

Save the Children/Nepal Child Survival 11 First Annual Report

**Agency for International Development
Cooperative Agreement # FAO-0500-A-00-5016**

October 1996

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INTRODUCTION

The Child Survival XI Project is located in Nuwakot District, a hilly area northwest of Kathmandu which falls in the Central Development Region. The project area covers *ilakas* 1, 12, and 13 and encompasses 14 Village Development Committees (VDCs). The total potential beneficiary population of the project area is 42,045. Of this, 8,409 are women aged 15 - 49 and 6,139 are children under five years.

The project area is primarily inhabited by Tamangs, who form the largest Mongolian/ Buddhist tribal community in Nepal, as well as one of the least developed. Four health posts (HPs) operating under the Ministry of Health (MoH) provide basic health services, and eight new sub-health posts (SHPs) are being developed to provide primary health care. However, both HPs and SHPs are inadequately staffed due to the difficulty of posting staff to rural areas.

GOAL

The goal of this Child Survival XI Project is to reduce infant, child and maternal morbidity and mortality by:

- increasing family-level health protective behaviors
- establishing private sector health commodity distribution and marketing systems at the community level
- promoting community-level health care management, and
- increasing women's literacy.

I. OVERVIEW OF YEAR ONE

[A] ANNUAL OBJECTIVES AND ACCOMPLISHMENTS:

The following tables summarize the objectives and accomplishments of the first year. Virtually all of the 49 objectives listed in the tables were met, with some accomplishments exceeding projections.

OBJECTIVE BY INTERVENTION	OBJECTIVES	ACCOMPLISHMENTS
<p>Immunization:</p> <p>1. To maintain the immunization coverage achieved in CS8 (28%).</p>	<ul style="list-style-type: none"> • Conduct 221 MCH mobile clinics providing health care services. • Organize EPI catch-up rounds at 8 sites. • Conduct two days' training on ARI and CDD for 47 NFE facilitators, and three days' training for five NFE facilitators on CS XI key messages. • 82 NFE facilitators to be trained on FP/MCH, EPI, CDD and STD/AIDS. • To develop and organize a variety of IEC activities and media to communicate key CS XI messages. 	<ul style="list-style-type: none"> • A total of 2124 under-five children and 690 pregnant and postnatal mothers benefited from 224 MCH mobile clinics held at 33 sites. • EPI catch-up rounds were organized at 8 sites, in close coordination with Village Health Workers (VHWs) of Hps and the DHO. • 47 NFE facilitators received training on ARI, CDD or FP. Of these, five NFE facilitators received three days' training about CS XI key messages. • 82 NFE facilitators received training on FP/MCH, CDD, EPI and STD/AIDS. • IEC activities and materials include: <ul style="list-style-type: none"> • 2300 CS XI key health message booklets, with 1400 copies in Nepali and 900 copies in Tamang. • 1500 copies of exercise books were produced. These exercise books are being used as training stationaries. • 100 copies of health related songs booklets were produced. • 200 display boards developed and placed throughout project area. • 251 children under one year have been completely immunized. • 125 women aged 15-49 years received first dose of TT.

OBJECTIVE BY INTERVENTION	OBJECTIVES	ACCOMPLISHMENTS
<p>ARI:</p> <p>1. 60% of mothers of children under 2 will know the danger signs of ARI</p> <p>2. 40% of mothers will seek and obtain appropriate treatment including antibiotics from MCH clinics, HP or other health professionals for children <2 with cough and rapid or difficult breathing.</p>	<ul style="list-style-type: none"> • Conduct 221 MCH mobile clinics providing health care services. • Gather baseline information on pneumonia treatment by community health workers. • Organize two days' training on vitamin A and ARI management for 89 CHVs. • Organize two days' training for 115 traditional healers on ARI and CDD. • Conduct two days' training on ARI and CDD for 47 NFE facilitators, and three days' training for five NFE facilitators on CS XI key messages. 	<ul style="list-style-type: none"> • 1292 under-five children with ARI received ARI treatment from 224 clinics. • A baseline study about pneumonia treatment by community health workers was conducted and final report is being prepared. • 89 CHVs received two days' training on Vitamin A and ARI management. • 22 traditional healers received training on ARI; 58 received training on CDD, vitamin A and ARI; and 35 received refresher training on both CDD and ARI, for a total of 115 traditional healers trained. • 47 NFE facilitators received training on ARI, CDD or FP. Of these, 27 received training on all three topics. Five NFE facilitators received three days training about CS XI messages.

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<p>ARI:</p> <p>1. 60% of mothers of children under 2 will know the danger signs of ARI</p> <p>2. 40% of mothers will seek and obtain appropriate treatment including antibiotics from MCH clinics, HP or other health professionals for children <2 with cough and rapid or difficult breathing.</p>	<ul style="list-style-type: none"> To develop and organize a variety of IEC activities and media to communicate key CS XI messages. 	<ul style="list-style-type: none"> IEC activities and materials produced included: Street dramas were organized to disseminate health messages about STDs and vitamin A/Nutrition, FP, sanitation, CDD, ARI, HIV/AIDS and the "Three Cleans" at 31 sites, in coordination with the Nawachandika Youth Club. A total audience of 4100 observed the drama performances. 100 copies of street drama script booklets were produced. Produced CS XI key health message booklets, with 1400 copies in Nepali and 900 copies in Tamang. 1500 copies of exercise books were produced. These exercise books are being used as training stationaries. 100 copies of health related song booklets were produced. 200 display boards developed and placed throughout project area. 9 display boards on ARI, ORS and FP were developed and placed in various public places. 6 mini-display boards were developed and placed throughout project area. 300 calendars were printed and distributed on the occasion of Nepali New Year. The calendars contained key messages on CDD, maternal health, ARI, HIV/AIDS and FP.*

***NOTE: THIS SECTION WILL BE REPEATED AS "IEC OUTPUTS."**

OBJECTIVE BY INTERVENTION	OBJECTIVES	ACCOMPLISHMENTS
<p>Family Planning:</p> <p>1. 15% of eligible couples will use temporary modern FP methods.</p> <p>2. 10% of eligible couples will use permanent modern FP methods.</p>	<ul style="list-style-type: none"> • Conduct MCH room services at least 98 times, providing maternal health services to more than 200 women. • Organize one FP sterilization camp. • Organize two days' refresher training for 201 CHVs on CDD, FP and Vitamin A. • Provide two days' training for 40 TBAs on maternal health/FP. • Organize training for 40 sales agents. • Provide three days training on maternal health and family planning for 52 women's groups' members. • Train 82 NFE facilitators on FP/MCH, EPI, CDD and STD/AIDS. 	<ul style="list-style-type: none"> • Maternal health services were provided 154 times through MCH rooms at two health posts and one sub-health post. 361 women benefited from these services, which included antenatal/ postnatal care, family planning services and FP counseling. • A male sterilization camp was organized jointly with the District Health officer (DHO) at two sites, sterilizing 28 clients (see Annex 3). A male/female sterilization camp organized by ADRA/Nepal benefited seven clients from the project area.. • 206 CHVs were trained on CDD, Vitamin A and comprehensive FP. • 40 TBAs were trained on maternal health/FP. • A total of 40 sales agents were trained: 12 on CDD, FP and maternal health; 20 on FP and 8 on social marketing. • 52 women's groups' members received training on maternal health and FP. • 82 NFE facilitators received training on FP/MCH, CDD, EPI and STD/AIDS. • A total of 1,360 condoms were distributed. • Total CYP is 81.

