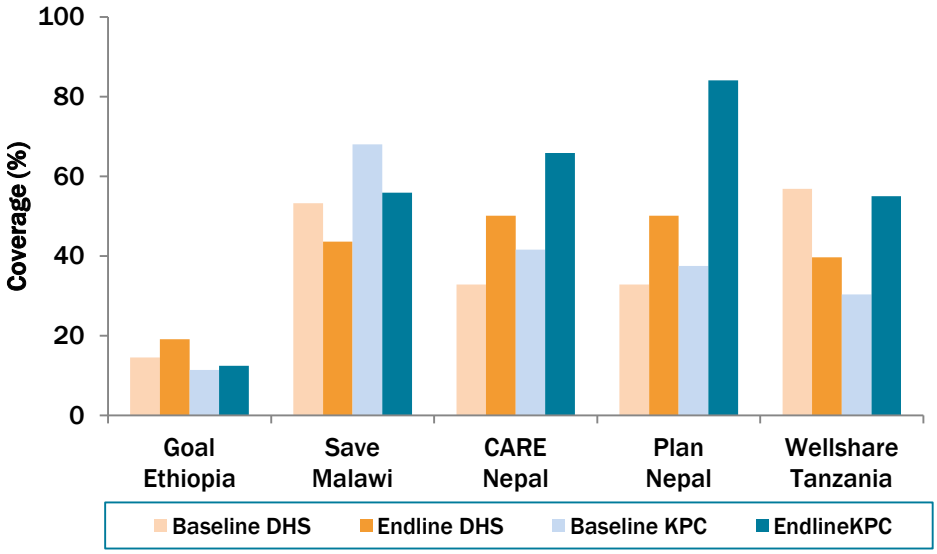
Table 5. KPC 4+ ANC visits non-CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	%Point Δ	Change Sig?
CARE	41.6	(5.3)	65.8	(5.1)	24.2	✓
GOAL	11.4	?	12.4	(6.1)	1.0	
PLAN *	37.5	(4.1)	84.1	(3.1)	46.6	✓
Save	68	?	55.9	(9.3)	12	
Wellshare	30.3	(7.2)	55.0	(7.0)	24.7	✓

* Collected information only from mothers of infants 0-5 months

CARE reported that utilization of ANC services was higher in their project districts than in other hilly or plain areas in Nepal (Nepal DHS 2011). In Nepal, mothers' groups and pregnant women's groups encourage women to attend ANC, and women receive 400 Nepalese rupees if they have four ANC visits. In Tanzania as a whole, while there was a decreasing trend in women attending four ANC visits, **Wellshare** reported a statistically significant increase of 25 percentage points in Karatu District. Their key BCC messages included the importance of ANC visits, and this was reinforced through home visits as well as community activities implemented by TBAs and CORPs. In **GOAL**'s project area, a total of 54% of mothers across the two project woredas reported attending at least two ANC visits (an increase from 34% at baseline) even though those seeking four or more ANC visits did not increase over the life of the project.

Figure 3. 4+ Antenatal Care Visits: A comparison of KPC and DHS data (2006/7–2011)

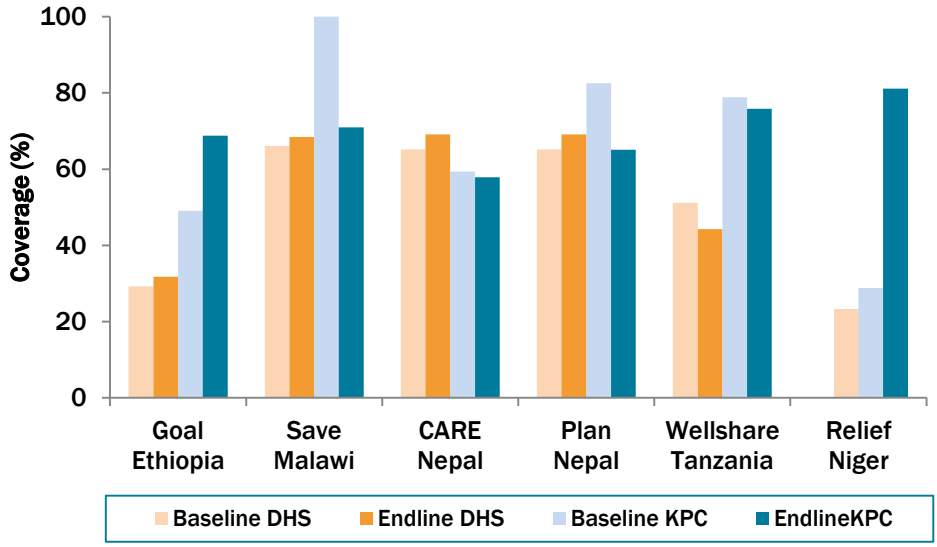


* Plan only collected information from mothers of infants 0-5 months

2. Maternal Tetanus Toxoid Immunization

The percentage of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations prior to the birth of their youngest child

Figure 6. 2+ Maternal Tetanus Toxoid Vaccinations: A comparison of KPC and DHS data (2006/7–2011)



Several projects focused on promoting antenatal care (ANC) and creating links between communities and health facilities for pregnant women. However, most groups did not discuss maternal tetanus toxoid (TT) immunization in their reports as a specific component of ANC in their project areas, nor did many discuss reasons for any changes (or lack thereof) in the TT indicator during their projects. Both grantees reporting significant increases in maternal TT immunization promoted ANC through their CSHGP projects.

The **GOAL** project team stated that increasing the percentage of pregnant women who had two or more antenatal visits was probably the major contributing factor to the increase seen in maternal TT coverage (49% to 69%). In Konni District, Niger, despite several vaccine stock-outs during the four year project period, the government's 2008 policy of free mother and child care and **Relief International**'s community sensitization activities may have contributed to the increased utilization of services, including tetanus toxoid vaccination during pregnancy.

Table 6. KPC 2+ maternal TT CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	59.4	(5.3)	57.9	(5.3)	-1.5	
GOAL	49.1	(9.2)	68.8	(8.6)	19.7	✓
Plan	92.2	(2.3)	65.1	(3.6)	-27.1	
Relief	28.8	(6.9)	81.1	(6.1)	52.3	✓
Save	100	(0.0)	71.0	(5.9)	-29.0	
Wellshare	78.9	(6.4)	75.8	(6.0)	-3.0	

3. Post-Natal Visit

The percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker (e.g., skilled birth attendant [SBA], CHW, or TTBA) within three days of his/her delivery)

Table 7. KPC newborn postnatal visit CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	5.7	(2.5)	46.1	(5.4)	40.4	✓
GOAL*	1.8	(2.4)	3.6	(3.4)	1.8	
Plan	36.4	(4.1)	71.1	(3.9)	34.7	✓
Relief	13.3	(5.2)	10.6	(4.5)	-2.7	
Save	43.7	(7.9)	58	(7.0)	14.3	
Wellshare	27.8	(7.0)	82.5	(5.3)	54.7	✓

* Only included visits that occurred within two days of delivery

Three organizations (**CARE**, **Plan**, and **Wellshare**) that focused on MNC technical interventions increased the newborn postnatal visit indicator in their project areas, and all did so substantially. In Nepal, FCHVs are incentivized with a small payment through the CBNCP to make post natal home visits on the first, third, seventh and twenty-ninth days after delivery, and this was cited by both **CARE** and **Plan** in their final evaluation reports. Additionally, in CARE's project area, a "qualitative evaluation found that the FCHVs were appreciative of the incentive and were spending more time on CBNCP activities." (CARE FE 34) CARE trained and equipped 142 HWs and over 700 community-based health workers/volunteers in CBNCP while also working with husbands and in-laws and obtaining public commitments to adopting positive MNH behaviors.

