AID/W
PD-ABI-725

AMENDMENT NO. 6

A.I.D. Project No. 367-0157

Child Survival/Family
Planning Services

The Project Grant Agreement, No. 367-0157, dated June 29, 1990 between His Majesty's Government of Nepal ("HMG/N" or "Grantee") and the United States of America, acting through the Agency for International Development ("A.I.D."), was last amended on April 30, 1993. The Project Grant Agreement is hereby further amended as follows:

1. To increase the life-of-project funding by $800,000, to increase the obligation by $1,050,000 (Attachment 1 hereto), to extend the Project Assistance Completion Date by an additional two years, and make other modifications to the Agreement.

2. On page 1, Article 2, Section 2.2(a), Incremental Nature of Project, delete the first sentence and insert in lieu thereof the following:

   "A.I.D.'s contribution to the Project, which is planned at Twenty-Three Million Three Hundred Thousand U.S. Dollars ($23,300,000), will be provided in increments."

3. On page 2, Article 3, Section 3.1, The Grant, delete the first sentence and insert in lieu thereof the following:

   "To assist HMG/N to meet the costs of carrying out the Project, A.I.D., pursuant to the Foreign Assistance Act of 1961, as amended, agrees to grant HMG/N under the terms of this Agreement an amount not to exceed Sixteen Million Forty-Three Thousand Two Hundred Forty-Three U.S. Dollars ($16,043,243), hereinafter referred to as the 'Grant'."

4. On page 2, Article 3, Section 3.3, Project Assistance Completion Date, delete "July 15, 1995", and in its place insert "July 15, 1997".

5. "Program Description" of Vitamin A Component in Annex 1, Amplified Project Description, is revised in its entirety and an amended "Program Description" is substituted in lieu thereof (Attachment 2 hereto). In addition, "Attachment A", Illustrative Financial Plan, to Annex 1, is deleted in its entirety and an amended "Attachment A" is substituted in lieu thereof.

6. Except as specifically amended herein, the Project Grant Agreement, as previously amended on September 24, 1990, June 10, 1991, August 28, 1991, August 31, 1992, and on April 30, 1993, shall remain in full force and effect.

IN WITNESS WHEREOF, His Majesty's Government of Nepal and the United States of America, each acting through its respective duly authorized representatives, have caused this Amendment to be signed in their names and delivered as of the date last written below.

ON BEHALF OF HIS MAJESTY'S GOVERNMENT OF NEPAL	ON BEHALF OF THE UNITED STATES OF AMERICA
BY: for R.P. Bhattarai Thakur Nath Pant	BY: Gerald R. Johnston
TITLE: Secretary Ministry of Finance	TITLE: Acting Director USAID/Nepal
DATE: August 5, 1993	DATE: 5 Aug 93

Attachment 1

Child Survival/Family Planning Services Project - Grant Agreement

Illustrative Financial Plan

(in U.S. $)

Category	LOP	Increase in LOP	Adjustment	Revised LOP	Obligation Thru A#5	Adjustment	Revised Obligation	This Obligation	Total Obligation
ical Assistance	7,683,655	689,167	250,000	8,622,822	7,683,655	-	7,683,655	889,167	8,572,822
ing	1,407,000	-	(37,000)	1,370,000	850,000	(37,000)	813,000	-	813,000
dities/Supplies	4,192,070	-	-	4,192,070	1,075,967	(50,000)	1,025,967	-	1,025,967
Cost Support	4,344,000	-	(100,000)	4,244,000	2,421,562	(100,000)	2,321,562	-	2,321,562
Support	-	110,633	567,000	677,633	-	567,000	567,000	110,633	677,633
uction	796,000	-	-	796,000	677,784	-	677,784	-	677,784
ations	200,000	-	-	200,000	100,000	-	100,000	-	100,000
	75,000	-	-	75,000	40,000	-	40,000	-	40,000
tion	1,285,000	-	(574,000)	711,000	274,000	(274,000)	-	-	-
NGO/PVO & CA	1,764,275	200	50,000	1,814,475	1,764,275	-	1,764,275	50,200	1,814,475
ngency	753,000	-	(156,000)	597,000	106,000	(106,000)	-	-	-
PROJECT COST	22,500,000	800,000	-	23,300,000	14,993,243	-	14,993,243	1,050,000	16,043,243