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<p>Family Planning:</p> <p>1. 15% of eligible couples will use temporary modern FP methods.</p> <p>2. 10% of eligible couples will use permanent modern FP methods.</p>	<ul style="list-style-type: none"> To develop and organize a variety of IEC activities and media to communicate key CS XI messages. 	<ul style="list-style-type: none"> IEC Outputs

OBJECTIVE BY INTERVENTION	OBJECTIVES	ACCOMPLISHMENTS
<p>CDD:</p> <p>1. 45% of children under age 2 with diarrhea will be treated with ORS.</p> <p>2. 65% of children under age 2 with diarrhea will be given the same or more food.</p> <p>3. 65% of children under age 2 with diarrhea will be given the same or more fluid.</p>	<ul style="list-style-type: none"> • Establish 14 ORT corners at Non-Formal Education (NFE) centers, and 64 ORT corners at clinics. • Organize two days' refresher training for 201 CHVs on CDD, FP and Vit. A. • Organize training for 40 sales agents on CDD, FP/MCH, and social marketing. • Organize two days' training for 115 traditional healers on ARI and CDD. • Conduct two days' training on ARI and CDD for 47 NFE facilitators and three days' training for five NFE facilitators on CD XI key messages. • 82 NFE facilitators to be trained on FP/MCH, EPI, CDD and STD/AIDS. 	<ul style="list-style-type: none"> • 14 ORT corners were established at NFE centers, and 1150 NFE participants were involved in JJ (ORS) preparation sessions. • 64 ORT corners were organized at MCH mobile clinics. CHVs and Maternal Child Health Workers (MCHWs) and On-the-Job Trainees of ANMs were involved in conducting ORS sessions. • 206 CHVs were trained on CDD, Vitamin A and comprehensive FP. • A total of 40 sales agents were trained: 12 on CDD, FP and maternal health; 20 on FP and 8 on social marketing. • 22 traditional healers received training on ARI; 58 received training on CDD, vitamin A and ARI; and 35 received refresher training on both CDD and ARI, for a total of 115 traditional healers trained. • 47 NFE facilitators received training on AIR, CDD or FP. OF these, 27 received training on all three topics. Five NFE facilitators received three days training about CS XI key messages. • 82 NFE facilitators received training on FP/MCH, CDD, EPI and STD/AIDS. • A total of 1,132 children under 5 were treated with Jeevan Jal (ORS). 2500 packets of Jeevan Jal were distributed and 834 packets were sold, for a total of 3334 packets used. • 2244 under-five children received deworming treatment course.

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OBJECTIVE BY INTERVENTION	OBJECTIVES	ACCOMPLISHMENTS
<p>HIV/AIDS/STDs</p> <p>1. Condom use during last act of intercourse among married men above 15 years will be increased by 100% above baseline, i.e., from 8.2% to 16.4%.</p>	<ul style="list-style-type: none"> • Organize training on HIV/AIDS for 25 club members. • Organize training on HIV/AIDS for 56 peer educators. • Organize 4 days long training on FP/MCH and HIV/AIDS for 10 HP staff. • Organize one sexually transmitted diseases (STDs) camp. • • Celebrate World AIDS Day and Condom Day. • Continue hot-line services. • • Provide training on HIV/AIDS for 7 sales agents. • 82 NFE facilitators to be trained on FP/MCH, EPI, CDD and STD/AIDS. 	<ul style="list-style-type: none"> • 25 club members received training on HIV/AIDS. • • 56 peer educators received training on HIV/AIDS counseling. • 10 HP staff (VHWs/MCHWs) received 4 days long training on FP/MCH and HIV/AIDS. • STDs camps were organized at four sites, treating a total of 351 clients. 37 of these clients were referred to hospitals (see Annex 2). • World AIDS Day and Condom Day were observed in coordination with local non-governmental organizations (LNGOs). A total audience of about 2,000 was present. • 7 sales agents received training on HIV/AIDS. • • 82 NFE facilitators received training on FP/MCH, CDD, EPI and STD/AIDS. • Answers to a total of 81 HIV/AIDS-related questions were posted anonymously on hot-line information boards. • A total of 1,360 condoms were distributed.

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<p>HIV/AIDS/STDs</p> <p>1. Condom use during last act of intercourse among married men above 15 years will be increased by 100% above baseline, i.e., from 8.2% to 16.4%.</p>	<ul style="list-style-type: none"> To develop and organize a variety of IEC activities and media to communicate key CS XI messages. 	<ul style="list-style-type: none"> IEC Outputs.

OBJECTIVE BY INTERVENTION	OBJECTIVES	ACCOMPLISHMENTS
<p>Nutrition/Vitamin A:</p> <p>1. 80% of children 6-60 months will receive Vitamin A supplementation (200,000 UI) every 6 months, children 6-12 months will receive half-dose.</p>	<ul style="list-style-type: none"> • Organize two vitamin A distribution camps. • Establish 18 kitchen gardens. • Organize two days' training on vitamin A and ARI management for 89 CHVs. • Organize two days' refresher training for 201 CHVs on CDD, FP and Vitamin A. 	<ul style="list-style-type: none"> • Two vitamin A camps were organized in October 1995 and April 1996. Vitamin A capsules were distributed by Community Health Volunteers (CHVs) in all 126 wards in the project area. A total of 3,971 children between the ages of 6 - 60 months (70% of the total) received vitamin A supplements (see Annex 1). • 18 kitchen gardens were established in coordination with the SA/NRM sector. • 89 CHVs received two days' training on Vitamin A and ARI management. • 206 CHVs were trained on CDD, Vitamin A and comprehensive FP.

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OBJECTIVE BY INTERVENTION	OBJECTIVES	ACCOMPLISHMENTS
<p>Maternal Health:</p> <p>1. 40% of women will attend at least one ANC visit prior to delivery.</p> <p>2. An increase of 30% above the baseline survey in the knowledge of women and family members of at least 3 danger signs during pregnancy, labor and postpartum.</p> <p>3. An increase of 30% above the baseline survey in the knowledge of women and family member of at least 3 appropriate actions to take during pregnancy/labor and postpartum period, when danger signs occur.</p>	<ul style="list-style-type: none"> • Establish 20 Clean Home Birthing (CHB) Kits sales agents. • • Conduct MCH room services at least 98 times, providing maternal health services to more than 200 women. • • • Develop and produce 150 bags with CS XI key maternal health messages. • Provide training on maternal health and clean home birthing kits for 16 TBAs. • Provide two days' training for 40 TBAs on maternal health/FP. • Organize training for 40 sales agents on CDD, FP, maternal health and social marketing. 	<ul style="list-style-type: none"> • 20 CHB Kits sales agents established. • 106 Clean Birthing Kits were sold by sales agents. • Maternal health services were provided 154 times through MCH rooms at two health posts and one sub-health post. 361 women benefited from these services, which included antenatal/postnatal care, family planning services and FP counseling. • 150 bags printed with maternal health messages were produced and distributed to various health volunteers, club members, school teachers and SC staff. • 16 TBAs were trained on maternal health and usage of clean home birthing kits. • 40 TBAs were trained on maternal health/FP. • A total of 40 sales agents were trained: 12 on CDD, FP and maternal health; 20 on FP and 8 on social marketing. • A Clean Delivery Day was also celebrated, with demonstrations of use of Clean Home Birthing Kits, processions, quizzes, etc. About 1,500 local residents participated in the program.

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<p>Maternal Health:</p> <p>1. 40% of women will attend at least one ANC visit prior to delivery.</p> <p>2. An increase of 30% above the baseline survey in the knowledge of women and family members of at least 3 danger signs during pregnancy, labor and postpartum.</p> <p>3. An increase of 30% above the baseline survey in the knowledge of women and family member of at least 3 appropriate actions to take during pregnancy/labor and postpartum period, when danger signs occur.</p>	<ul style="list-style-type: none"> • Provide three days training for 52 women's groups' members on FP and maternal health. • 82 NFE facilitators to be trained on FP/MCH, EPI, CDD and STD/AIDS. • To develop and organize a variety of IEC activities and media to communicate key CS XI messages. 	<ul style="list-style-type: none"> • 52 women's groups members received training on maternal health and FP. • 82 NFE facilitators received training on FP/MCH, CDD, EPI and STD/AIDS. • IEC Outputs

SUSTAINABILITY/OTHER ACCOMPLISHMENTS

- 19 MCH mobile clinic management committees have been applying cost recovery methodology to promote financial sustainability in the provision of community health services. Clinic cost recovery approaches include instituting service fees, registration fees, and, in the case of one clinic, obtaining funds from its VDC. Some committees have initiated a charge of 15 - 25% of total cost for medicine. A sum of Rs. 53,207 (US \$ 933) was collected from registration, service fees and charges for medicines at various clinic sites.
- Financial support was provided to the Sikharbesi Health Post management committee for repairs and latrine construction.
- Coordination meetings with DHO, LNGO, HP and SHP staff were held five times. A Health sectoral meeting was conducted.
- 20 school health society members received four-days training on first aid. 36 school health society members received three-days training on leadership and management.
- An IEC strategic planning workshop was organized for 24 participants from eight LNGOs/clubs and SC local staff.
- A 30-cluster survey was conducted from November 6-21, 1995. A summary of the results of the baseline survey of CS XI and of the final survey of CS VIII was presented to government staff, VDC members, schoolteachers, club/committee members, key community members and SC staff.
- Qualitative research regarding IEC was conducted to explore the appropriate media/channel/approach to reach unreached target groups, particularly the Tamang community. The report is in the process of finalization.
- Social market research has been completed to explore strategies to develop self-sustained health commodities distribution and marketing mechanism. The preparation of the report is in process.
- A CS XI DIP was prepared on February 12 - 15, 1996.