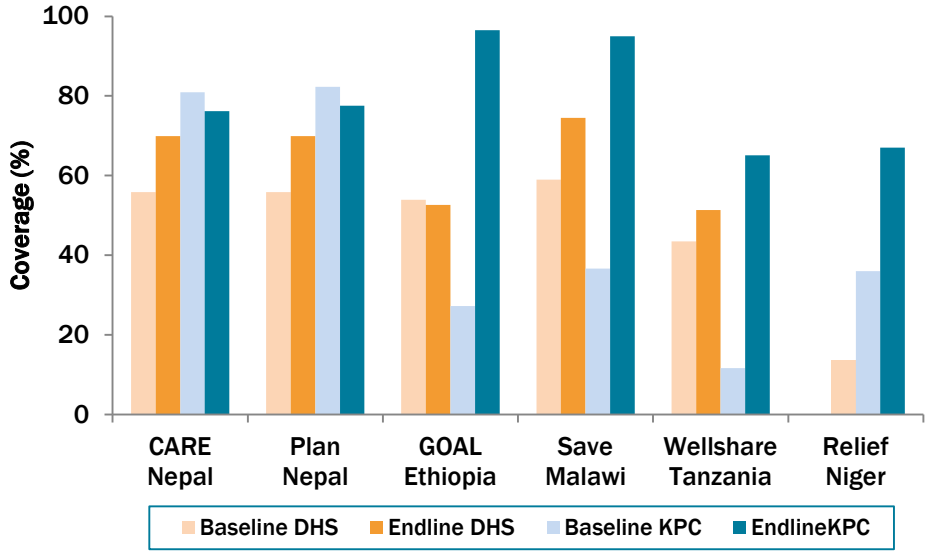
In Malawi, HSAs were trained to make home visits to pregnant women during pregnancy and the first week after delivery, but training did not occur until late in the project (17 of 28 districts had begun training HSAs in 2011), and the increase in newborn postnatal visits was not found to be significant. However, in **Save the Children**'s larger household survey, newborn postnatal visits received within two days of delivery did show a significant increase (from 8% to 31%)[5]. A larger increase was not seen in the three CBMNC focus districts, perhaps because many HSAs did not live in their communities, which limited their ability to make home visits, particularly early PNC visits. Additionally, there was pressure on HSAs to work at health facilities or health posts. In areas implementing community case management (CCM), HSAs were required to staff a health post/village clinic, and in other areas most HSAs spent one to two days a week helping to provide preventive services at some sort of facility, which reduced the amount of time they were able to spend in the community. Training in the CBMNC home visit package lasted ten days, during which HSAs learned to identify pregnant women, make three visits during pregnancy, one visit within 24 hours of childbirth, and PNC visits on days three and eight.

Nutrition

4. Exclusive Breastfeeding (EBF)

The percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours (i.e., who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours)

Figure 5. Exclusive breastfeeding 0-5 months: A comparison of KPC and DHS data (2006/7–2011)



The two organizations that did not report statistically significant increases in exclusive breastfeeding (**CARE** and **PLAN**) had baselines that were higher than 80%. The remaining four projects, which had baselines ranging from 12% to 37%, all reported increases of at least thirty percentage points. Across the board, endline EBF estimates were higher than national estimates. Impressive gains were made in Sub-Saharan Africa (Ethiopia, Malawi and Tanzania) where project areas lagged well behind the national averages but surpassed those averages in 2011. **Relief International** also reported a large increase, but there were not DHS data available for comparison. They did note, however, that their endline estimate was more than twice that found by the national-level Nutrition and Child Survival Survey of June 2010 (27%).

Mother breastfeeding
(GOAL / Ethiopia)

In Awassa Zuria and Boricha woredas in Ethiopia, 1640 Care Groups and 981 community health promoters (CHPs) promoted early breast feeding and mobilized mothers to exclusively breast feed children 0-5 months. Essential nutrition actions (ENA) behaviors were introduced into the Southern Nations, Nationalities, and Peoples Region by previous projects before **GOAL**'s CSHGP project started, but GOAL's SBCC strategy extended promotion of healthy behaviors, including immediate and exclusive breastfeeding and appropriate complementary feeding through repeated home visits conducted by Care Group volunteers.

Table 8. KPC exclusive breastfeeding CATCH indicator results

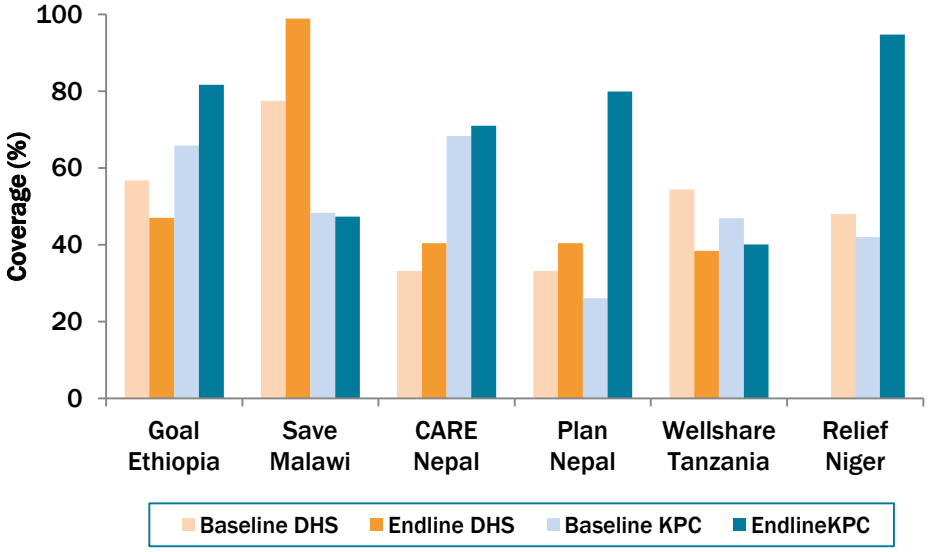
PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	80.9	(7.5)	76.2	(8.3)	-4.7	
GOAL	27.2	(8.2)	96.5	(3.4)	69.3	✓
PLAN	73.4	(5.9)	81.1	(4.2)	7.7	
Relief	36.0	(14.4)	66.7	(12.8)	30.7	✓
Save	36.6	(12.6)	95.0	(5.3)	58.4	✓
Wellshare	11.6	(9.6)	65.1	(12.8)	53.5	✓

Immediate breastfeeding

The percentage of children age 0-23 months who were breastfed within one hour of birth

Many groups that focused on EBF also reported an early/immediate breastfeeding indicator, or the percentage of newborns that were breastfed within one hour of birth, even though it was not part of the Rapid CATCH.

Figure 6. Breastfeeding within one hour of delivery: A comparison of KPC and DHS data (2006/7–2011)



* Plan and CARE only collected information from mothers of infants 0-5 months

** Wellshare and Save included no prelactal feeds in their indicator definition

Plan showed a large increase in immediate breastfeeding although EBF was widely practiced. Interestingly, both immediate and exclusive breastfeeding were common in **CARE**'s project area in the Far Western Region at baseline. **Relief International** reported that the indicator more than doubled in their project area, and at endline they had the highest coverage (95%) reported amongst all those who measured immediate breastfeeding.

Table 9. KPC immediate breastfeeding non-CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE*	68.3	(5.0)	71.0	(4.9)	2.7	
GOAL*	65.8	N/A	81.6	N/A	15.8	?
PLAN	26.1	(3.7)	79.9	(3.4)	53.8	✓
Relief	42	N/A	94.7	N/A	52.7	?
Save**	48.3	(8.0)	47.3	(9.3)	-1.0	
Wellshare**	46.9	(7.9)	40.1	(6.9)	-6.8	

* Collected information from mothers of infants 0-5 months
** Includes no prelactal feeds in their indicator definition

5. Infant and Young Child Feeding (IYCF)

The percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

More could have been included in reports about the IYCF indicator. Grantees – even the three who included nutrition as an intervention area – did not provide much information about changes observed, and yet all three reported statistically significant increases. In **GOAL**'s project area, as mentioned above in the EBF section, volunteers put a large amount of effort into promoting complementary feeding practices. Breastfeeding was almost universal in **Relief International**'s intervention area (although not exclusive breastfeeding), and at endline, breastfed children were more likely to be fed a minimum frequency of meals than non-breastfed children (44% or 138/324 vs. 24% or 8/34). In Relief International's midterm evaluation, a recommendation was made to include activities focused on complementary feeding during the second half of the project since during the first half, Relief primarily focused on immediate and exclusive breastfeeding. However, there were no specific activities detailed in the FE report. The lack of information provided by **CARE** may, in part be due to the project's focus more on the newborn through the CB-NCP and to their nutrition focus only coming in the form of support to the district health office in strengthening implementation of CB-IMCI.

