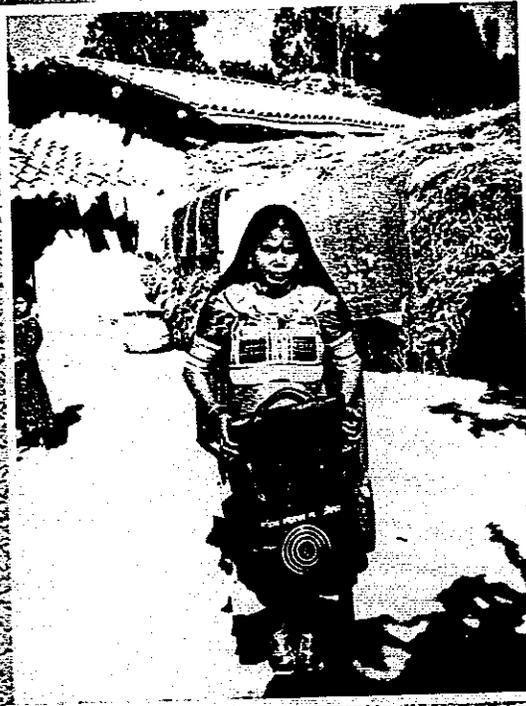


SERVICES PROJECT (LCHSSP)

REPORT OF CHILD HEALTH MONITORING ACTIVITIES



July 1998 - June 1999
(NFY-2055/56)



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Cover Page Photos:

Left: FCHV, Morang District, Eastern Region Counting Respiratory Rate of Child to Detect Pneumonia
Right: FCHV, Kanchanpur District, Far-Western Region Ready to Provide Services in her Community

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Acronyms/Abbreviations

AHW	Auxiliary Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ANM	Assistant Nurse Mid-wife
ARI	Acute Respiratory Infections
BPC	Blue Plastic Cup
CBAC	Community-Based ARI/CDD
CDD	Control of Diarrheal Diseases
CHFS	Child Health Field Staff
CHW	Community Health Workers (FCHV, VHWMCHW)
D/J	Dharmi/Jhankri
DDC	District Development Committee
DHO	District Health Office
EPI	Expanded Program for Immunization
FCHV	Female Community Health Volunteer
FP	Family Planning
HF	Health Facility
HMG/N	His Majesty's Government/Nepal
HPI	Health Post Incharge
I/NGO	International Non-Governmental Organization
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IVACG	International Vitamin A Consultative Group
JSI	John Snow, Incorporated
LCHSSP	Logistics and Child Health Support Services Project
LMIS	Logistics Management Information System
LSIP	Logistics System Improvement Plan
MASS	Management Support Services
MCHW	Maternal Child Health Worker
MOH	Ministry of Health
NGO	Non-Governmental Organization
NID	National Immunization Day
NTAG	Nepali Technical Assistance Group
NVAP	National Vitamin A Program
OPD	Out Patient Department
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PPM	Parts Per Million
RR	Respiratory Rates
SHP	Sub-Health Post
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VAC	Vitamin A Capsules
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization

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A. Introduction to JSI and the LCHSSP

John Snow, Incorporated (JSI), has been working continuously in Nepal since 1981 to provide technical support to the Ministry of Health (MOH) of His Majesty's Government (HMG). Under the current Logistics and Child Health Support Services Project (LCHSSP), JSI is contracted by USAID to provide technical assistance for the implementation of USAID's bilateral agreement with the MOH for support to the Logistics and Child Health programs from June 1997 through June 2002. Annex 1 shows the LCHSSP organogram.

Description of Activities:

Logistics: JSI assists the Logistics Management Division, MOH in the development, implementation and institutionalization of an integrated Logistics System Improvement Plan (LSIP) to ensure year-round availability of family planning and specific health commodities at all MOH health facilities at the district and sub-district level.

Major accomplishments to date include: implementation of a nationwide logistics management information system (LMIS) that is being used by decision makers; dejunking of district stores and health facilities and training staff in best logistics practices; introducing an inventory control procedure designed to ensure constant supply of essential health commodities at service delivery points.

During the LCHSSP JSI will assist the MOH to: develop planning tools to improve the procurement and distribution system; expand use of LMIS data for decision making; streamline and improve the commodity procurement process; finalize implementation of inventory control in all 75 districts and rationalize drug use.