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Attachment 2

AMENDED ANNEX 1

AMPLIFIED PROJECT DESCRIPTION

CHILD SURVIVAL/FAMILY PLANNING SERVICES

VITAMIN A COMPONENT

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ACRONYMS

AID	Agency for International Development/Washington
AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
DANIDA	Danish International Development Agency
DCPO	Dana Center for Preventive Ophthalmology
DPHO	District Public Health Office
FAO	Food and Agriculture Organization of the United Nations
FCHV	Female Community Health Volunteer
FHA/PVC	Food and Humanitarian Assistance/Private Voluntary Cooperation
HKI	Helen Keller International
HMG	His Majesty's Government
HP	Health Post
IMPACT	Food and Nutrition Monitoring Project
IU	International Units
MCH	Maternal and Child Health
MIS	Management Information System
MLD	Ministry of Local Development
MOA	Ministry of Agriculture
MOEC	Ministry of Education and Culture
MOH	Ministry of Health
MUAC	Mid-upper Arm Circumference
NCP	National Commission on Population
NGO	Non-governmental Organization
NNIPS	Nepal Nutrition Intervention Project, Sarlahi
NNJS	Nepal Netra Jyoti Sangh
NPC	National Planning Commission
OA	Ophthalmic Assistant
PHC	Primary Health Care
PVO	Private Voluntary Organization
R&D/N	Bureau of Research and Development, Office of Nutrition
SCF	Save the Children Federation
TAG	Technical Assistance Group
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development/Nepal
VACSP	Vitamin A Child Survival Project
VDC	Village Development Committee
VHW	Village Health Worker
VITAL	Vitamin A Field Support Project
VITAP	Vitamin A Technical Assistance Project

ANNEX 1

I. EXECUTIVE SUMMARY

A. INTRODUCTION AND BACKGROUND

During recent years three different research projects have been conducted in Nepal to look at the impact of vitamin A on child health and mortality. The three studies were based on different approaches and assumptions. The Vitamin A Child Survival Project (VACSP) was implemented in seven districts in the terai, while each of the other two studies (NNIPS I and Jumla) were implemented in single districts in the terai and hills, respectively. The findings of all three studies showed a significant decline in vitamin A mortality rates for children 6-60 months through vitamin A supplementation using high-dose (200,000 IU) capsules.

Consistent with two earlier national surveys, these studies also found a consistently high prevalence of vitamin A deficiency in the study sites. The prevalence of the vitamin A deficiency is not uniform throughout the country, and region-specific prevalence is not clearly defined. However, an unacceptably high prevalence (see annex 1) of vitamin A deficiency was found in the terai region of the country where nearly 50% of the target population lives. This high prevalence and the success of interventions in addressing the problem has encouraged the government of Nepal (HMG) to implement a National Vitamin A Deficiency Prevention and Control Program.

The data generated during the implementation of the three studies were presented and discussed among HMG, national and international agencies during a workshop held in Kathmandu February 11-12, 1992. During the workshop HMG expressed its commitment to implementation of a multi-sectoral national program for the prevention and control of vitamin A deficiency, involving various sectors and ministries (Agriculture, Education, Local Development), and lead by the Ministry of Health (MOH).

At present, 200,000 IU vitamin A capsules are supposed to be available for treatment at the health post level in 45-50 districts as a part of regular MOH activities. The recommendation of the National Workshop was that capsules be delivered throughout the country, on a preventative basis, through the use of female Community Health Volunteers (FCHVs), as the interim phase of a long-term strategy to prevent and control vitamin A deficiency.

B. OBJECTIVES

The primary objective of the program is to reduce child mortality and reduce vitamin A deficiency to a level that no longer constitutes a public health problem through dietary supplementation of high-dose vitamin A capsules, and to institutionalize the skills of MOH staff in recognition of xerophthalmia and provision of vitamin A for case treatment.

The secondary objective is to bring about a change in dietary behavior of the target group through nutrition education, increased home production, consumption and preservation of vitamin A-rich foods, proper breastfeeding and child feeding practices.

C. VITAMIN A PROGRAM STRATEGIES

Three program implementation strategies have been identified to address vitamin A deficiency in Nepal:

- Dissemination of vitamin A capsules, treatment protocols and xerophthalmia recognition cards to all hospitals, health centers, health posts and clinics throughout the country to assure treatment of clinical cases;

- Distribution of high-dose vitamin A capsules to children on a semi-annual basis as a preventative measure; and

- Changes in dietary behavior through nutrition education, increased maternal literacy, improved breastfeeding and child feeding practices, and increased production and consumption of vitamin A-rich foods.

The national program will initiate and implement the three strategies concurrently with the expectation that the second strategy will be gradually phased out as the long term strategy takes effect.

Field-level implementation will involve prophylactic supplementation of high-dose vitamin A capsules, in concert with nutrition education, to enable mothers to meet the daily requirements of children through locally available food sources. These two approaches will be implemented together as a single package for reducing vitamin A deficiency. Efforts will focus on areas with the highest prevalence rate of xerophthalmia. Depending upon the degree of reduction of xerophthalmia the capsule distribution component may be withdrawn while the long term strategy, nutrition education, kitchen gardens, and maternal literacy will continue. Treatment for clinical cases will continue to be provided as part of the general delivery of acute health care services.

In accordance with the recommendations of the vitamin A workshop and the National Health Policy of HMG of Nepal the control of vitamin A deficiency will be achieved through a multi-sectoral approach which will mobilize not only different ministries of the government, but also various non-governmental organizations (NGOs), private voluntary organizations (PVOs), and donor agencies.