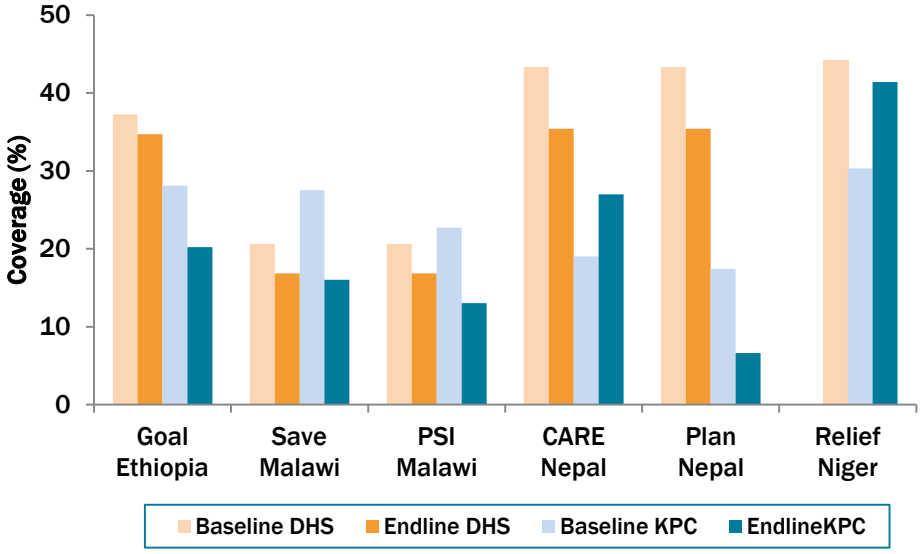
Table 10. KPC infant and young child feeding (IYCF) CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	3.7	(2.6)	15.1	(4.6)	11.4	✓
GOAL	25.4	(8)	57.9	(9.1)	32.5	✓
Relief	38.1	(8.6)	58.6	(8.6)	20.5	✓

6. Underweight

The percentage of children age 0-23 months who are more than two standard deviations below the median weight-for-age according to the WHO/NCHS reference population

Figure 7. Underweight: A comparison of KPC and DHS data (2006/7–2011)



Because malnutrition is a crosscutting area, all projects were considered to have LOE relevant to the CATCH underweight indicator. Neither Concern nor Wellshare, however, collected the indicator at endline, and in general, the indicator was not commented on in final evaluation reports, except in the case of **Relief International**. In their project area, increases in exclusive breastfeeding and complementary feeding practices were reported, but the percentage of underweight children was higher at endline compared to baseline. Relief International attributed this in part to repeated episodes of food insecurity during the project period. In Konni District in 2009, 169 villages were identified by the local government food security watching committee system to have a crop deficit of up to 80%, and in 2009/2010, almost half of Niger's population was estimated to be food insecure. (Relief FE 23) In Nepal, both **CARE** and **Plan** reported baseline and endline estimates below the national average. Plan was the only NGO to report a statistically significant decrease in the indicator, while the indicator reportedly increased in CARE's project area but no explanation was given. In Malawi, both **Save the Children** and **PSI** reported baselines above the national average but endline values at or below the national average four to five years later.

Table 11. KPC underweight CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	19.0	(4.2)	27.0	(4.8)	8.0	
Concern	19.7	(3.3)	N/A	N/A	N/A	
GOAL	28.1	(8.2)	20.2	(7.9)	-7.9	
PLAN	11.9	(2.8)	6.8	(2.1)	-5.1	✓
PSI	22.7	(6.7)	13.0	(4.7)	-9.7	
Relief	30.3	(7.0)	41.4	(7.3)	11.1	
Save	27.5	(7.6)	16.0	(4.8)	-11.5	
Wellshare	27.4	(7.5)	N/A	N/A	N/A	

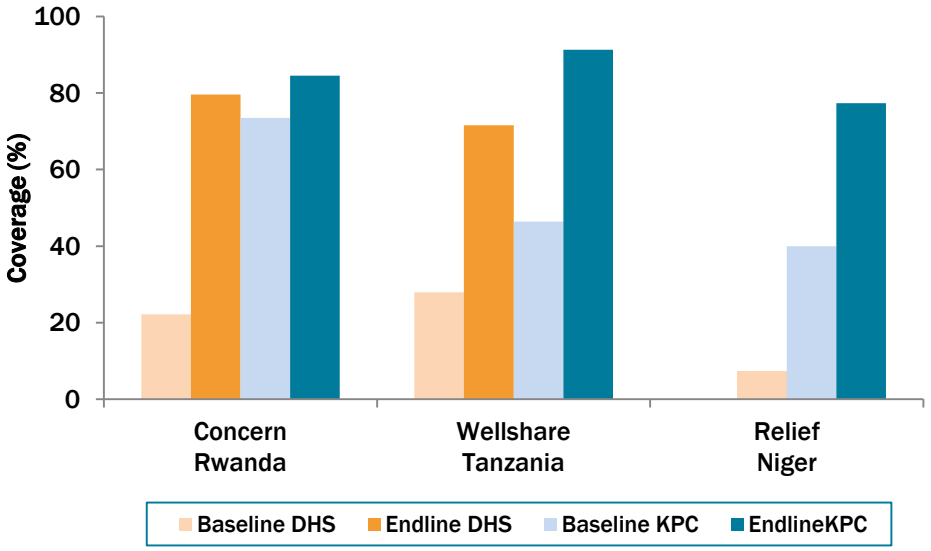
Malaria

There are two malaria-related CATCH indicators that grantees are required to report if working in malaria endemic areas: prompt treatment of children with fever with antimalarials and insecticide-treated net (ITN) use by children. Please keep in mind that seasonality may have played a role in the survey results; survey dates are reported in the report annex.

7. Child Use of Insecticide-Treated Nets (ITNs)

The percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk area, where bed net use is effective) the previous night

Figure 8. Child ITN use: A comparison of KPC and DHS data (2006/7–2011)



GOAL reported that their targeted woredas were located in lowland areas where malaria is endemic year round with an intense seasonal peak around July but that USAID-supported malaria programs are not active in the area because the region as a whole only has "hot spots" of malaria. GOAL worked with the MOH and other organizations to distribute LLINs in both woredas twice – in 2005/06 and again in 2009/2010. Therefore, the MOH expected LLIN ownership to be close to 100% in both woredas, but the figure reported in GOAL's endline KPC report was much lower (42%), and ITN use by children the night before the survey was only 21%, even though the survey took place in August. The results of a separate ITN utilization survey, conducted in August shortly after the KPC survey using the same clusters, showed ownership to be around 83%, almost double the result found in the KPC survey (use, however, was not reported). During GOAL's project, more than sixteen hundred Care Groups and CHPs were trained, conducted home visits, and participated in mobilization efforts highlighting the importance of sleeping under an LLIN. GOAL's efforts to reach every household in which a pregnant woman or young child lived supported the government in addressing inequities in malaria prevention.

The Ethiopian government and partners also conducted several indoor residual spraying (IRS) campaigns in the last years of the project. GOAL participated in the IRS campaigns in addition to the LLIN campaigns but was the only partner intensively working at the household level to increase coverage of key malaria behaviors. As of 2011, household IRS was used almost universally in the two target woredas. LLIN use was still promoted for use in sprayed houses, but the final evaluation reported noted that LLIN and IRS coverage should be considered together to understand malaria prevention behaviors practiced.

In Konni District, Niger, public sector facilities and NGOs implemented large-scale distribution of ITNs. Despite public sector stock outs of nets during the project period, **Relief International**'s BBC activities around peak malaria transmission periods, the increased availability of ITNs in the communities, and net retreatment activities organized by Relief International may have contributed to the 37 percentage point increase in child ITN use.

In Rwanda, LLIN use was promoted by CHWs during home visits and other educational opportunities throughout **Concern Worldwide**'s six targeted districts.

In Karatu District, Tanzania, **Wellshare** promoted ITN use through BCC activities. Karatu also benefited from the national distribution of ITNs to pregnant women and children under-five through the President's Malaria Initiative (PMI) and the Global Fund. At the time of the FE, even though Karatu was no longer a focus area for PMI because malaria prevalence in the district was relatively low overall, reported child ITN use was high (91%).