[B] TRAINING/WORKSHOPS FOR PROJECT STAFF

Training is crucial in enhancing the professional capabilities of staff so that they can provide a high standard of health care. The following table describes the workshops and training sessions organized for staff members:

SR #	TYPE AND SITE OF TRAINING	DURATION	PARTICIPANTS
1.	TBA Master TOT Kathmandu	Jan . 7 - 12, 1996	1 Staff Nurse (see Annex 5)
2.	ARI Workshop/Observation Tour, Chitwan/Hetauda	Jan. 17 - 22, 1996	2 Staff Nurses 1 Public Health (PH) Program Officer (see Annex 6)
3.	TOT Siraha	May 12 - 21, 1996	1 Community Medicine Assistant (CMA)
4.	Qualitative Research Training Workshop, Gorkha	May 29 - 31, 1996	2 Staff Nurses 1 Health Officer 1 District Program Coordinator (DPC) 1 CMA 2 Auxiliary Nurse Midwives (ANMs) 1 Social Marketing Coordinator 1 IEC Officer 1 PH Program Director 1 PH Program Officer
5.	Participatory Management for Social Change, CODAY International Institute, Canada	July 1 - Sept. 6, 1996	1 DPC

[C] TECHNICAL SUPPORT

Continuing technical assistance supported and strengthened program planning, management implementation and monitoring. Technical support obtained included the following:

- Dr. STEPHEN BEZRUCHKA facilitated a three-day long training workshop on Qualitative Research for CS XI Staff from May 29 - 31, 1996. The workshop was organized according to the recommendation of the CS VIII Final Evaluation Team. A total of 11 CS XI staff participated in the workshop.
- Dr. ASHMA RANA, Senior Gynecologist from Tribhuvan University Teaching Hospital, assisted in conducting the Sexually Transmitted Diseases (STDs)/Gynecological Camps held from March 10-21, 1996 at four sites in Nuwakot District (see Annex 2).

- Dr. KESHAV RAJ DHUNGANA, DHO from the District Hospital, Trisuli, assisted in conducting male sterilization camps at two sites from February 7-11, 1996 in Nuwakot District (see Annex 3).
- Ms. MARY ANNE MERCER helped to finalize the CS XI DIP.
- Ms. SUSAN D. ROE is assisting in exploring innovative IEC strategies, by developing concepts for IEC campaigns focusing on STDs/HIV/AIDS prevention, Reproductive Health/FP, and Safe Motherhood. She also provided assistance in developing the IEC program of the CS XI project from August 1 to October 31, 1996.

[D] COMMUNITY HEALTH COMMITTEES:

MCH mobile clinics were established in 33 sites of 14 VDTs to provide health services to children under five years and mothers. At the initiation of these clinics, prior to implementation, 31 mobile clinic management committees were formed. The key role and responsibilities of these committees include: to help in management of the clinics, for example registering of mothers/children, collecting fee, seating arrangement for clients, keeping mothers in queue; motivating mothers to attend clinics; disseminating health messages; conducting regular meetings; and recording and reporting. To strengthen these clinics various trainings and workshops were organized by SC/US. The topics of the training program include: management and leadership, accounting, cost recovery methodology, proposal writing and key health messages.

Regular meetings have been conducted to discuss clinic management and its improvements. Technical support from the SC/US team has been provided to run the clinics. 19 MCH mobile clinic management committees have been applying cost recovery methodology to become financially sustainable to run the clinics. As per the phase over-plan in the DIP, the process of federation has begun. The workshop for the federation process was organized, and 7 MCH mobile clinic management committees were federated into two main committees and renamed as health management committees. These two federated health management committees, at the apex, will be responsible to provide overall supervision, monitoring and guidance to specified areas in ilaka # 13. These two health management committees will be provided support for the development of the committees' constitution and for process of registration as a LNGO. (see Annex 7).

Mothers' groups at each ward are involved in monthly meetings conducted by CHVs. During the meeting sessions, CHVs provide health education, motivate them to attend MCH mobile clinics and inform about distribution of vitamin A capsules for the children between 6-60 months of age.

Women's Rehabilitation Centre (WOREC), a NGO, was provided equipment and materials to support its comprehensive health clinics. WOREC is providing health services in Sikharbesi VDC to children and mothers.

Three LNGOs - WOREC, Nawachandika Youth club and Shivapuri Youth club received DGIS/HIV/AIDS-sub-grants to implement HIV/STDs prevention and education programs. These LGNOs have completed a Baseline Survey. A qualitative study was also conducted regarding sexual belief and behaviour. The key interventions of these LNGOs include: condom promotion, HIV/AIDS awareness programs, and sexually transmitted disease (STDs) treatment and prevention integrated with family planning. Nawachandika Youth club members received training on street drama. This club is organizing street dramas effectively. It also organized a three day eye camp.

Quarterly coordination meetings are conducted among LNGOs, DHO/HP staff, and SC/US, each one taking a leading role on a turn-by-turn basis. The last meeting was organized by SC/US. The next meeting will be organized by Nawachandika Youth club. This type of coordination meeting is playing a crucial role in strengthening the health care delivery system and eliminating duplication of services being provided to the target population.

[E] LINKAGES MADE

Linkages are vital to successful program implementation. Continuous linkages were made at all levels to enhance program effectiveness.

1. National Level:

- ◆ Formal correspondence was made with the Nutrition Section, Ministry of Health (MoH).
- ◆ Frequent correspondence was made with the CDD/ARI section, MoH and with JSI/Nepal.
- ◆ SC/US, as a member of the TBA/FCHVs Network Committee, attended four meetings.
- ◆ Formal correspondence was made with the National Health Training Center (NHTC) and the National AIDS and STDs Prevention Center.
- ◆ SC/US actively participated in the Safe Motherhood at the Community Level Support Group .

- ◆ Linkages were made with Yale University for a pneumonia care survey.
- ◆ Linkages were made with Tribhuvan University Teaching Hospital (TUTH) for technical support.

Major outcomes of these linkages are:

- ◆ Vitamin A capsules and Vitamin A registers for CHVs were obtained from the Nutrition Section, MoH.
- ◆ An agreement was established with the CDD/ARI section to implement Pneumonia Case Management at the Community Level as a pilot project in SC/US working areas, with support from JSI/Nepal.
- ◆ A revised training package for TBAs was received from NHTC. One SC/US staff member was trained on the TBA Master TOT by NHTC.
- ◆ A medical student from Yale University assisted in conducting a baseline study regarding pneumonia case management by community health workers at the community level.
- ◆ STD camps were conducted by a gynecologist of Tribhuvan University Teaching Hospital.

2. District Level:

- ☉ CS XI project orientation meeting was organized with DHO and other line agencies. 29 participants attended the orientation meeting.
- ☉ A formal coordination meeting was held with District level teams.
- ☉ Formal correspondence was made with DHO and DEO.

Major outcomes of these linkages are:

- ◆ An opportunity was provided by District Development Committee (DDC) to attend DDC's coordination meeting. (see Annex 8)
- ◆ DHO assisted in organizing FP sterilization camp.
- ◆ Linkage with DHO has become stronger.
- ◆ DHO has planned to involve SC/US staff in MIS training.

3. Local Level:

- Formal meetings with Health Post Incharges (HPIs) were organized.
- Coordination meetings with VDC members, club members, and community groups were organized.
- Regular meetings with MCH mobile clinic management committees were conducted.
- Quarterly meetings with CHVs are being held regularly.
- VDC level joint coordination meeting with VDC Chairperson and its members, LNGOs, women's group members, women management committee, MCH mobile clinic management committee and self-help groups was conducted.
- Formal coordination meetings with local clubs were organized.

Major outcomes of these linkages are:

- ◆ HPIs assisted to conduct trainings.
- ◆ HPIs helped to organize MCH mobile clinics.
- ◆ Health Post Staff (VHWs) conducted EPI Catch up rounds by themselves.
- ◆ EPI equipment was made available for EPI catch up rounds by DHO.
- ◆ VHWs helped to conduct training for CHVs.
- ◆ MCHWs helped in TBA training program.
- ◆ MCH mobile clinic committees initiated a cost recovery process for financial sustainability of their clinics.
- ◆ Seven MCH mobile clinic committees federated to become two main MCH management committees.
- ◆ The clubs are organizing street dramas and other awareness programs independently.
- ◆ LNGOs and clubs submitted proposals and sub-granted to organize programs such as NFE classes. They also received DGIS-HIV/AIDS sub-grants from SC/US.