USAID will provide technical assistance and support for the national program through a Vitamin A Technical Assistance Group (TAG), which will work under the direction

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of the Nutrition Section of the MOH, to assure implementation of this program.

II. ACTIVITY DESCRIPTION

The national vitamin A program will include three basic activities (capsule distribution, case treatment and nutrition education). Several additional activities will be coordinated by the Technical Assistance Group (TAG) and Nutrition Section, and will be implemented by NGOs, PVOs and other agencies. In accordance with the recommendation of the National Vitamin A Workshop, basic activities will be conducted in every priority district while additional activities which will be implemented whenever resources are available and where supporting agencies agree to collaborate.

A. BASIC AND ADDITIONAL ACTIVITIES

Basic activities will be implemented through existing MOH staff, through technical assistance from USAID and other donors.

- Prophylactic supplementation of high-dose vitamin A capsules semi-annually, according the following schedule:
  Baisak (April/May) during the peri-measles season and before the beginning of the high-risk season for xerophthalmia.

  Post-Tihar (October/November) prior to the harvest season, to boost vitamin A stores for the accelerated growth that often follows.

- Case treatment with vitamin A capsules of xerophthalmia, measles, severe malnutrition, and severe diarrhea, in accordance with WHO/UNICEF/IVACG guidelines.

- Nutrition education activities and promotion of home gardening to be carried out utilizing various communications media, including community-level health workers and DPHO and health post staff.

Additional activities will be implemented through the staff of supporting ministries, NGOs and PVOs (e.g., Swiss Red Cross, CARE, Save the Children/UK and US, Seva Foundation, Helen Keller International, Christofel Blindenmission). USAID will provide support for these activities through grants and will monitor implementation approaches and experience to assess their suitability for incorporation into the long-term strategy.

- Maternal literacy will be promoted as much as possible in coordination with District Education Offices, NGOs and PVOs.

- Expansion of dietary supplementation to older children 61-120 months), as recommended by the national vitamin A workshop.

- Promotion of food production and preservation activities to increase the availability and consumption of vitamin A-rich foods by the target population.

- Treatment of vitamin A-related diseases and promotion of immunization.

B. TARGET POPULATION AND DOSAGE

The target population for the national vitamin A program is children 6-60 months. In accordance with international guidelines, the following preventative treatment protocol will be used:

Children 6-11 months	one oral dose of 100,000 IU two times per year during campaign
Children 12-60 months	one oral dose of 200,000 IU two times per year during campaign

Special emphasis will be given during the semi-annual campaigns to severely wasted children, in order to be sure they receive the vitamin A, and that their mothers receive special training from the FCHV.

Although international guidelines recommend that post-partum women be delivered a high-dose supplement within one month of delivery, this target population will not be included in the Nepal national program at the outset. It is, however, recommended that this important target group be added at the first possible opportunity, to help to assure adequate vitamin A status in lactating women and their breastfed children under six months.

Case treatment with vitamin A will be in accordance with the following WHO/UNICEF/IVACG guidelines:

Severely ill children (measles, acute or prolonged diarrhea) will be treated with a single oral dose of 200,000 IU (100,000 IU for children 6-11 months). This dose should not be given to children who have already received a high-dose vitamin A supplement within the preceding month.

All children with night blindness or other clinical signs of xerophthalmia:

- One dose immediately upon diagnosis
- One dose the following day

- One dose four weeks later

The target population for the nutrition education activities and promotion of kitchen gardens will be mothers of children 6-60 months as well as pregnant and lactating women. This population will also be the priority target for adult literacy and post-literacy activities.

C. IMPLEMENTATION

1. Public Health System

The program will be implemented through the existing infrastructure of the primary health care (PHC) network utilizing the District Public Health Offices (DPHO), Health Posts, Village Health Workers (VHWs), Maternal Child Health (MCH) workers and FCHVs. In addition, case treatment will be provided by hospitals, health posts, PHC centers and clinics.

In accordance with the long term strategy, these activities will become part of the routine activities of the MOH system. At the district level, NGOs and organizations working on nutrition or vitamin A-related activities will also be involved as facilitators for the PHC system and will collaborate and coordinate with the DPHO offices.

The key personnel for delivery of the vitamin A activities to the community will be VHWs, MCH workers and FCHVs. The FCHVs will implement the basic activities under the supervision of the VHWs, and MCH workers will also be involved in the program depending upon their availability.

In regions where FCHVs are not active, alternative delivery systems may be utilized, possibly utilizing Village Health Workers or Maternal Child Health Workers, through targeting population concentrations, or through NGO programs working in the district. These alternative systems will be determined during planning sessions at the district level.

No additional staff will be placed at the district or health post level. Temporary technical assistance for implementation, training and supervision will be provided for to assure that DPHO staff have the skills required to sustain the program as part of their regular district-wide health care activities. Technical support will be terminated in each district, when it is not longer require.