Table 12. KPC child ITN use CATCH indicator results

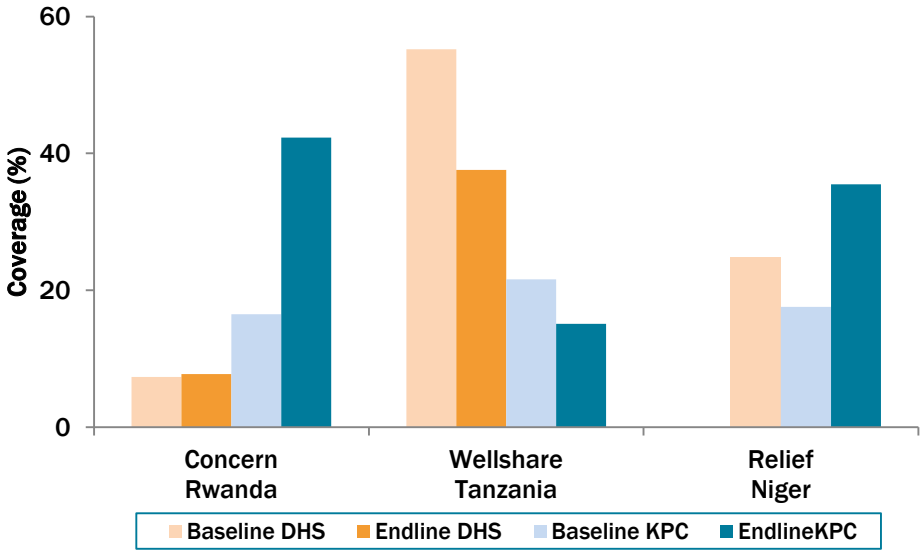
PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern*	73.5	(3.6)	84.5	(6.9)	9.0	
GOAL*	22.8	(7.7)	21.2	(7.5)	-1.6	
Relief	40	(7.5)	77.3	(6.3)	37.3	✓
Wellshare*	46.4	(7.8)	91.3	(4.0)	44.9	✓

* PVOs working in President's Malaria Initiative (PMI) countries

8. Treatment of Fever in Malaria Zones

The percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours of the onset of the fever

Figure 9. Prompt Treatment with Antimalarials: A comparison of KPC and DHS data (2006/7–2011)



* Concern collected data for children 0-59 months

According to the baseline KPC survey implemented in **Concern Worldwide**'s project area, the six targeted districts were already well ahead of the national average in prompt treatment of fever, and by the endline KPC survey, they were even farther ahead. Although malaria was not endemic in two of the six districts targeted by **Concern Worldwide** in Rwanda, in at least parts of the malaria-endemic districts, community-level presumptive malaria treatment was being implemented before the CSHGP project started. CHWs were giving a combination of Amodiaquine/Sulfadoxine and Pyrimethamine until artemisin combination therapy (ACT) was phased in (October 2007).

At the time of the endline KPC survey, rapid diagnostic tests (RDTs) had been almost fully implemented in two districts, while still being phased in in the other four. With the introduction of RDTs and the shift towards diagnostic testing at all levels of the health system, the definition of correct fever treatment changed between the baseline and endline assessments. At endline, correct treatment was defined as "a child with fever who was seen by a trained provider within 24 hours of onset and either given presumptive treatment or tested with an RDT and treated in accordance with the results of the test." Concern noted that children who were tested were more likely to receive correct treatment: "89% of children who had access to an RDT received correct treatment, compared to just 29% of those who were not tested and treated presumptively….Possible explanations for this include recent training and uneven implementation of the RDTs. Some of the cases of incorrect treatment could be children who were referred to a health center but never went. It is also possible that, in areas where presumptive treatment is still the norm, CHWs decided not to give antimalarials to some children with fever who they believe do not have malaria." (Concern FE KPC 16-17) Overall, though, the fever treatment indicator increased significantly from 17% to 44%.

In Awassa Zuria and Boricha woredas, Ethiopia, the increase in prompt fever treatment with antimalarials, from 8% to 20%, was non-significant. During **GOAL**'s CSHGP project, 60 HEWs were trained on the diagnosis of malaria and on how to refer complicated cases. However, the majority of respondents who sought care in GOAL's project area did so from a nurse at a health center, despite HEWs at health posts also having access to anti-malarial treatment. The final evaluation report cited "erratic health post opening times and lack of reliable stocks" as the main reasons for mothers opting to seek care at health centers rather than at health posts.

As of 2011, Niger's national malaria program recommended ACT as first-line treatment, fansidar as second-line treatment, and quinine as third-line treatment. The definition of correct treatment, therefore, changed between the start and end of the project. In **Relief International**'s baseline KPC survey, chloroquine and amodiaquine were included in the indicator's numerator because the new treatment guidelines were still coming into effect. At endline, both chloroquine and amodiaquine were still being provided as treatment for fever but neither was included in the indicator's numerator. Had the numerator included chloroquine or amodiaquine at endline, appropriate treatment would have been 63% (136/216) instead of the reported 36%. Even without chloroquine and amodiaquine included in the indicator's numerator, there was a statistically significant increase in the indicator over the life of the project.

In **Wellshare**'s project area in Tanzania, the indicator did not increase, but a decreasing trend in malaria prevalence and in increasing trend in deaths attributed to pneumonia prompted a shift towards recommending the use RDTs or laboratory tests to confirm malaria before treatment is provided in areas known to have low transmission rates. Wellshare introduced the use of RDTs among health workers to help them distinguish between non-malarial fevers and malaria. After training, health workers were given an initial supply of RDTs, but after they ran out, they had to once again treat fevers without using RDTs because they were not supplied through the health system. Wellshare primarily focused on raising awareness among caretakers to facilitate danger sign recognition and early care-seeking, and while their efforts are not reflected in the fever treatment CATCH indicator, please see the pneumonia care-seeking indicator.

Table 13. KPC prompt fever treatment CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern*	16.5	(4.3)	42.3	(6.6)	27.1	✓
GOAL	7.9	(5)	20.2	(7.4)	12.3	
Relief	17.6	(7.5)	35.5	(8.4)	17.9	✓
Wellshare	21.6	(11.6)	15.1	(9.1)	-6.5	

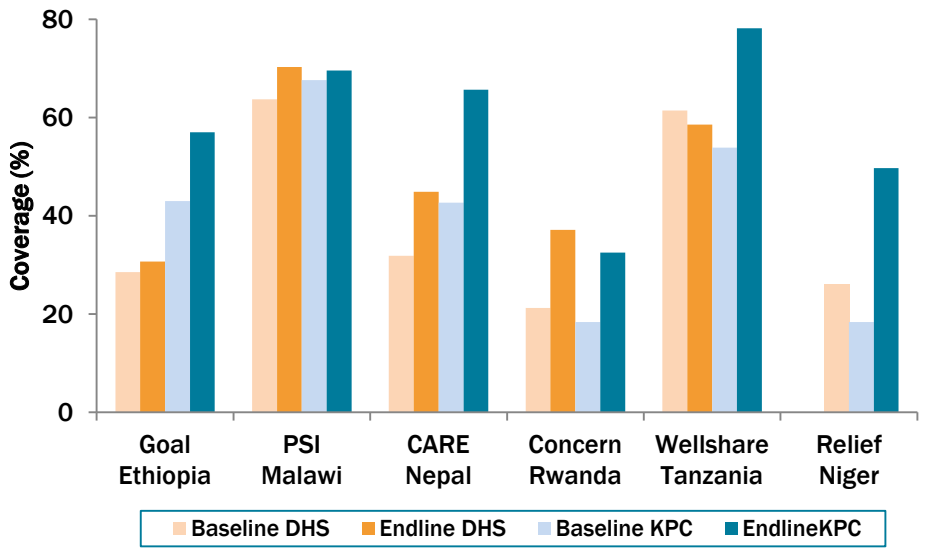
* Collected data for children 0-59 months

Diarrhea

9. Oral Rehydration Therapy (ORT) Use

The percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHFs)

Figure 10. Oral rehydration therapy use:A comparison of KPC and DHS data (2006/7–2011)



* Concern collected data for children 0-59 months

Although the Rapid CATCH indicator looks only at ORT coverage, a few grantees incorporated zinc into their CDD interventions, so when available, information on zinc is included in the narrative below even though it does not directly relate to the indicator.

In Konni District, Niger, there was a statistically significant increase in ORT use, from 18% at baseline to 50% at endline, but **Relief International** stated that ORS coverage could have been (and still could be) further improved if it were distributed directly at the household level through Care Group volunteers. During their project, ORS was only available at health posts. In end-of-project focus group discussions, mothers stated that they were encouraged by Care Group volunteers to seek immediate care at the facilities and to stay away from "self-treatment" when their children became sick.