II. CONSTRAINTS, UNEXPECTED BENEFITS AND LESSONS LEARNED

Constraints:

- ◆ Some community-level workers such as CHVs, VHWs and MCHWs are not residents of the wards or VDCs they are working in, due to various factors, including the fact that selection is done by MoH staff. This makes it difficult for workers to fulfill their responsibilities, and access to health services suffers as a result. SC/US will coordinate with DHO/HP in an attempt to minimize the situation.
- ◆ Inadequate budget at DHO level for purchasing the equipment and drugs. SC/US provided support to move a deep freeze to project area and logistic support for EPI catch up rounds.
- ◆ Many HP staff are absent from their posts or are present only sporadically, which again leads to difficulties in coordinating activities. Although a number of sub-health posts are being developed in VDCs, difficulties are experienced in posting staff.
- ◆ Supervision and follow-up from the district level to government staff is inadequate, contributing to poor quality care in some parts of the project area.

SC/US has brought these problems to the attention of the appropriate officials within the Ministry of Health; the government is aware of these problems. In the interim, SC/US has been working with a variety of community organizations to support the health services in the area in light of these difficulties.

Lessons Learned:

- ☞ Involvement of VHWs/MCHWs in training programs of CHVs/TBAs was very helpful. A strong linkage and relationship developed among them after training programs, wherein they got an opportunity to know each other closely. VHWs and MCHWs have become more confident in their roles and responsibilities by training CHVs and TBAs.
- ☞ Coordination with health post staff, LNGOs and DHO play a vital role in implementing the project activities. Consequently, the Health Post Incharges have assisted in health camps, training programs and MCH mobile clinics. HP staff organized EPI catch up rounds. LNGOs/ Clubs began to organize IEC activities such as street drama by themselves.

Unexpected Benefits:

- ☞ 20 Depo-provera clients have shown an interest in having trainings regarding family-planning (FP) particularly Depo-provera and FP counseling. They were provided training. As a satisfied group, they started to hold discussions with their peers and neighborhood women.

III. CHANGES IN PROJECT DESIGN

[A] During the process of preparing the DIP, some objectives were revised based on SC XI baseline information. No changes have been made in DIP objectives. An overview of the past and current status of all objectives is given below :

Interventions	Proposal	DIP
I. Child Health		
1. Immunizations	-----	Maintain the 29% immunization coverage achieved in CS VIII .
2. ARI	75% of mothers of children under 2 will know the danger signs of ARI.	60% of mothers of under-2 children will know the danger signs of ARI.
	40% of mothers will seek and obtain appropriate treatment, including antibiotics, from CHVs, TBAs or other health professionals for under-2 children with cough or difficult breathing.	40% of mothers will seek and obtain appropriate treatment, including antibiotics, from MCH clinics, HP or other health professionals and community health workers for under-2 children with cough and rapid or difficult breathing.
3. Control of Diarrheal Disease (CDD)	* 45% of under-2 children with diarrhea will be treated with ORS.	Same
	* 65% of under-2 children with diarrhea will be given an unreduced or increased amount of food and fluid.	65% of under-2 children with diarrhea will be given an unreduced or increased amount of food. * 65% of under-2 children with diarrhea will be given an unreduced or increased amount of fluid.
4. Nutrition/ Vitamin A	* 60% of children below 60 months will receive a vitamin A supplement (200,000 IU) every six months. Children 6 - 12 months will receive a half dose.	* 80% of children 6 - 60 months will receive vitamin A supplementation (200,000 IU) every 6 months. Children 6 - 12 months will receive a half dose.

Interventions	Proposal	DIP
<p>II. Maternal Health</p> <p>1. Antenatal Care (ANC)</p>	<ul style="list-style-type: none"> * 75% of pregnant women will attend at least one antenatal visit prior to delivery. * An increase of 30% above the baseline survey will occur in the knowledge of women and family members of at least five danger signs during pregnancy, labor/delivery and postpartum period. * An increase of 30% above the baseline survey will occur in the knowledge of women and family members of at least five appropriate actions to take during pregnancy, labor/delivery and the postpartum period, when danger signs occur. 	<ul style="list-style-type: none"> *40% of women will attend at least one antenatal visit prior to delivery. *An increase of 30% above the baseline survey will occur in the knowledge of women and family members of at least three danger signs during pregnancy, labor and the postpartum period. *An increase of 30% above the baseline survey will occur in the knowledge of women and family members of at least three appropriate actions to take during pregnancy/labor and the postpartum period, when danger signs occur.
<p>2. HIV/STDs</p>	<ul style="list-style-type: none"> * Condom use among men above 15 years old will increase 100% above baseline. 	<p>Condom use during last act of intercourse among married men above 15 years will be increased by 100% above baseline, i.e. from 8.2 % to 16.4 %.</p>
<p>3. Family Planning</p>	<ul style="list-style-type: none"> * 15% of couples 15 - 49 will use a temporary modern family planning method. * 15% of couples 15 - 49 will use permanent methods of family planning. 	<p>15% of eligible couples will use temporary modern methods of family planning.</p> <p>10% of eligible couples will use permanent modern family planning methods.</p>

[B] STAFFING

New Appointments

Two new positions, Social Marketing Coordinator and Health Officer, were created during the proposal preparation period for CS XI. The following new staff have been hired:

Name	Designation	Date of appointment
Bharat Mani Pant	Health Officer	April 24, 1996
Rabi R. Chitrakar*	Social Marketing Coordinator	August 5, 1996
Hari Lal Dhakal*	CMA	November 6, 1996

*Mr. Rabi R. Chitrakar has been hired to fill the vacancy created by the resignation of Mr. Utsav K. Udash.

*Mr. Hari Lal Dhakal has been hired to fill the vacancy created by the resignation of Mr. Fairaj Tamang.

Transfers

The following staff members have been shifted as per project requirements:

Name	Designation	Date of Transfer	Area Transferred	
			From	To
Tulsi Gurung	Field Coordinator	July 25, 1996	Ilaka 13	Ilaka 1
Jamuna Lama	Field Coordinator	July 25, 1996	Ilaka 12	Ilaka 13
Ranjana Poudel	Senior ANM	January 1, 1996	Ilaka 13	Ilaka 1
Krishna Bahadur Gurung	Field Coordinator	June 2, 1996	Ilaka 1	Ilaka 12
Hari Lal Dhakal	CMA	January 1, 1996	Ilaka 1	Ilaka 12

Resignations

The following staff members resigned from the agency:

Name	Designation	Date of Appointment	Date of Resignation
Fairaj Tamang	CMA	Nov. 1, 1993	July 1, 1995
Utsav K. Udash	Social Marketing Coordinator	May 14, 1996	June 22, 1996

Reasons for Resignations

Mr. Udash resigned from the agency to pursue higher studies at his own expense. Mr. Tamang left the agency to join another agency.

Names of Project Personnel

A reviewed organogram containing names of the project staff appears in Annex 9.

IV. BUDGET AND EXPENDITURE

[A] Not applicable - No changes have been made.

[B] Not applicable. Budget expenditure has been proceeding as expected, and major budget revisions are not anticipated at this time.

V. FOLLOW UP OF DIP REVIEW

Responses to Detail Implementation Plan (DIP) review comments responses are attached in Annex 10.

Annex - 1
A Brief Report of
VITAMIN A CAMP, NUWAKOT

INTRODUCTION

Save the Children US (SC/US) has been working in Nuwakot District since 1992. CS XI, which started in October 1995, is the continuation of CS VIII in the same project area. Nutrition education/vitamin A supplementation is one of the six interventions of the CS XI project. Vitamin A distribution campaigns are organized every six months in the SC/US working area. Vitamin A and nutrition education programs play an important role in preventing malnutrition and night blindness in young children. The project team is working to increase awareness about the need to consume locally available foods rich in Vitamin A, such as green leafy vegetables, yellow fruits and beans. Community residents are encouraged to produce these vegetables in their own kitchen gardens.

Three vitamin A distribution and nutrition awareness campaigns were organized in April 1996. A total of 3,971 children between 6-60 months age (70% of the total population of that age) received vitamin A supplementation according to MoH norms.

STRENGTHS OF THE CAMPAIGN

- Vitamin A registers were received from the Nutrition Section, Child Health Division, Ministry of Health (MoH). These are used by Female Community Health Volunteers (FCHVs).
- Most of the FCHVs, community leaders and MCH mobile clinic management committee members actively participated in the vitamin A camps and nutrition education programs.
- Nutrition education sessions were conducted by MCHWs and FCHVs using posters and flip charts.
- Integration of the program with MCH mobile clinics made service delivery easier and saved the time of mothers.

PROBLEMS ENCOUNTERED

- Difficulties were encountered in involving all mothers with children of the targeted age due to geographical distance and widely scattered houses.
- Some of the illiterate FCHVs needed helpers to fill out the vitamin A registers.
- At some sites, older children also requested vitamin A capsules.