2. NGOs, PVOs and Other Field Projects

NGOs can provide important contributions to the national program by introducing small scale sustainable innovations, especially in non-priority districts and in non-health sectors. In particular, they can conduct pilot projects from which follow-on

activities can be planned. As stated in the Eight Five-Year Plan (1992-1997) by the National Planning Commission, the government's approach will be to rely increasingly on the initiative, enterprise and innovation in the private sector and non-governmental organizations. In accordance with this approach, the MOH will seek the involvement of NGOs and other field project to provide technical support for the national program. All NGOs willing to follow the guidelines set by the Nutrition Section will be encouraged to participate in the control of vitamin A deficiency through coordination with the DPHOs. Some NGOs have developed extensive and effective delivery networks that could be used as entry points for distribution of vitamin A capsules, to create awareness through education of mothers about the importance of vitamin A, and to encourage increased production, preservation and consumption of foods rich in micronutrients.

To increase the number of districts which can be covered by the national program, the Nutrition Section will rely on NGOs such as NNJS, HKI, CARE, Save the Children US and UK, and United Mission to Nepal to assist in program implementation. USAID will provide small grants to NGOs interested in developing complementary vitamin A program interventions, in particular for intervention strategies which contribute to the long term objectives of increased production and consumption of vitamin A-rich foods. These NGOs will be informed of the national policy guidelines for implementation, and will be coordinated at the central level to assure collaboration with the national strategy. Regular meetings will be held to disseminate findings from the intervention strategies used by NGOs, to share program experiences and lessons learned, and to assure close coordination with the national program.

D. TARGET AREAS

The target area for the case treatment with vitamin A is all hospitals, Health Posts, PHC centers and clinics throughout the country.

The short-term strategy has a phased implementation process over the following five years in 33 priority districts identified by the MOH. Among these 33, selection of priority districts for phased implementation will be made according to the following criteria:

1. Prevalence of xerophthalmia.
2. Population of target children.
3. Presence of FCHVs already trained in the district.
4. Presence of active NGOs and other projects to support activities.
5. Activities of other ministries which are complimentary to MOH plan.

Existing prevalence data indicates that the highest rates of xerophthalmia are in the terai region, where the highest concentrations of the target population are found. In accordance with the above criteria, the program will begin in the central terai and

expand eastward and westward in the following years. An assessment will be conducted in the Far and Mid-western regions to prioritize and revise the list of districts which will added over time.

The national program intends to expand the coverage of the program throughout the country over the long term.

E. PLANNING AND COORDINATION

The success of the long term objectives of the national vitamin A program will rely on the close collaboration and support from multiple sectors of HMG and other agencies and organizations working in Nepal. Several critical components of the long term strategy will require significant efforts from non-health sectors, including literacy training, increased agricultural production and preservation of vitamin A-rich fruits and vegetables and integration of nutrition education into agriculture and education curricula. The National Planning Commission (NPC) will play the lead role in assuring collaboration between ministries, through regular planning meetings. The Technical Assistance Group (TAG) and Nutrition Section will work closely with the National Population Commission (NPC) to mobilize vitamin A activities in non-health sectors and with UNICEF and FAO to assure coordination of activities.

An initial planning meeting will take place in Kathmandu during February 1993 to orient central level staff of the MOH, collaborating ministries, NGOs, PVOs and donor agencies to the implementation strategy of the national vitamin A program. The purpose of the meeting will be to deliver a well-coordinated program package to the district level. Working sessions will be held to encourage each sector to identify strategies to provide support and implementation methods for the national program. A working session for NGOs and PVOs will be held to coordinate their vitamin A activities with the MOH program and to identify related activities (e.g., agriculture, health education, literacy, community development) that may be on-going in districts not included in the priority 33.

Coordination with NGOs working in districts not included in the priority 33 will also allow implementation of vitamin A activities to begin in these regions. For example, Save the Children is conducting vitamin A activities in Gorkha district, which is not among the 33; United Mission of Nepal is conducting a nutrition program in Lalitpur district. Charitable organizations such as Rotary, the Jaycees, and the Lions clubs may be tapped to provide support services for MOH vitamin A activities. Coordination among these groups and with the Nutrition Section can enhance the national program and provide lessons learned for future expansion into these districts.

The first orientation and planning meeting will be followed by annual planning and review meetings to present the results of monitoring, progress toward program objectives, and to modify or redirect program activities.

Planning for implementation will be conducted at the district level in collaboration with DPHO staff. This will allow multi-sectoral district level staff to be involved in implementation from the beginning, will allow planning to take place at the same time as district level training, and will enhance the sustainability and commitment of district level staff to the national program.

District level planning will be especially important for districts in the hill regions. Where most FCHVs are not currently active alternative distribution systems will have to be utilized, such as through the EPI program, through outreach clinics, in specific sites where populations are clustered, etc.