In Rwanda, care-seeking for diarrhea was consistently lower than for both fever and pneumonia throughout **Concern**'s project, and according to the FE report, progress in CDD was far less impressive than for malaria and pneumonia, perhaps because "insufficient attention" was paid to diarrhea by caretakers. Although the project ORS indicator lagged behind the national figure in 2011, improvement in ORS use (19% to 33%) showed a trend similar to that of the Rwanda DHS. Two positive project results were increases in other CDD-related indicators: increased fluid intake and continued feeding during an episode of diarrhea (which improved from 36% to 61% and from 22% to 57%, respectively).

In addition, treatment of diarrhea with zinc progressed from less than 5% to 22% during Concern's project. International Rescue Committee (IRC) piloted adding zinc to diarrhea treatment in Ngoma and Kirehe districts starting 2005, and the practice was included in all CHW trainings throughout Concern's project. At the time of the endline KPC survey, Rwanda was in the process of introducing new blister packaging for zinc "designed to reduce spoilage, simplify stock management, and improve proper administration. This transition was accompanied by stock outs, at both the facility and community levels as existing stocks began to expire, accounting at least somewhat for the low rate of zinc coverage for children with diarrhea at the time of the survey." (Concern FE KPC 18)

GOAL started training HEWs in their target woredas in the administration of ORS and zinc for diarrhea and supplying health posts with zinc and ORS in May 2009 after zinc was added to Ethiopia's essential drug list. The use of zinc was, therefore, not included in the mid-term or baseline surveys, but at endline, 21% of caregivers who reported that their child had diarrhea stated that they used zinc with ORS to manage diarrhea in the home, while 57% reported using ORS alone.

In Malawi, **PSI** reported ORT coverage similar to that of the DHS. PSI introduced their Thanzi brand of ORS with USAID/Malawi support in 1999, and it "became a well- accepted, widely-used treatment for diarrhea, with steady annual increases in sales." (PSI FE 13) During their CSHGP project, PSI worked on a national scale to distribute Thanzi ORS through commercial outlets and to implement a multi-channeled BCC campaign promoting proper use of their products as well as adoption of improved hygiene and sanitation practices. PSI, in partnership with local NGOs and CBOs, also established community-based distribution channels with field volunteers known as Safe Water and Hygiene Promoters (SWHPs). SWHPs promoted early recognition and treatment of diarrhea with ORS. The final evaluation team noted an increased availability and use of ORS but was concerned with the high production cost of Thanzi ORS as compared to the sale price; during the project, the product was heavily subsidized.

Because the MoH did not see zinc as a priority, PSI's efforts related to zinc supplementation – both including them in diarrhea case management guidelines and including them in their social marketing strategy – were delayed. After the midterm evaluation, though, zinc was approved for inclusion in diarrhea case management guidelines, and PSI helped to pilot zinc through a CIDA-funded CCM project. Although they were unable to do so during their CSHGP project, PSI plans to bundle Thanzi ORS and zinc for social marketing going forward.

In Karatu District, Tanzania, child health messages included continuous feeding and/or breastfeeding during bouts of diarrhea and use of ORS. Although DHS showed a downward trend in ORT, **Wellshare** reported a non-significant increase, from 54% to 78%.

Table 14. KPC oral rehydration therapy use indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	42.7	(13.6)	65.7	(13.9)	23.0	
Concern*	18.4	(5)	32.5	(7.1)	14.1	✓
GOAL	43.0	(9.1)	57.0	(9.1)	14.0	
PSI	67.6	(12.3)	69.6	(12.6)	2.0	
Relief	18.4	(7.7)	49.7	(10)	31.3	✓
Wellshare	53.9	(14.6)	78.2	(12.3)	24.3	

* Collected data for children 0-59 months

10. Point-of-Use (POU) Water Treatment

The percentage of households of children age 0-23 months that treat drinking water effectively (ie. by boiling, chlorination, solar disinfection, or filtration to reduce or eliminate microbiological contaminants)

According to their FE report, increased point-of-use (POU) water treatment was a particularly strong accomplishment of **GOAL**'s project. WaterGuard distribution for treatment of household drinking water began towards the end of 2008 and continued monthly through Care Group volunteers until March 2010 when the social marketing of WaterGuard began. In their baseline KPC survey, water filtration (specifically using a cloth) was the most commonly cited form of water treatment; in the final survey, however, the majority of respondents (74%) reported using WaterGuard to treat their drinking water. GOAL collaborated with PSI, who provided technical assistance and supplies of WaterGuard, to introduce the product and practice of water treatment to the project area. While a network of suppliers was developed, supplies were distributed for free and the ability of families to sustain use through purchases was studied. According to information collected in focus group discussions, mothers stated plan to pay for WaterGuard after the project ends; they know where to buy it and feel it is affordable.

In Konni District, Niger, **Relief International** reported a statistically significant increase in POU water treatment, from 18% to 50%. Their behavior change messages included locally and culturally-appropriate methods for protecting water quality.

PSI promoted two POU water treatment products – a solution and a powder. The WaterGuard liquid safe water solution (SWS) was launched in 2002 using organizational funds, but it was later picked up through USAID's Point of Use Water Disinfection and Zinc Treatment (POUZN) program. The powder, WaterGuard Wa Ufa, PSI's branded PUR, for turbid water, developed by Procter & Gamble (P&G) in collaboration with the U.S. Centers for Disease Control and Prevention (CDC), was launched in 2006 using a P&G grant. PSI's project aimed to "increase levels of self-efficacy and outcome expectations for POU water treatment and related hygiene and sanitation practices." (PSI FE 8) Trained by PSI staff and supervised by field officers, SWHPs sold POU products to their surrounding community. The products were promoted using a nationwide multi-dimensional BCC strategy.

The final evaluation team noted an increased availability of and access to POU water treatment products but was concerned with the high cost of production of WaterGuard relative to the sale price – as they were with Thanzi ORS. The evaluation team recommended that "current and potential new donors consider [continued] subsidies for WaterGuard products especially for vulnerable groups, for inclusion in the hygiene kits and in case of emergencies such as cholera epidemics or during stock outs in the public sector." (PSI FE 9)

In Karatu District, Tanzania, POU water treatment was promoted throughout **Wellshare**'s project area, but WaterGuard and PUR were not consistently available, and the POU indicator did not increase over the life of the project. WaterGuard, while available in larger villages and Karatu, was generally not available in rural communities. POU water treatment was generally limited to boiling water; however, some reportedly did not like the taste of boiled water. There were also beliefs that PUR left a toxic residue. The FE team concluded that to actually increase the POU indicator, it would take much more effort plus significantly increased access to water treatment products and BCC activities to overcome some of the negative perceptions and objections to using those products.

Table 15. KPC point-of-use water treatment CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	14.8	(3.8)	15.5	(3.9)	0.7	
Concern	29.2	(3.9)	63.0	(8.6)	34.8	✓
GOAL	5.3	(4.1)	74.3	(8.1)	69.0	✓
PSI	56	(7.9)	50.9	(7)	-5.1	
Relief	15.2	(5.5)	75.4	(6.3)	60.2	✓
Wellshare	43.5	(7.7)	47.3	(7.0)	3.8	

11. Soap at the place for hand washing

***2006 Indicator*:** **The percentage of mothers of children aged 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing and who washed their hands with soap at least two of the appropriate times during the previous 24 hours**

***2007 Indicator*:** **The percentage of mothers of children aged 0-23 months who live in a household with soap at the place for hand washing**

Soap protection at a hand washing station (PSI / Malawi)

In Niger, **Relief International** reported the promotion of hand washing to be a challenging activity even though they reported a large increase in the associated CATCH indicator. The project adopted a phased introduction of BCC packages. Hand washing messages were introduced during the second year, after MNC and breastfeeding messages, and therefore did not benefit from as much sensitization time. Furthermore, soap and detergent could neither be left in the open air by latrines because birds, hens or domestic animals tended to move or spoil them nor kept inside a container because the soap would melt or dilute in the midday heat. Not least, soap and detergent were costly. To address this last issue, the project began training women in soap making in 2010. The skills training was well-received, and community members expressed interest in continuing the activity. Mothers interviewed also shared that there was much less diarrhea in the community since they adopted more hygienic practices, such as hand washing with soap.

The final evaluation team commended **PSI** for the flexible approach they took working with partners to incorporate water, sanitation and hygiene messages into various existing platforms and for their innovative solutions for day-to-day challenges and problems, such as using the top half of a plastic bottle to protect soap at a hand washing station from being eaten/taken by animals (see photo on the left). However, the team was

concerned by a decrease in the indicators measuring overall hand washing practices, especially those measuring the use of soap. The team recommended that additional research be conducted to better understand this decrease [from 45% to 17%].