IMPRESSIONS

- Trained FCHVs are able to run vitamin A camps with the help of other community residents.
- All FCHVs should be made literate.
- It is essential to increase awareness among postnatal mothers about nutritious foods containing vitamin A and prevention of night blindness/malnutrition.

Annex - 2

A BRIEF REPORT ON GYNECOLOGY/STDs CAMP, NUWAKOT

Introduction

A Gynecology/STDs camp was organized and conducted in Nuwakot from March 10-21, 1996 under Save the Children US. Four areas were covered: Samundratar (two days), Ghyamphedi, Routbesi and Kaule/Likhu (one day each). This camp was conducted with the help of Save the Children US staff and Dr. Ashma Rana, MBBS, DGO, MD Gyn/Obs, a lecturer at Kathmandu's Teaching Hospital.

Aim/Objectives

Nuwakot is a typically remote area of Nepal, with road transport limited to Apra (on the way to Samundratar) and Salya Maidan (for Likhu). The area's medical facilities are few and difficult to reach, and residents seldom seek medical services unless they are critically ill, due to illiteracy as well as lack of available facilities. Some areas, like Ghyamphedi and Routbesi, are well-known for girl trafficking and prostitution. Due to illiteracy and ignorance, men and women practice unsafe sex, which in the long term can lead to STDs. The few local pharmacies appear to be inadequately treating STD clients by usually treating only one partner. The health post was unable to handle the situation, so this camp proved to be both appropriate and timely.

1. Study

- a. Common gynecological problems.
- b. Rough estimate of prevalence of STDs.
- c. Awareness of STDs.

2. Management

- a. Syndromic management of clients with STDs.
- b. Syndromic management of vaginal discharge.
- c. Use of ring pessary in genital prolapse.
- d. Simple gynecological procedures like polypectomy.

Programming

The camp's four locations were selected according to population in need and population at risk.

All gynecological cases were seen, including men who reported with symptoms of STDs. A few women with other ailments apart from STDs were also seen. None of the patients were left unattended. Medicines were distributed to those requiring them.

Observation Results

	Total No. Pt	Female	Male	Total STD	Male	Female
Samundratar	93	91	2	2	1	1
Ghyamphedi	9	5	4	2	2	0
Routbesi	15	15	0	2	0	2
Likhu	105	92	13	4	2	2
All 4 places	222	203	19	10	5	5

STD = 10  5 Female / 203
5 Male / 19

MEDICAL DIAGNOSIS

Clinical Diagnosis	Samundratar	Ghyamphedi	Routbesi	Likhu	Total
☞ Normal finding	12	1	1	5	19
☞ Pregnancy	2	-	3	12	17
☞ VDS	11	-	-	15	26
☞ PID	8	-	1	6	15
☞ Puerperal sepsis	-	1	-	-	1
☞ STD	2	-	2	2	6
☞ Primary infertility	1	-	-	6	7
☞ Secondary infertility	1	-	1	2	4
☞ Cervical erosion	7	-	-	1	8
☞ Cervical polyp	-	-	-	2	2
☞ DUB	5	-	-	6	11

Clinical Diagnosis	Samundrata	Ghyamphedi	Routbesi	Likhu	Total
☞ Prolapse	34	2	4	26	66
☞ Primary dysmenorrhoea	-	-	-	1	1
☞ UTI	3	-	1	1	5
☞ Miscellaneous	2	-	2	7	11
☞ Fibroid	-	-	-	1	1
☞ Leukoplakia vulva		1	-	-	1
☞ Gyn Malignancy					
• Cervical cancer	0	-	-	-	0
• Endometrial cancer	1	-	-	-	1
☞ Contraception	2	-	-	-	2
Total	91	5	15	93	204

★ 19 Male

UTI = 6

STD = 5

Miscellaneous = 8

	Samundratar	Ghyamphedi	Likhu	Total
UTI	1	1	4	6
STD	1	2	2	5
Misc.	-	1	7	8

Recommendations

It was a pleasure for me to work with the enthusiastic staff of Save the Children US. Everyone was very encouraging and cooperative, and understanding. A brief introductory meeting between local staff and the visiting doctor prior to the scheduled camp might facilitate better planning and management.

An important aspect to consider is the question of quality versus quantity. In some instances a single doctor may not be sufficient to conduct the necessary work. Schedules are so tight that it is difficult for a person unaccustomed to the circumstances to cope. It would be advisable to be prepared to offer an alternative should the visiting doctor become ill. Another recommendation is to hold a camp in the same place for three to four days, to save time and walking distances for the staff.

It should be noted that the number of patients treated in Routbesi was relatively small, as the camp was held on a Saturday and many people were unaware that services would be available.

Annex - 3

A Short Report on Vasectomy Camp

Save the Children US (SC/US) Nuwakot organized a Male Sterilization Camp for vasectomies from February 7-11, 1996. Specific camp dates and venues were: Feb. 7-8 at Samundratar and Feb. 10-11 at Salle Maidan Health Post in Kaule (Likhu). The camps were jointly organized by the Nuwakot District Health Office (DHO) and Save the Children US, Nuwakot. A total of 28 persons from three areas benefited from this camp.

OBJECTIVES

1. Promote family health
2. Increase community awareness on FP
3. Decrease maternal and child mortality and morbidity.

SUMMARY OF THE CAMP

A total of 28 persons benefited. Of these, seven clients were from Ilaka 1; three were from Ilaka 13 and 18 were from Ilaka 12. Technicians, drugs and advertisement materials were provided by the DHO, while SC/US provided other motivation, advertising, logistic support, camp management support and financial support to technicians.

LESSON LEARNED

- A. Time appointments: Due to the joint program between the DHO and SC/US, it is difficult to take time from the DHO.

RECOMMENDATIONS

Male sterilization was not very popular and relatively few clients attended the camps. Currently about 100 women are joining in a request for a female sterilization camp in Samundratar, covering Ilakas 12 and 13. This camp will be coordinated with ADRA/Nepal.

Annex - 4
A BRIEF REPORT ON THE MCH CLINIC COST RECOVERY WORKSHOP
MARCH 20 - 22, 1996
LIKHU, NUWAKOT

Introduction

Save the Children US has been implementing a child survival project since 1992 in Ilakas 1, 12 and 13 of Nuwakot District, covering 42,045 potential beneficiaries.

A key project component are the 210 MCH mobile clinics held every year to provide preventive and promotive care to targeted potential beneficiaries. Some 31 MCH mobile clinic management committees had been formed to assist in the operation and administration of these clinics. SC/US has been providing training and support to enhance the capabilities of MCH mobile clinic management committees. A steady effort has been made to strengthen these committees. SC/US has placed an equal emphasis on strengthening the financial capacity of these committees. As part of this effort, a study was conducted to determine potential cost recovery methodology in all sectors in Nuwakot. Based on the results of this study, a three-day cost recovery workshop was held from March 20-22, 1996 in Likhu. Six key members of the MCH Mobile Clinic Management (MCHMC) Committees and ten SC/US staff had participated in the workshop.

Objectives of the Workshop

- Provide an overview of cost recovery methods.
- Analyze the existing MCH mobile clinic cost recovery system.
- Assist MCH mobile clinic management committees in planning programs using cost recovery.
- Prepare a cost recovery plan and a follow-up plan.

Content of the Workshop

- Meaning of cost recovery.
- Reasons for cost recovery.
- Goals/objectives and process of cost recovery.
- Current existing cost recovery system of MCH mobile clinic management committees - a situation analysis.
- How to sustain MCH mobile clinics.
- Role of MCH mobile clinic management committees in cost recovery.
- Preparing a cost recovery plan.
- Exploration of alternative cost recovery means.
- Developing a reporting system.
- Management of funds.
- Potential follow-up to cost recovery workshop.

Workshop Process

Day 1

The workshop began with a welcome address by Mr. Keshab Nath Khanal, District Program Coordinator. Workshop objectives were presented by Naramaya Limbu. The norms of the workshop were determined by participants and expectations were collected by Thaneshwor Koirala. The methodology adopted for the workshop was fully participatory.

Outcome of Day 1

All participants actively participated in small groups yielding the following outputs.

- **Definition of cost recovery:**

The groups' various definitions can be summarized as follows: Cost recovery is a programming process that involves analysis of income, expenses and other resources which impact the program's objectives/goals as well as its sustainability. Cost recovery can improve the efficiency and effectiveness of program delivery.