F. TRAINING

Training of MOH staff will be a very important component of the national vitamin A program, and will be conducted on an on-going basis through out the program.

It is expected that training will increase the awareness of staff at all levels about the importance of vitamin A to child health and survival, thus assuring commitment at all levels to sustained program intervention. At the central level training of Nutrition Section staff will be provided to strengthen the capacity of staff to monitor, supervise and over the five year period take over management of the national program. At the district level, training will increase the motivation of staff to provide the necessary supervision to assure implementation. And at the health post level, it is expected that regular supervision, support and training will enhance the FCHVs stature in the community, her ability to perform her work adequately, and serve as an incentive to perform not only the vitamin A activities, but her other community health responsibilities as well.

Training will be conducted at a variety of levels:

Central Level

Training in monitoring, supervision and data analysis as monitoring and assessment data becomes available.

Training of trainers. A cadre of multi-sectoral trainers will be drawn from collaborating ministries, the Institute of Medicine, and the Institute of Community Health, FAO's training program, etc., to receive training in training methodologies and vitamin A intervention strategies. This cadre will serve as trainers for district-level staff.

District Level

Immediately following the initial implementation planning meeting, vitamin A capsules, treatment protocols and xerophthalmia recognition cards will be distributed to all

hospitals, health posts, PHC centers and clinics. At the first opportunity training in the importance of vitamin A nutrition for child health and survival will be conducted, as well as orientation to the national program, during central meetings of DPHO Officers-in-Charge.

For each district:

Initial training and planning, prior to first capsule distribution - 7 days; 25-30 district-level staff; multi-sectoral team of trainers.

Content: General vitamin A nutrition, case treatment, monitoring and supervision, planning for implementation

Annual training/planning meeting to present monitoring data and modify implementation plan - 3 days; 25-30 district-level staff; multi-sectoral team of trainers.

Health Post Level

For each Health Post:

Initial training, prior to first capsule distribution - 3 days; 45-50 VHWs and FCHVs; multi-sectoral team of trainers.

Content: General vitamin A nutrition, capsule distribution, food sources, promotion of production and use in child feeding.

Semi-annual refresher training to present monitoring data, go over techniques and provide contact and support for community-level workers. 2 days/year; 45-50 VHWs and FCHVs; Health Post and DPHO trainers.

Vitamin A nutrition training will be added to the regular VHW and FCHV training, held annually at the Health Post level. Special focus will be given to training in nutrition education, especially as, over time, the FCHVs' skills in supplementation become strong and require less attention. Strong nutrition education skills will allow them to give appropriate information to mothers regarding child-feeding practices.

For NGOs, PVOs, other agencies

Training will be made available to NGOs, PVOs and other agencies interested in working to improve vitamin A nutriture through a coordinating group under the direction of the Nutrition Section and the Technical Assistance Group (TAG). Training will focus on increasing awareness of the importance of vitamin A for child health and survival, developing interventions which address the long-term objectives of the

national program, capsule treatment and distribution protocols, and developing mechanisms to support district and community level vitamin A activities.

G. SUPERVISION

The supervision for MOH vitamin A activities will be conducted as part of the regular program of the PHC network. In the initial years, additional supervision will be provided by Technical Assistance Group (TAG) personnel, as and when necessary. In addition, the Technical Assistance Group (TAG) will provide coordinating, trouble-shooting and institution-building support at the district level during the initial years, to facilitate transfer of skills to district-level staff and collaboration between central and district levels for monitoring and supervision. Supervision of field activities by Technical Assistance Group (TAG) staff will be phased out as complete supervision for activities is assumed by MOH staff, over the five year period.

In order to assure that NGO and PVO programs for vitamin A capsule distribution conform to the protocols and strategies of the MOH national program, an NGO coordinating body will be established. The Nutrition Section and the Technical Assistance Group (TAG) will coordinate regular meetings to discuss the activities of various agencies, and updates on modifications to the national program strategy and implementation plans.

H. INFORMATION, EDUCATION AND COMMUNICATIONS MATERIALS DEVELOPMENT

A variety of educational interventions will be required to implement the program, including development of materials for training, promotion of appropriate foods and health and feeding practices, protocols for case treatment, literacy and post-literacy curricula, and newsletters to provide feedback to the field and information exchange between collaborating agencies. Production of materials will be supported by USAID in collaboration with UNICEF, through a variety of sources, and will be coordinated by the Technical Assistance Group (TAG) and the Nutrition Section.

The IEC component will be planned and developed through a multi-sectoral steering community, including participation from the NPC, UNICEF, ministries, Helen Keller International and other NGOs. A variety of media will be used to promote vitamin A nutrition, including print media, radio and informal education methods.

An initial step by the Technical Assistance Group (TAG) will be to gather together all materials that have been produced in support of vitamin A, nutrition and child health, to assess the resources that are available and the need for additional materials.