In Rwanda, **Concern Worldwide** promoted the use practical options (such as tippy taps for hand washing) complemented by health promotion messages, and at endline, 41% of households visited by Care Groups had a hand washing station, but villagers reported that soap had to be hidden indoors or would be eaten by goats; thus, the soap indicator was only 19% but still higher than baseline (2.5%).

Table 16. KPC soap at the place for hand washing CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	53.5	(5.4)	81.0	(4.2)	27.5	✓
Concern	2.5	(1.3)	18.5	(6.9)	16.0	✓
GOAL	29.8	(8.4)	31.9	(8.6)	2.1	
PSI	45	(8)	16.9	(5.3)	-28.1	
Relief	11.5	(4.9)	23.7	(6.2)	12.2	✓
Wellshare	0.0	(0.0)	18.8	(5.5)	18.8	✓

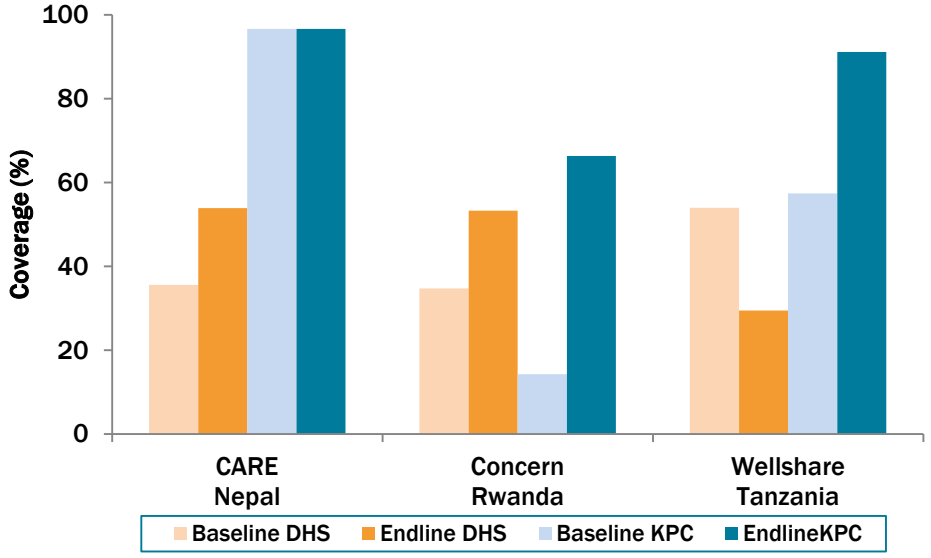
* CARE definition: Percentage of mothers of children age 0–23 months who live in household with soap at the place for handwashing and/or brought the soap by respondents within one minute at the time of interview

Acute Respiratory Infections

12. Pneumonia Case Management

The percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health care provider (i.e., doctor, nurse, auxiliary nurse or CHW trained in CCM of pneumonia)

Figure 11. Pneumonia care-seeking: A comparison of KPC and DHS data (2006/7–2011)



* Concern collected data for children 0-59 months

CCM of pneumonia was phased in during the first two years of **Concern**'s project. In 2007, the MOH approved community-level treatment of pneumonia using Amoxicillin. After CHWs were trained on the use of respiratory timers, treatment began in the project area in 2008. Care-seeking for respiratory symptoms progressed nationally, but KPC survey data indicate an even more substantial increase in the six project districts, from just 13% to 63%, "suggesting that progress in the [project]-supported districts may [have been] responsible for over 40% of the national improvement in the last five years." (Concern FE 14)

In Tanzania, **Wellshare**'s technical interventions for pneumonia included caregiver education to recognize and seek timely medical care for pneumonia symptoms, in addition to exclusive breastfeeding for infants to six months of age and provision of vitamin A every six months. Antibiotics were not available at health posts to treat pneumonia until the last year of the project, but impressive gains were still reported in the care seeking indicator, which at baseline was on par with the national average, but then significantly increased to over 90% while the national average plummeted.

CARE was the only other PVO to specifically focus on pneumonia in their project, supporting the national CB-IMCI package in their project area. At baseline, care-seeking was already high – and well above the national average – and remained so at endline.

Table 17. KPC pneumonia care seeking indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	96.6	(4.8)	94.4	(7.6)	-2.2	
Concern*	14.3	(4.3)	66.3	(8.6)	52.0	✓
Wellshare	57.4	(13.6)	91.1	(10.6)	33.7	✓

* Collected data for children 0-59 months

Immunization

13. Access to Immunization Services (DPT1)

***2006 Indicator*: The percentage of children age 12-23 months who received DPT1 vaccination before they reached 12 months, as verified by vaccination card or mother's recall**

***2007 Indicator*: The percentage of children age 12-23 months who received DPT1 vaccination, as verified by vaccination card or mother's recall**

***DPT: diphtheria-tetanus-pertussis**

CARE was the only PVO to include immunization as a project focus, and although they did, the LOE was limited (5%). Immunization efforts were not specifically discussed in the final evaluation report beyond stating that immunization was a component of the national CB-IMCI package, which CARE supported by assisting the "district health office in integrating, coordinating and monitoring the ongoing program at facility and community level." (CARE FE 6) DPT1 coverage in Doti district increased over the lift of the project; however, it is unclear if it also did in Kailali district because there was an error in reporting baseline DPT1 coverage by mothers' recall.

Table 20. KPC access to immunization services indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE *	85.2	(8.3)	97.6	(3.8)	12.4	✓

* Doti district only; there was an error found in the value reported for Kailali district at baseline

14. Health System Performance (DPT3)

2006 Indicator: **The percentage of children age 12-23 months who received a DPT3 vaccination before they reached 12 months, as confirmed by the child's vaccination card *OR* the mother's recall.**

2007 Indicator: **The percentage of children age 12-23 months who received a DPT3 vaccination, as confirmed by the child's vaccination card *OR* the mother's recall.**

DTP3 coverage is an indicator of the strength of a health system because delivery of DPT3 requires three contacts with the health system at appropriate times, and DPT is generally given through routine national immunization programs rather than campaigns. DPT3 immunization coverage significantly increased in **CARE**'s project area.

By measuring both DPT1 and DPT3, the dropout rate can be calculated. Dropout rates are another measure of the strength of a health system, demonstrating its potential to reach children with the final dose in a series of three vaccinations. While strong health systems guarantee a sufficient number of contacts with children at appropriate times to ensure high coverage with three doses of DPT, weaker systems might be able to reach a child with the first dose in the series, but not the third.

The dropout rate improved from 9.1% at baseline to 6.4% at endline in Doti district as coverage of both DPT1 and DPT3 increased in the district. Overall, the endline dropout rate was 3.2%. See the previous indicator, Health System Access (DPT1), for more information on CARE's immunization activities.

Table 21. KPC health system performance (DPT3) indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	84.7	(6.0)	95.6	(3.6)	10.9	✓

15. Measles Vaccination

The percentage of children age 12-23 months who received a measles vaccination, as confirmed by the child's vaccination card *OR* the mother's recall.

Measles immunization coverage, unlike DPT coverage, did not increase significantly in **CARE**'s project area. See indicator 13, Health System Access (DPT1), for more information on CARE's immunization activities.

Table 22. KPC measles vaccination indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	83.5	(6.2)	86.8	(5.9)	3.3	

Family Planning

16. Adequate Child Spacing

The percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Table 18. KPC adequate child spacing indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Save	90.8	(6.3)	94	(3.7)	3.2	
Wellshare	69.7	(7.2)	82.0	(6.3)	12.3	

In Mzimba District, Malawi, birth spacing was already being practiced by most women at the time of **Save**'s baseline KPC survey (91%).

Family planning (FP) is a national priority in Tanzania, and availability of services and commodities improved during the life of **Wellshare**'s CSHGP project. In Karatu District, Wellshare reported a non-significant 12 percentage point increase in child spacing, but a larger increase in the use of modern FP methods (from 31% to 65%). Child spacing activities focused on increasing demand for modern FP methods. Project BCC messages included the importance of adequate child spacing, the use of modern FP methods and discussing these issues with one's partner. Wellshare integrated FP content into TBA and CORP training. During home visits, TBAs and CORPs conducted FP counseling and referred women and their husbands to health facilities for services. A variety of modern FP methods, including injectables and pills, were available free of charge at government health facilities. Longer-lasting methods were available from Marie Stopes Tanzania's clinic, which experienced sporadic closures during Wellshare's project, but continued to provide outreach services throughout the district. The project demonstrated that mobilized communities and health volunteers working in partnership can lead to substantial increases in the use of modern FP methods by mothers of infants "when the formal health sector is motivated and there is a consistent supply of multiple contraceptive methods."