- **Reasons for cost recovery:**

The participants discussed this question in small groups and presented their findings. The final list of reasons appears below:

- To improve and maintain effectiveness of the program.
- To provide continued services to rural communities.
- To sustain clinic operation.
- To balance income by reducing expenses and increasing funds.
- To increase self-reliance.
- To strengthen MCH mobile clinic management committees.
- To improve program efficiency.
- To encourage proper use of resources.
- To minimize expenses and maximize coverage.
- To fulfill community needs.
- To improve the health status of mothers and children.
- To develop a feeling of community ownership.
- To reduce donor dependency.

Outcome of Day 2

Current Situation

Members from each MCH mobile clinic management committee presented the current situation. A summary of the facts learned:

- There are a total of 33 clinic centers in the project impact area.

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- Ilaka 1 conducts 67 clinics per year; Ilaka 12 conducts 98 clinics, and Ilaka 13 conducts 50 clinics.
- Clinic committees in Ilaka 1 had collected Rs. 13,640 to date. The figures for Ilakas 12 and 13 were Rs. 13,103 and Rs. 23,052, respectively. Total funds collected were Rs. 49,795.
- Current clinic expenses average Rs. 1,340 per clinic.
- Funds are primarily generated from the following sources:

- Registration fee - for mother	Rs.	5
- for child	Rs.	8 - 10
- Service fee	Rs.	2

Enhancing Clinic Sustainability

The following recommendations were made by the groups:

- Strengthen the capabilities of committee members.
- Adopt/apply cost recovery approach.
- Train technical manpower for each committee.
- Coordinate with DHO/HP and MOH to deliver health services.
- Encourage the active involvement and participation of committee members.
- Encourage transparency in terms of finances as well as program delivery.
- Increase funding.
- Mobilize local resources.
- Strengthen committees' ability to obtain registration, and to develop a constitution and policy guidelines.
- Analyze and mobilize funds on a regular basis.
- Discourage free services.
- Organize regular workshops.
- Provide follow-up for workshops.

Familiarization with steps of the cost recovery process

The steps of the cost recovery process were presented in detail, and an example of clinic cost recovery methodology was given.

Outcome of Day 3

Each MCH mobile clinic management committee prepared a one- year plan applying cost recovery, based on the given example.

Summary of Plans

S.#	Committee Name	Present Clinic Cost (in Rs.)	Cost After Applying Cost Recovery Approach	% of Cost Covered	Remarks
1.	Samundratar Clinic	996	238	24	
2.	Shyaure Committee, Sikre	1380	586	42	
3.	Maidan, Likhu	1140	305	27	
4.	Tutung, Raluka	1740	377	22	
5.	Juwalamukhi, Talakhu	1420	285	20	
6.	Tome, Sundara Devi	800	230	29	

Projected average cost recovery for the first year is 27%.

Follow-up Plan

Group members also prepared a follow-up plan, described below:

Ilaka-level follow-up workshop

- Ilaka 1, last week of Chaitra.
- Ilaka 12, third week Baishakh.
- Ilaka 13, third week Baishakh.

- Orientation meetings were planned by the committees as follows:

	Name of Clinic	Centre	Date
1.	Jwalamukhi Clinic	Clinic site	2052/12/10
2.	Maidan Clinic	Maidan Primary School	2052/12/17
3.	Samundratar Clinic	Health Post	2052/12/14
4.	Tutung Clinic	Tutung Centre	2052/12/12
5.	Tame Clinic	Sundara Primary School	2052/12/15
6.	Shyaure Clinic	VDC Building	2052/12/15

- The group also developed a report format.

The workshop was evaluated daily as well as at the conclusion of the course. All members actively participated in the workshop and seemed very enthusiastic about implementing the plan.

Annex - 5

A BRIEF REPORT ON THE TBA MASTER TRAINING OF TRAINERS

A six-day training on TBA Master Training of Trainers (MTOT) was held in Kathmandu at Tripureshwor from January 7-12, 1996. The training was organized by the National Health Training Center (NHTC), Teku. Partial support by Redd Barna/Nepal covered the cost of facilitators, training materials, etc. A total of 12 participants from nine different INGOs underwent training. There were two participants each from Care Nepal, Swiss Development Corporation, and Save the Children US, and one each from Save the Children UK, Redd Barna/Nepal, ADRA/Nepal, Institute of Community Health, W/N, and United Mission to Nepal.

OBJECTIVES

- ✦ To develop competence-based training (CBT) skills.
- ✦ To provide orientation on varieties of teaching and learning methods.
- ✦ To introduce the revised TBA initial manual and family planning package.
- ✦ To create uniformity in providing messages for TBAs and in training manuals.

METHODOLOGY

- ❖ Body mapping
- ❖ Games
- ❖ Group discussion/presentation
- ❖ Demonstration
- ❖ Role playing
- ❖ Case study
- ❖ Story telling
- ❖ Songs
- ❖ Question/Answer
- ❖ Brainstorming

CONTENTS

- * National TBA training flow chart
- * Role of Master Trainer in TBA programs
- * Selection criteria for TBA and TBA trainers
- * Effective demonstration technique
- * Coaching
- * Body Mapping
- * Questioning
- * Illustrated lecture
- * Training hints

- * Teaching method
- * Training Approach
 - Competency based training
 - Humanistic training
 - Participatory training
- * Positive training climate
- * Role of NGO/INGOs in TBA program

OVERALL IMPRESSIONS

The training was very useful in enhancing the skills and knowledge of SC/US staff, as well as HMG staff. Most of them are involved in TBA programs in remote areas.

Some new and interesting topics discussed included body mapping, which helps teach illiterate people about the different parts and organs of the body; discussion of what constitutes a positive training climate; and the coaching and the illustrated lecture.

Participation from various INGOs made the training an excellent opportunity to share ideas and experience regarding TBA program delivery.

RECOMMENDATIONS

As all TBAs in SC/US's Nuwakot project area are already trained, training should instead be organized in the working areas of other NGO/INGOs which are affiliated with the TBA program. One-day TBA orientation meetings should be organized with local HP leaders in order to select TBAs, followed by six days' TBA TOT for midwives. Following this, ten days' Basic Training for TBAs should be conducted.

Prepared by
Roma Raut
Ilaka 12, Nuwakot

Annex - 6

A SHORT REPORT ON PNEUMONIA CASE MANAGEMENT WORKSHOP/FIELD VISIT *Nuwakot*

In order to initiate a Pneumonia Case Management Pilot Program in SC/US's impact area in Nuwakot District, three members of the CS XI project staff attended a two-day workshop followed by a two-day observation visit. The program was held at Hetauda and Chitwan from January 18-21, 1996. There were a total of 20 participants: two from the Child Health Division (ARI/CDD Section), one from USAID, seven from JSI/Nepal, three from the Chitwan District Health Office (DHO), four from the Makwanpur DHO, and three from SC/US (Ms. Naramaya Limbu, Mr. Netra Bhatta and Ms. Roma Raut). SC/US staff and JSI staff then conducted a joint field observation field visit at Makwanpur on January 20 and Chitwan on January 21.

Objectives of the ARI Observation Visit

- To acquire knowledge and experience on pneumonia case management by Female Community Health Volunteers (FCHVs) at the grassroots level, including physical checkup, referral and recording/reporting systems.
- To investigate the ARI strengthening program from the DHO to the grassroots levels.

Day 1

Overall objectives of the workshop were presented by the Director of the Child Health Division, MOH, Dr. Chhatra Amatya. A presentation was made by the District Health Officers of Chitwan and Makwanpur regarding the ARI program's achievements, and problem and concerns encountered during delivery of the program. An interesting session was facilitated by JSI/Nepal staff on supervision system standards.

Day 2

The group was divided into teams, and SC and JSI staff participated in the group work for developing action plans for the District Health Offices of Chitwan and Makwanpur.. These action plans on supervision systems from the DHO level down to the grassroots level were then presented by the two district leaders.

Day 3

The third day was spent on a field visit observing the ARI strengthening program conducted by two different districts, in terms of the performance of CHVs, the supervision system, and the recording and referral system. The majority of the CHVs were observed to be performing well, except in the case of one, who could not accurately count the respiration rate of a child.

The following activities were observed:

- Counting method of respiration rate
- Assessing the mother's ability to recognize signs of pneumonia
- Medicine (cotrim) distribution and dosage
- When and how to do follow-up visits
- Referral system
- Recording/reporting

A health post was also visited, and the following observations were made:

- The recording/reporting system was kept up-to-date
- VHWs and CHVs were closely supervised
- A good referral system was in operation

Day 4

On the final day of the observation tour, the team visited one health post, one sub-health post, one VHW and two CHVs in Chitwan.

Conclusion

The program launched by Chitwan District appears to be operating better than that of Makwanpur District, mainly because Makwanpur is a hilly area and transport is more difficult. This type of program is also possible to implement in Nuwakot, and could be effective given close supervision and appropriate referral points.