A library of vitamin A materials will be maintained by the Technical Assistance Group (TAG), including relevant research materials, reference documents, training and

promotional materials and publications produced as part of the national program. This will serve as a resource for NGOs, ministries and collaborating agencies involved in child health and nutrition.

A vitamin A program newsletter will be produced by the Technical Assistance Group (TAG) to provide feedback to the field on program implementation, lessons learned and monitoring results, as well as to reinforce training and increase general nutrition knowledge. It will be published on a semi-annual basis, timed to coincide with preparations for each capsule distribution campaign and will help to alert and prepare field workers for the upcoming campaign.

In addition, other newsletters produced for distribution to district and community level staff will be utilized to disseminate appropriate information. This may include having a vitamin A page in widely distributed newsletters.

III. ASSESSMENT AND MONITORING

A. ASSESSMENT

Central to the approach to establish a viable national vitamin A deficiency control program in Nepal is the need to assess the risk for xerophthalmia among large areas within the country. This will help the Ministry of Health to plan program expansion so that available resources are utilized in the most cost effective way.

This task will be addressed by carrying out assessments of several districts to determine the magnitude of xerophthalmia. The data will be analyzed by the MOH with technical assistance from the Technical Assistance Group (TAG) and presented during planning meetings, to review and formulate plans of action for program implementation in priority areas.

Assessments will take place over a five month period, April-August, which has been demonstrated to be the period of highest risk for xerophthalmia. The purpose of the assessments is to collect baseline data of the prevalence of xerophthalmia, as well as to determine a set of coverage objectives which could be achieved over time. Expansion of the activities to the districts with high prevalence of xerophthalmia will follow the assessments.

The program plan is based on assessment of at least five new districts each year. However, it may be possible to complete assessment surveys in as many eight districts in some years, depending on the logistics and workload requirements presented by the location, topography and population of the specific districts selected.

Since the purpose of the assessments is essentially to identify priority districts based on xerophthalmia rates, only a limited range of information will be collected at the

household level. This will include:

1. Location of the household
2. Age of child
3. Xerophthalmia - yes or no
   If yes: XN, X1B, X2, X3A, X3B, or XS
4. Mid-upper arm circumference (MUAC)
5. Occupation of father
   If farmer, owns land or tenant
6. Maternal literacy

This information will define the magnitude of vitamin A deficiency (based on prevalence of X1B) and identify additional entry points in the family for interventions leading toward the long term goals of the program, should capsule distribution be warranted. It will, of course, also provide baseline information for the intervention program, if initiated.

The clinical examinations will be conducted by ophthalmic assistants (OAs) who will administer vitamin A capsules or appropriate treatment for xerophthalmia and other vitamin A-related diseases, or other eye problems observed in children surveyed. Capsules will be left with mothers to complete the course of treatment.

Identification of capsule distribution by NGOs and activities related to the national program which are being conducted by other ministries and NGOs in each district will have been determined prior to the survey.

The assessment surveys will be implemented jointly by program staff and a commercial survey firm under subcontract. The Technical Assistance Group (TAG) and program staff will work closely with the Nutrition Section in survey planning, implementation, data analysis and interpretation.

B. MONITORING

Monitoring is an effective tool for assessing real coverage of the program as well as taking timely corrective action to improve implementation. The monitoring of the interventions in the districts included in the program will be conducted by surveying a sub-sample of the total number of children beneficiaries and the FCHVs and VHWs involved in the activities. This activity will take place during the winter season by Technical Assistance Group (TAG) staff. The data will be analyzed in the Nutrition Section and the results presented to DPHO Offices for review and joint discussions regarding necessary actions. Coverage of children under 5 years for capsule distribution in the will be 40% after the first year of distribution and training of FCHVs, 50% for the second and 60% for the third. Coverage for the hill districts will be determined after the assessments.

Monitoring efforts will be concentrated on samples of children in those areas of each district where the prevalence of xerophthalmia is highest. The following information will be collected, in keeping with the purposes of:

1. Allow the Nutrition Section and Technical Assistance Group (TAG) to assess the adequacy of the program process and track progress toward the objectives;
2. Provide clues regarding key constraints to achieving target coverage; and
3. Update information regarding the nature and magnitude of complementary activities of other ministries and NGOs, and the degree of networking with the national program in the community/district.

Monitoring information collected at the VDC level will include:

1. Percent of children under 5 receiving one capsule per year.
2. Percent of children under 5 receiving two capsules per year.
3. MUAC of children in survey.
4. Percent of FCHVs receiving allotment of capsules on schedule.
5. Percent of FCHVs attending last training session.
6. Percent of literate mothers.
7. Percent of mothers who can identify dark green leafy vegetables (DGLVs) as a good source of vitamin A.
8. Percent of children consuming Vitamin A rich foods.
9. Percent of families with kitchen garden.