Concluding thoughts

Overall indicator observations

The utility of Rapid CATCH indicators should be reviewed regularly to ensure relevance to grantee work and resonance with global health efforts. Newer indicators, including IYCF and newborn postnatal visit within three days, both introduced to the Rapid CATCH in 2006 when several of these projects began, have shown positive results. The newborn postnatal visit indicator has subsequently been updated for projects beginning in or after 2008 to capture visits within the first two days of delivery to better align with global efforts. Going forward, there is interest in tracking whether postnatal visits occur at a

facility or at home. Additionally, as malaria RDTs become more prevalent and pneumonia is recognized as a more prominent cause of death (compared to malaria) in many areas, the fever treatment indicator, which currently assumes malaria, needs to be reviewed. Requiring the maternal TT immunization indicator should also be reviewed to determine its purpose since many grantees do not focus efforts on strengthening the supply chain for a service offered through government programs and also since four or more ANC visits became a CATCH indicator in 2008. There were a few CATCH indicators related to project technical intervention areas (e.g., IYCF, underweight, and maternal TT), even if only indirectly, that grantees did not address/comment on at all in their final evaluation reports other than to report the numerical survey results. Specific instructions and/or examples about the kind of details grantees should report may be required if more information is desired.

What have we learned?

As in past years, CSHGP grantees have demonstrated improved health coverage in their project areas. Notable points of learning from this cohort include the following:

1. Government policies can make a difference. For example, in Nepal government policies to pay incentives to both FCHVs and pregnant women and to recruit and train local women to be midwives were cited as key assets to increasing access to and use of SBAs, health facilities for delivery and postnatal care. In this supportive environment, Plan and CARE were able to work with government and community partners to strengthen training efforts and to equip birthing centers.

2. Approaching access from three directions—training providers, building and equipping birthing centers, and increasing community awareness of these services—was correlated with an increased percentage of institutional deliveries and deliveries with skilled attendants in both CARE and Plan's project areas in Nepal. Likewise, in Rwanda, training and equipping CHWs for CCM of diarrhea, malaria and pneumonia while also raising awareness increased care-seeking and treatment coverage among children under five.

3. TBAs were successfully "repositioned" by three grantees (Wellshare, GOAL, and Relief International) to serve as educators, advocates for women, and delivery assistants in emergency situations while also promoting facility deliveries with skilled providers.

4. HEWs and TTBAs helped to ensure clean deliveries in GOAL's project area in Ethiopia where most deliveries occurred at home, while training providers in clean delivery practices and providing clean delivery kits in Relief International's project area in Niger likely increased use of clean delivery kits for facility births.

5. Regular, focused, community-level interactions, including womens' support groups and home visits, between health volunteers and pregnant women and caretakers may have successfully influenced positive behavior change reported in most project areas. For example, such interactions may have successfully encouraged:

    - ANC visits among pregnant women in CARE and Plan's project areas in Nepal and in Wellshare's project area in Tanzania.

    - Exclusive breastfeeding in GOAL's project area in Ethiopia, as well as in Relief's and Wellshare's project areas in Niger and Tanzania, respectively.

6. Grantees found the hand washing with soap indicator difficult to influence and measure because of environmental, cultural and financial factors. To address these barriers, in PSI's project area, an innovative soap cover was used at some hand washing stations to protect the soap from animals, and in Relief International's project area, women were trained in soap making.

7. GOAL successfully introduced WaterGuard as a POU water treatment option in their project area in Ethiopia. WaterGuard use was promoted by Care Group volunteers as free product distribution eventually transitioned to a social marketing approach with technical assistance from PSI. Wellshare also promoted use POU commodities in Tanzania but found that their success was minimized because the products were not readily available throughout their entire project area and more intense behavior change efforts were needed to overcome negative perceptions associated with the products.

8. It seems that net distribution is not enough to encourage use, at least for children under two. Relief International (Niger) and Wellshare (Tanzania) engaged communities in various education and net maintenance activities, which may have contributed to increases reported in net use by children.

For more information, please contact the MCHIP PVO/NGO Support Team at info@mchipngo.net

Final Evaluation Citations

- *Community Responsive Antenatal, Delivery and Life Essential (CRADLE) Support Program (MANASHI) Final Evaluation Report*; CARE; Gopinath, R.; 23 December 2011
  KPC Report by: SOLUTIONS CONSULTANT P. LTD.
  http://www.mchipngo.net/documents/cs_dox/CARE/Nepal/23/FINAL/CARE_Nepal_FE.zip

- *Final Evaluation of the Kabeho Mwana Expanded Impact Child Survival Program*; Concern Worldwide ; Sarriot, E., *et. al.*; 22 December, 2011
  KPC Report by: Langston, A; Jackson, S.; Luz R.
  http://www.mchipngo.net/documents/cs_dox/CONCERN/Rwanda/22/FINAL/CONCERN_Rwanda_FE.zip

- *Sidama Child Survival Project Final Evaluation Report*; GOAL; Capps, J.M.; O'Reilly, S.; Hogan, E.; 23 December 2011
  http://www.mchipngo.net/documents/cs_dox/GOAL/Ethiopia/23/FINAL/GOAL_Ethiopia_FE.zip

- *Local Innovation for Better Outcomes for Neonates (LIBON) Project Final Evaluation Report*; Plan; Maskey, M. K.; Das Shrestha, B.; Dahal, D.; Bahadur Rana, S.; Anand, H.; 23 December 2011
  KPC Report by: Bhakta Khoju, H. (Rural Community Development Society)
  http://www.mchipngo.net/documents/cs_dox/PLAN/Nepal/23/FINAL/PLAN_Nepal_FE.zip

- *Integrated Diarrhea Prevention Program Malawi Final Evaluation Report*; Population Services International; Pacqué, M.; Silungwe, N.; Sambakunsi, T.; 15 December 2011
  http://www.mchipngo.net/documents/cs_dox/PSI/Malawi/22/FINAL/PSI_Malawi_FE.pdf

- *Healthy Start Child Survival Program Final Evaluation Report*; Relief International; Pacqué, M.; 15 March 2012
  KPC report by: Hallarou, M.
  http://www.mchipngo.net/documents/cs_dox/RI/Niger/23/FINAL/RI_Niger_FE.pdf

- *Malawi Newborn Health Program Final Evaluation Report;* Save the Children; Murray, J.; Waltensperger, K. Z.; Gamache, N., et al; 31 December 2011
  KPC Report prepared by: Limbika Vilili, G.; Sangole, N.; Maluwa Banda, D.
  http://www.mchipngo.net/documents/cs_dox/SC/Malawi/22/FINAL/SC_Malawi_FE.zip

- *WellShare International Final Evaluation Report Tanzania Child Survival Project*; Capps, J. M.; March 2012
  KPC report by: Mullins, J.; Augustino, I.; Ehrlich, L. C.
  http://www.mchipngo.net/documents/cs_dox/MIHV/Tanzania/22/FINAL/MIHV_Tanzania_FE.zip

Annex I: CATCH indicators reported but not relevant to project LOE

The CATCH indicators below were discussed earlier in the report for grantees that focused on relevant technical areas. The CATCH indicators below are not associated with grantees' technical intervention areas and, therefore, cannot be linked to project achievement, but the data are shared below as supplemental, reference information. Although grantees did not intervene in these areas, increases could potentially be in indirectly related to project efforts (e.g., overarching cross-cutting and capacity building strategies).