Annex - 7

A Brief Report of Health Management Committees Formation Area # 13, Gaun Kharka, Nuwakot.

Save the Children US has been implementing a multi-sectoral programs with the main objectives to reduce the maternal and child morbidity and mortality rate in its impact area. In order to achieve the objectives, SC/US implements different types of health programs: MCH clinics, training to health volunteers, different health camps etc. Among these programs, the main program of the health sector is MCH services. SC/US is conducting MCH mobile clinics at 10 (ten) different spots bimonthly in Ilaka # 13. Clinic committees were formed to manage the clinics to collect funds and to assist at the clinics.

As per our plan, we have formed 2 health management committees named Dupcheswar Health Committee and Amarjyoti Health Management Committee in Nayachepar and Rautbesi by federating the nearest 4 MCH mobile clinic management committees and 3 MCH mobile clinic management committees respectively. Each federated committee has 9 (nine) members.

A plan was made to develop these Health Management Committees as local institutionalized NGOs (clubs) by the end of 1997. At that time, committees will be responsible for managing and conducting the MCH clinic in their respective areas/villages independently.

To become institutionalized LNGOs, the committees will get different types of technical support such as trainings, workshops, meeting and technical assistance, and will develop their own constitution before legalization.

The federated committees' names, addresses, and positions are as follows:

1. Dupcheswor Health Management Committee

Centre: Nayachepar

Committee Representatives from: Bolgaun, Nayachepar, Purgau and Sanugolphu Clinic Committees

S.No.	Name of Executive Members	Address	Position	Remarks
1.	Som Bahadur Tamang	RBS - 5	Chairman	
2.	Gimari Tamang	GNK - 7	Vice-Chairman	
3.	Ram Singh Tamang	BTN - 9	Treasurer	
4.	Nasir Tamang	BTN - 6	Secretary	
5.	Sonam Dorjee Sherpa	GNK - 8	Member	
6.	Sherpa Tamang	RBS - 1	Member	
7.	Jeet Bahadur Tamang	BTN - 7	Member	
8.	Bir Bahadur Tamang	BTN - 5	Member	
9.	Sun Bahadur Tamang	BTN - 9	Member	

Key:

- RBS : Rautbesi VDC
- BTN : Betani VDC
- GNK : Gaun Kharka VDC

2. Amarjyoti Health Management Committee

Centre: Rautbesi

Committee Representatives from: Rautbesi, Odare and Jimnang.

S.No.	Name of Executive Members	Address	Position	Remarks
1.	Ram Chandra Thapa	RBS - 6	Chairman	
2.	Bomjan Tamang	GNK - 2	Vice-Chairman	
3.	Gyani Maya Tamang	BTN - 1	Treasurer	
4.	Basudev Acharya	RBS - 7	Secretary	
5.	Ram Hari Lama	BTN - 2	Member	
6.	Gita Maya Tamang	RBS - 2	Member	
7.	Ram Hari K.C.	RBS - 4	Member	
8.	Sudarsan Khatiwada	RBS - 7	Member	
9.	Dhana Bahadur Tamang	BTN - 1	Member	

Conclusion:

We have already formed 2 Health Management Committees (Federated Health Management Committees). The committee members need more support to be very active. Most of the members are illiterate, and they have to be mobilized by different types of ongoing training, workshops and meetings. They have to read and write in order to be capable to manage and conduct the clinics independently and smoothly.

If they get proper support in every aspect, they will be able to manage and conduct the clinics independently at the end of the project period.

Prepared by:
Netra Prasad Bhatta

Annex - 8

A BRIEF REPORT ON DDC COORDINATION MEETING *Bidur, Nuwakot*

On July 1, 1996, a District Coordination Meeting was held at the District Development Committee (DDC) Head Office in Bidur, Nuwakot. The meeting was chaired by DDC chairperson Mr. Mukunda Raj Sitaula. The meeting was organized by the DDC for the line agencies of Nuwakot District. A total of 23 members from various line agencies actively participated.

Participants were as follows:

<u>Organization</u>	<u>No.</u>
DDC Chairman, Vice-Chairman, LDO and other staff	5
DDC Members	5
Agriculture Development Division	2
District Irrigation Office	2
Regional Soil Examination Lab	2
Nepal Red Cross Society	1
District Education Office	1
District Road Division	1
Horticultural Centre	1
District Drinking Water Office	1
District Cooperative Office	1
Save the Children US, Nuwakot Office	1

Total	23
	==

Objectives

- To create transparency regarding the program delivery system of each line agency.
- To share program planning and implementation.
- To discourage duplication of programs.

Mr. Sitaula opened the meeting by welcoming all participants and explaining the objectives of the meeting. A short introduction was given by each participant, and representatives from each organization then presented a brief description of their programs, objectives and achievements.

Recommendations Made by the DDC

- Information should be shared with the DDC before launching any program.
- Organizations should coordinate with the DDC during program planning.
- Progress reports should be provided to the DDC in quarterly, semi-annual, and annual form.

Conclusion

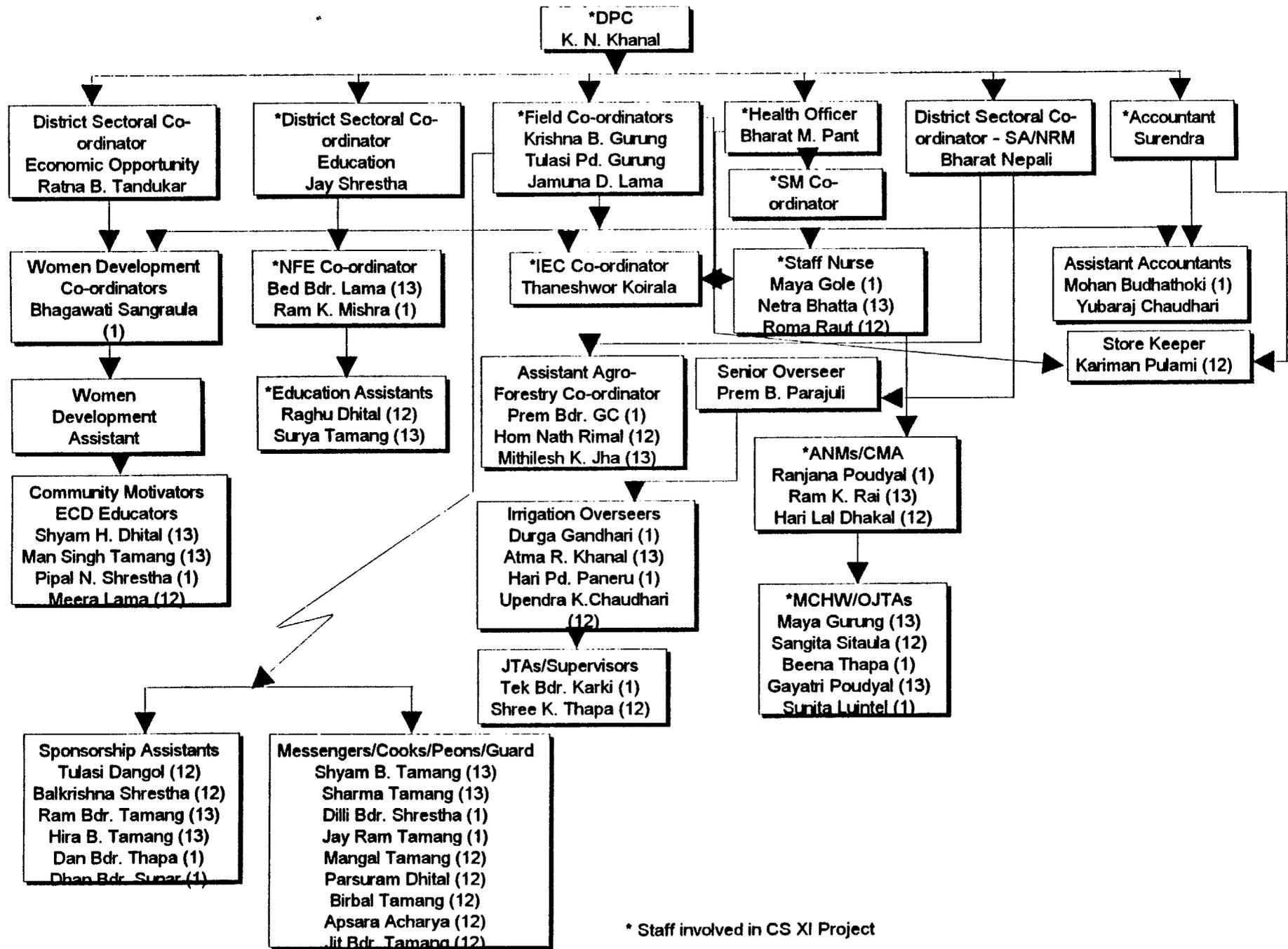
Due to the FY closing and the DDC's consequently busy schedule, the meeting was very short; nevertheless, it was informative and beneficial to all.