Monitoring information collected within the MOH system will include:

1. Percent of FCHVs in the district who received capsules on schedule.
2. Adequacy of capsule stocks at Health Post level.
3. Adequacy of capsule stocks at Primary Health Center level.
4. Adequacy of capsule stocks in hospitals.
5. Adequacy of capsule stocks at DPHO level.
6. Adequacy of capsule stocks at regional warehouse.
7. Appropriate rotation of stocks at levels 2-6.

Monitoring of complementary activities, to be gathered at the district level, will estimate coverage, effectiveness and degree of networking with:

1. Ministry of Agriculture - nutrition related activities, especially vitamin A.
2. Ministry of Education - nutrition related activities, especially vitamin A.
3. Ministry of Local Development - nutrition related activities, especially vitamin A.
4. NGOs - health activities, especially vitamin A.
5. NGOs - community development activities, especially those related to vitamin A.

6. Adult literacy programs.

Monitoring results will be utilized (a) to modify or intensify the training and supervision components, (b) to provide feedback to field staff through newsletters and training sessions, and (c) for program management and planning purposes.

The monitoring function will gradually be phased into the new MOH management information system (MIS), which is planned to be developed with support from DANIDA. This is a government-wide MIS, so it will eventually allow the exchange of vitamin A-related monitoring results across ministries.

IV. MANPOWER DEVELOPMENT

In order to assure the ability of the MOH to eventually take over implementation, supervision and planning of the national vitamin A program, considerable efforts will be focussed on manpower development. Emphasis will be placed on training of MOH staff at all levels and transfer of appropriate skills.

A. TRAINING OF TRAINERS

A training of master trainers at the central level will be organized every year to provide training to MOH staff and NGOs regarding program implementation activities and techniques.

Approximately 125 people will be trained each year. Master trainers will be drawn from various sectors, including health, agriculture, local development, and education. Training may be conducted through community health worker training programs such as the Institute of Community Health, and FAO's training and curriculum development program.

At the regional level master trainers will provide training to DPHO staff, who will in turn train health post staff, VHWs, MCH workers and FCHVs.

B. TRAINING OF FCHVs

Training of FCHVs is considered an essential element of the national strategy. It is hoped that the training which will be provided will serve as valued incentive for the FCHVs who are otherwise uncompensated for their work, and the primary motivation for delivering vitamin A services. Capsule distribution and nutrition education skills may give the FCHVs a special status in the community which will encourage them to participate more actively in community health programs. The capsule distribution also allows them to provide something to the community beyond good advice, thus increasing their stature as "real" health care workers.

As much as is possible, literacy training for FCHVs will also be provided through the work of other ministries and NGOs, as an additional incentive for increased activity and as an essential tool for improving health care in Nepal.

C. TRAINING FOR THE NUTRITION SECTION

Manpower development for the Nutrition Section is also an important focus of the national program, as responsibility for planning, implementation, and supervision of the program lies with this Section of the MOH. The Technical Assistance Group (TAG) will operate as a technical assistance resource for the Nutrition Section and provide training and transfer of skills so that full management responsibility for a national vitamin A program can be transferred to the MOH. Support for selected training outside Nepal will be provided based on identification of skill development needs within the Nutrition Section.

The Nutrition Section's capacity for monitoring and supervision will be developed through training and through close collaboration with Technical Assistance Group (TAG) in data analysis and interpretation, IEC materials development, and policy planning.

V. REVISED IMPLEMENTATION PLAN

A. IMPLEMENTATION SCHEDULE

	Activity	Units	Date
1.	PP Amendment Approval	USAID committee	July 1992
2.	Project Authorization signed; Project Agreement signed with MOH	DIR, MOH, MOF,	Sept. 1992
3.	USAID/Nepal Plan for Assistance to National Vitamin A program prepared/ approved	HFP/VITAL, MOH, UNICEF	Nov/Dec 1992
4.	PIO/T for Buy-in prepared	HFP, MOH	Jan. 1993 Jan. 1994
5.	National Meeting to Introduce Vitamin A program; Technical Assistance Group (TAG) established	HFP, MOH, NPC, NGOS, other donors	Feb. 1993

6.	New subcontracts with NGOs	HFP/TA Contractor, MOH	Apr/May 1993 Apr/May 1994 Apr/May 1995
7.	Vit. A Surveys in 5-8 new districts	TAG, MOH, Sub-contract firm	May-Aug 1993 May-Aug 1994
8.	Project Agreement Amendment signed with MOH	DIR, MOH, MOF	June 1993
9.	Capsule Distribution maintained in selected districts	TAG, MOH, NGOs, HFP, UNICEF	June 1993
10.	Detailed planning for - Jul 93 - Jul 94 - Jul 94 - Jul 95 - Jul 95 - Jul 96 - Jul 96 - Jul 97	TAG, MOH, HFP, UNICEF NGOs	 June 1993 June 1994 June 1995 June 1996
11	Capsule Distribution maintained and expanded	TAG, MOH, HFP, UNICEF, NGOs	Oct/Nov 1993, 94, 95, 96
12.	Annual Review Meeting	TAG, MOH, NPC, HFP, UNICEF NGOs	Feb. 1994 Feb. 1995 Feb. 1996 Feb. 1997
13.	Final Evaluation	MOH, USAID	Jan 1997