Maternal and Newborn Care

1. Skilled Birth Assistance

Table 23. KPC skilled birth assistance CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	40.2	(4.0)	95.0	(3.9)	54.8	✓
PSI	45	(8)	76.2	(6.0)	31.2	✓

2. Maternal Tetanus Toxoid Immunization

Table 24. KPC 2+ maternal TT CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	84.3	(3.0)	78.9	(7.5)	-5.4	
PSI	42	(7.9)	40.7	(6.9)	-1.3	

3. Post-Natal Visit

Table 25. KPC neborn postnatal visit CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	13.8	(2.8)	30	(8.2)	16.2	✓
PSI	47.0	(8.0)	49.6	(7.0)	2.6	

Nutrition

4. Exclusive Breastfeeding (EBF)

Table 26. KPC exclusive breastfeeding CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	87.7	(5.4)	83.3	(12.2)	-4.4	
PSI	34.7	(15.2)	70.7	(8.8)	36.0	✓

5. Infant and Young Child Feeding (IYCF)

Table 27. KPC infant and young child feeding (IYCF) CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	N/A	(N/A)	N/A	(N/A)	N/A	
PLAN	53.2	(5.5)	72.0	(6.3)	18.8	✓
PSI	31.1	(8.6)	19.9	(8.1)	-11.2	
Save	N/A	(N/A)	N/A	(N/A)	N/A	
Wellshare	25.9	(7.9)	26.6	(7.3)	0.7	

6. Underweight – Not applicable.

All grantees were discussed in the earlier section

Malaria

7. Child Use of Insecticide-Treated Nets (ITNs)

Table 28. KPC child ITN use CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	18.2	(5.9)	73.0	(4.8)	54.8	✓
Concern	73.5	(3.6)	66.7	(8.9)	-6.8	
PSI	81	(6.3)	60.9	(6.8)	-20.1	
Save	61.3	(7.8)	74	(6.7)	12.7	

8. Treatment of Fever in Malaria Zones

Table 29. KPC prompt fever treatment CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	N/A	(N/A)	N/A	(N/A)	N/A	
PLAN	44.8	(8.2)	73.8	(9.8)	29.0	✓
PSI	20	(9.5)	37.1	(8.6)	17.1	
Save	2.3	(2.4)	38	(9.2)	35.7	✓

Diarrhea

9. Oral Rehydration Therapy (ORT) Use

Table 30. KPC oral rehydration therapy (ORT) use CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Plan	34.9	(9.8)	78.9	(10.6)	44.0	✓
Save	11.8	(8.5)	57	(11.3)	45.2	✓

10. Point-of-Use (POU) Water Treatment

Table 31. KPC point-of-use water treatment CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Plan	22.1	(3.5)	20.5	(3.4)	-1.6	
Save	21.2	(19.7)	25	(5.7)	3.8	

11. Soap at the place for hand washing

Table 32. KPC soap at the place for hand washing CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Plan	66.1	(4)	80.3	(3.4)	14.2	✓
Save	1.7	(2)	30	(6)	28.3	✓

Acute Respiratory Infections

12. Pneumonia Care Seeking

Table 33. KPC pneumonia care seeking CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
GOAL	54.4	(9.1)	58.7	(11.1)	4.3	
Plan	41.5	(6.6)	59.9	(11.1)	18.4	✓
PSI	8	(8)	53.7	(15.3)	45.7	✓
Relief	18.2	(7.3)	45.5	(10)	27.3	✓
Save	51.9	(15.4)	75	(11.5)	23.1	

Immunization

13. Access to Immunization Services (DPT1)

Table 20. KPC access to immunization services indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	69.8	(5.6)	100	(0)	30.2	✓
GOAL	84.2	(6.7)	78.6	(7.6)	-5.6	
PLAN	91.6	(3.9)	95.2	(3.5)	3.6	
PSI	68.9	(11.0)	98.3	(3.3)	29.4	✓
Relief	44.5	(11.8)	78.3	(10.4)	33.8	✓
Save	82.1	(10.0)	83.0	(7.4)	0.9	
Wellshare	48.9	(12.1)	77.5	(8.7)	28.6	✓

14. Health System Performance (DPT3)

Table 21. KPC health system performance (DPT3) indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	65.0	(5.8)	100	(0)	35.0	✓
GOAL	65.8	(8.7)	63.4	(8.9)	-2.4	
PLAN	52.5	(6.9)	88.9	(5.1)	36.4	✓
PSI	66.7	(11.2)	90.6	(7.5)	23.9	✓
Relief	28.5	(10.7)	40.8	(12.4)	12.3	
Save	74.0	(7.0)	79.0	(8.0)	5.0	
Wellshare	54.2	(12.1)	71.3	(9.4)	17.1	

15. Measles Vaccination

Table 22. KPC measles vaccination indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
Concern	91.9	(3.3)	100.0	(0)	8.1	✓
GOAL	72.8	(8.2)	78.1	(7.6)	5.3	
PLAN	82.2	(5.3)	87.5	(5.4)	5.3	
PSI	72.6	(10.6)	91.5	(7.2)	18.9	✓
Relief	29.9	(10.8)	49.7	(10.1)	19.8	
Save	84.8	(9.4)	87.0	(6.6)	2.2	
Wellshare	85.5	(8.5)	94.4	(4.8)	8.9	

Family Planning

16. Adequate Child Spacing

Table 34. KPC adequate child spacing indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	N/A	(N/A)	N/A	(N/A)		
Concern	78.5	(3.8)	87.5	(6.6)	9.0	
GOAL*	N/A	(N/A)	N/A	(N/A)		
PLAN	N/A	(N/A)	N/A	(N/A)		
PSI	77.9	(7.4)	77.8	(6.5)	-0.1	
Relief	N/A	(N/A)	N/A	(N/A)		

* Collected data on a 33 month birth interval

Vitamin A/Micronutrients

17. Child Vitamin A

***2006 Indicator*:** The percentage of children age 6-23 months who received a dose of Vitamin A in the last six months by the mother's recall

***2007 Indicator*:** The percentage of children age 6-23 months who received a dose of Vitamin A in the last six months as verified by health card or mother's recall

None of the eight projects had a designated level of effort in vitamin A supplementation; therefore, the CATCH indicator associated with this technical intervention area cannot be link to project achievement, but the data are shared below in tables as supplemental, reference information. Although grantees did not intervene in this area and they cannot be linked to project achievements, increases could potentially be in indirectly related to project efforts to improve communities' access to health services.

Table 19. KPC child vitamin A supplementation CATCH indicator results

PVO	Baseline (%)	CI (%)	Endline (%)	CI (%)	% Point Δ	Change Sig?
CARE	71.5	(6.5)	40.5	(6.4)	-31.0	(-)
Concern	65.8	(4.5)	80.0	(8.3)	14.2	✓
GOAL	67.5	(8.6)	72.6	(8.2)	5.1	
PLAN	80.0	(4.4)	85.3	(4.9)	5.3	
PSI	65.8	(8.8)	76.9	(8.6)	11.1	
Relief	10.7	(5.5)	73.3	(7.7)	62.6	✓
Save	76.1	(8.6)	83.0	(5.8)	6.9	
Wellshare	53.9	(9.1)	88.9	(5.5)	35.0	✓

Annex II: Detailed baseline and endline KPC survey information

PVO	Sampling Method	Baseline Denominator	Baseline Dates	Endline Denominator	Endline Dates	Notes
CARE	Cluster	660	3/2008	660	3/2011	30 villages x 11 HHs x 2 districts
Concern	LQAS	570	2-3/2007	120 (well) 395 (sick)	6-7/2011	BL: 6 dist x 5 SAs x 95 HHs EL: 6 dist x 20 HH (well), 61-74 HH (sick) Well-child (0-23 mo); Sick-child (0-59 mo)
GOAL	LQAS	114	2/2008	114	8/2011	6 SAs x 19 communities
PLAN	LQAS	532 (2 dist) 133 (Bara)	2/2008 (2 dist) 6/2006 (Bara)	532 (2 dist) 133 (Bara)	6-7/2011	35 SAs x 19HHs Parsa: 13 SAs=247 (2007 CATCH) Sunsari: 15 SAs=285 (2007 CATCH) Bara: 7 SAs=133 (2000+ CATCH)
PSI	Cluster	300	2-3/2007	391	6-11/2010	3-stage stratified cluster sampling Baseline KPC survey in Salima District Endline data extracted from 2010 DHS in Salima District
Relief	Cluster	330	1/2008	358	9/2011	BL: 30 clusters x 11HH from 453 villages in target district EL: 30 clusters x 12HH from 61 focus villages
Save	Cluster	300	2/2007	450	6/2011(?)	BL: 30 Clusters x 10 HHs EL: 45 Clusters x 10 HHs Over-sampled 15 clusters in the Ekwendeni catchment area 22 from Ekwendeni area, 23 from non-Ekwendeni area
Wellshare	Cluster	340	2-3/2007	390	6/2011	BL: 34 clusters x 10HHs EL: 30 clusters x 13HHs