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Annex - 9

Organogram of Nuwakot District in Excel

Save the Children US, District Organogram - Nuwakot



Annex - 10

RESPONSES TO TECHNICAL REVIEW OF CS XI DIP

Following are the responses to comments to technical responses of the CS XI DIP:

1. The District Management Team (DMT) holds overall responsibility for EPI programs. The team is comprised of the District Health Officer (DHO), the District Public Health Officer (DPHO), the District EPI Supervisor and the cold chain assistant. At health post (HP) levels, HP team members are responsible for EPI programs, while Village Health Workers (VHWs) and Community Health Volunteers (CHVs) are key persons implementing the programs at the individual community level.

At the district level, the EPI Supervisor and cold chain assistant monitor the quality of care. VHWs are supervised by health post staff. Save the Children US (SC/US) will provide training to HP and Sub-Health Post (SHP) staff on quality EPI care. SC/US will also provide logistical support for maintenance of the cold chain system and for the development of a cold chain monitoring system, and will support quality monitoring at peripheral levels. Immunization is provided at MCH mobile clinics with the active involvement of SC/US staff. VHWs provide vaccines to children on those days, under the guidance of SC/US staff.

2. All reports are based on the activities of VHWs and their records of these activities. VHWs' records include a census of the target population in the *ilaka*, and lists of the number of children under one year and of the women of child-bearing age (WCBA) (i.e. 15 - 44 years of age) who are immunized at each session. This data is compiled according to a tally sheet and is entered in immunization registers for children and for women. Every month, before the immunization session, VHWs should take a local census with the help of the CHVs in their *ilakas* and should enter eligible candidates in the registers, assigning the same number to each entered person on their immunization card. The VHWs issue immunization cards to all new infants/WCBA being vaccinated. They instruct them to save the cards and bring them to each immunization session, and to every HP and SHP visit. Without these cards and registers, it would be almost impossible to accurately count the number of fully immunized women and children.

Before closing the session, VHWs add the number of infants and WCBAs immunized from the tally sheets to get the exact number of target, vaccinated and defaulter populations for each antigen and dose. They then submit the monthly session total to the HP. With the help of CHVs, VHWs will identify and follow-up these. CHVs motivate defaulters to appear for immunizations. SC/US field staff will

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also provide follow-up to strengthen the program, and will hold meetings with VHWs and CHVs on a quarterly basis.

Health Post In-Charges (HPIs) will review all the Village Development Committees' (VDCs) immunization reports and make sure that VDCs with low coverage are flagged for further action and investigation, in consultation with the VDC members and CHVs. VDC reports are then collected at the HP level to generate an *ilaka*-level immunization report that goes to DPHO. The DPHO and DHO review the *ilaka* reports to check coverage, give feedback to HPIs and prepare monthly district-level immunization reports. HPIs and DHOs use these monthly reports to maintain and display a monthly immunization monitoring chart which gives a clear picture of progress or regression in each *ilaka* and district.

Recording and reporting of Vitamin A distribution takes place in a similar manner. CHVs distribute Vitamin A in their wards and keep records on their registers. These registers are provided by the Nutrition Section, Ministry of Health (MoH). CHVs submit the data to HP/SHP through VHWs and to SC/US.

3. SC/US will transmit the information of both suspected and actual outbreaks to the DHO and will provide training for community leaders, volunteers, and HP/SHP staff regarding case identification and management. The project team will also perform field visits to outbreak areas to assess the situation, and will transmit the outbreak information to the DHO, who provides it to the MoH at the central level.
4. Vitamin A capsules for both children and women are provided by the National Vitamin A Program, Child Health Division (CHD), MoH through the DHO. The project will ensure the supply of Vitamin A capsules. CHVs distribute the capsules every six months in their wards. CHVs are provided training before Vitamin A distribution camps, and SC/US and HP staff supervise CHVs during these camps. Before distributing the capsules, a name list of children between 6 - 60 months is prepared. As some CHVs are illiterate, literate helpers are also trained to help them in recording and reporting. The distribution day is scheduled by the National Vitamin A Program, CHD, MoH. CHVs, NFE Supervisors and NFE facilitators inform the public about the distribution date, targeting mothers of children between 6 - 60 months. Children who missed distribution dates are followed up by CHVs. They are also provided Vitamin A capsules during MCH mobile clinics.

Recently, CHD/MoH circulated policy guidelines regarding Vitamin A distribution for postnatal mothers. According to MoH norms, postnatal women will be given Vitamin A supplementation immediately following birth of children, or as soon as possible up to six weeks. The dosage is 200,000 IU. These doses will be provided by TBAs and through MCH mobile clinics and MCH room services at HPs / SHPs.

5. The project team has reviewed and prepared treatment guidelines to be used at MCH mobile clinics to ensure quality care is provided. Both case management in facilities and the quality of health education regarding CDD will be managed by the team, using prepared assessment guidelines.
6. Re: "Marketing for the Treatment of ARI through CHVs and Pharmacists": these guidelines will be implemented in close coordination and collaboration with JSI/Nepal and CHD/MoH and DHO/HP. Three key staff of SC/US have made a field visit to observe the Pneumonia Case Management Project operating in Chitwan and Hetauda districts, which is implemented by JSI/Nepal, DHO and CHD/MoH. The team acquired knowledge and experience regarding pneumonia treatment by CHVs at the community level. Other SC/US key staff will make a field visit to Dang, where the Red Cross Society markets antibiotics for the treatment of pneumonia. Based on these inputs, the team will prepare a plan for a supervision and follow-up system similar to the procedure established in Chitwan and Hetauda. A baseline study was conducted to assess the present situation regarding pneumonia treatment by community health workers at the community level. The study was carried out with the help of a medical student from Yale University. The final study, as well as the evaluation of the project, will be shared with other agencies and the MoH in order to extend methodology to other parts of the project area as well as other non-project areas.
7. Since there is no evidence to date to support promoting the reduction of indoor air pollution as a strategy to prevent pneumonia, this strategy will be dropped and key messages will be reviewed in order to delete it. Other remaining strategies will be kept as is.
8. DHO had provided training on the new simplified MIS to its staff. The new MIS system will also be introduced in project areas. The same nationally standardized forms and procedures will be followed.

ANNEX 11

PIPELINE ANALYSIS

CHILD SURVIVAL 11: NEPAL

COOPERATIVE AGREEMENT FAO-0500-A-00-5018

YEAR 1: EXPENSES VS. BUDGET

	EXPENSES 8/31/98	YR1 BUDGET	YR 1 BALANCE	% SPENT
SALARIES	18,516.42	26,263.00	7,746.58	70.5%
FRINGES	7,923.77	12,978.00	5,054.23	81.1%
TRAVEL	2,968.69	1,500.00	(1,468.69)	197.9%
CONSULTANTS	5,735.90	3,250.00	(2,485.90)	178.5%
PROCUREMENT	10,781.75	14,083.00	3,301.25	78.6%
OTHER	15,687.35	22,970.00	7,282.65	68.3%
TOTAL DIRECT	61,613.88	81,044.00	19,430.12	76.0%

LIFE OF GRANT: CUM EXPENSES VS. BUDGET

	YR 2 BUDGET	YR 3 BUDGET	YR 4 BUDGET	CUM ACTUAL	TOTAL BUDGET	BALANCE	% SPENT
	28,889.00	31,778.00	34,956.00	18,516.42	121,888.00	103,369.58	15.2%
	13,973.00	15,067.00	16,271.00	7,923.77	58,289.00	50,365.23	13.6%
	5,000.00	5,000.00	1,500.00	2,968.69	13,000.00	10,031.31	22.8%
	10,750.00	2,250.00	9,000.00	5,735.90	25,250.00	19,514.10	22.7%
	7,038.00	7,138.00	3,738.00	10,781.75	31,997.00	21,215.25	33.7%
	23,220.00	23,166.00	21,798.00	15,687.35	81,164.00	75,466.65	17.2%
TOTAL DIRECT	88,870.00	84,399.00	87,283.00	61,613.88	341,576.00	279,962.12	18.0%

YEAR 1 = 09/30/95-09/30/96

YEAR 2 = 10/01/96-09/30/97

YEAR 3 = 10/01/97-09/30/98

YEAR 4 = 10/01/98-09/29/99

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