B. IMPLEMENTATION MANAGEMENT

1. HMG and Counterpart Project Management

The government entity responsible for implementing the activities described in this project amendment will be the Ministry of Health (MOH). Various levels of the MOH structure and functions at each level have already been described in the Project Paper. The Chief of the Public Health Division oversees the Nutrition Section, through which the majority of project activities will be implemented, and which will be responsible for day-to-day implementation. The Secretary, Minister of Health, by virtue of his position, is Vice-Chairman of the National Nutrition Policy Coordination Committee (NNPCC) which is chaired by the National Planning Commission. Donors, NGOs and technical ministries involved in vitamin A programs will be represented on the NNPCC.

2. USAID Project Management

The responsibilities for USAID project management continue to be the Office of Health and Family Planning.

3. Technical Assistance

USAID will provide support for technical assistance to the MOH for implementation of the national vitamin A program through a Vitamin A Technical Assistance Group (TAG) working under the Public Health Division's Nutrition Section. A Nepali organization, working with technical assistance and management support from A.I.D.'s R&D Bureau cooperative agreements/contracts and/or USAID contracts/grants, will serve as the Technical Assistance Group (TAG) for the national program. The primary role of the Technical Assistance Group (TAG) is as follows:

- Serve as liaison between the MOH and district level staff in implementation of the national vitamin A strategy.
- Provide on-going technical assistance to the MOH Nutrition Section.
- Responsible for implementation, coordination, monitoring and assessment and capacity building of the Nutrition Section to phase in all project management elements to the permanent MOH structure during the five-year period.
- Assure planning and coordination between collaborating ministries, NGOs, and donor agencies, under the direction of the Nutrition Section and NPC.

C. CONTRACTING MODALITIES

Assistance for technical and management support and services to the MOH, the TAG, NGOs and local firms will be obtained from buy-ins to A.I.D.'s R&D Bureau cooperative agreements/contracts and/or direct USAID contracts/grants.

Any other procurement actions necessary to the implementation of activities described in this amendment will be according to the guidelines outlined in the project paper.

D. MONITORING, EVALUATION AND AUDIT PLANS

1. Monitoring

Primary responsibility for project monitoring by USAID will be with the Office of Health and Family Planning and with the USAID project committee. Project monitoring

will be accomplished through site visits and through routine progress reports provided by the Technical Assistance Group (TAG) on behalf of the MOH counterpart office (Nutrition Section) and implementing agencies. Consultations with MOH, consultant staff, and other donor representatives will also be used as means of monitoring progress.

The annual workplan and budget developed and agreed upon by USAID, the MOH and the TAG will provide yearly up-dated criteria against which the project's accomplishments and progress will be assessed.

Reports from the MOH/TAG and other sub-contractors will provide information for measuring progress. Contractors will prepare quarterly progress reports and trip reports. MOH/TAG, NGO and other contractor reports will contain fiscal information that will be used in financial monitoring.

2. Evaluation

USAID and selected representatives of the Public Health Division's Nutrition Section will conduct an annual internal review of the national vitamin A program with the TAG in the process of reviewing/approving the annual workplan.

An external evaluation of vitamin A activities will be performed as part of all project components after approximately 3 1/2 years of implementation, i.e., early 1997. The evaluation will consider progress vis-a-vis established plans and targets set by the national level vitamin A program. Results and issues identified will be used for the design of continued USAID support to this sector if deemed appropriate at the time.

3. Audit

Elements of this project amendment will be subject to the same audit terms as outlined in the project paper.

Attachment A

ANNEX 1 - AMPLIFIED PROJECT DESCRIPTION

Child Survival/Family Planning Services Project - Grant Agreement

Illustrative Financial Plan

(in U.S. $)

CATEGORY	USAID LOP	HMG/N LOP	TOTAL LOP
Technical Assistance	8,622,822	615,000	9,237,822
Training	1,370,000	260,000	1,630,000
Commodities/Supplies	4,192,070	16,703,000*	20,895,070
Local Cost Support **	4,244,000	1,269,000	5,513,000
Field Support	677,633	- 0 -	677,633
Construction	796,000	50,000	846,000
Evaluations	200,000	- 0 -	200,000
Audit	75,000	- 0 -	75,000
Inflation	711,000	2,150,000	2,861,000
Local NGO/PVO & CA	1,814,475	180,000	1,994,475
Contingency	597,000	1,246,000	1,843,000
TOTAL PROJECT COST	23,300,000	22,473,000	45,773,000

* Includes commodities and supplies provided by other donors.

** Includes support for NGO/PVO grants and Cooperative Agreements.