Child Health Team:

Standing left to right - H.L.Rajbansh, K.Lamichhane, H.Tiwari, G.Gurung, D.R.Karki, B.R.Acharya, N. Paudel, R.Bhandari, T.P.Pant, B.B.Karki, N.B.Swar
Sitting left to right - I.Bhattarai, D.D.Karki, S.Karki, P.Dawson, D.Poudel, S.H.Sharma, M.Chamlin

Child Health: To support child health programs, JSI provides direct technical assistance to the MOH for the conduct of the National Control of Diarrheal Diseases (CDD), Acute Respiratory Infections (ARI) and Female Community Health Volunteer (FCHV) programs. Through a subcontract with the Nepali Technical Assistance Group (NTAG), JSI supports the Child Health Division in the implementation of the National Vitamin A Program; and through a subcontract with Management

Support Services (MASS) funding is provided to implement USAID's supplemental workplan support.

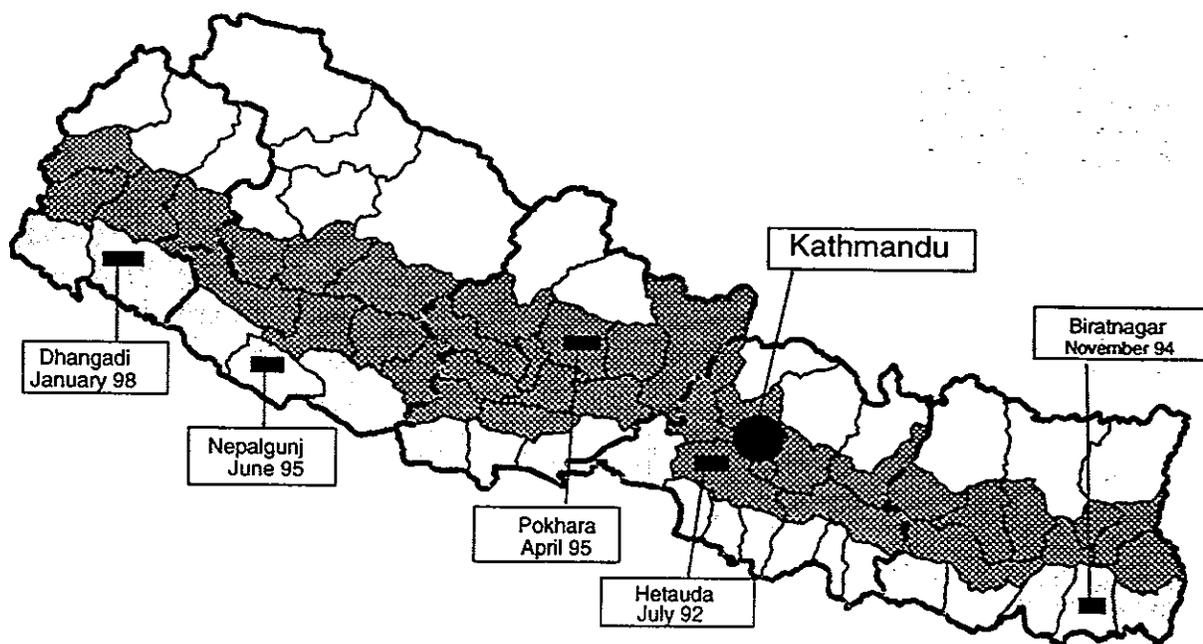
At the Central Level, the JSI Child Health team assists with planning, training, budgeting, monitoring and analyses of program implementation. Through a network of Regional Field Offices, JSI supports the MOH's monitoring, supervision and feedback mechanisms to strengthen program implementation.

Major accomplishments include: successful expansion of a community-based program which supports FCHVs to diagnose and treat “pneumonia” cases and refer more seriously ill children in 11 districts; improved FCHV awareness about danger signs of dehydration and appropriate home care, including correct preparation of oral rehydration solution (ORS) and improved availability of ORS in health facilities and in the community; development of a “combined” child health training package which reaches not only to HFs but beyond to include the community level health workers; expansion of the NVAP to currently cover 53 districts (as of April 1999) while maintaining high capsule coverage; and increased recognition of the FCHV as an important provider of some health services as well as health education in her community.

Future plans include working with the Child Health Division to support: expansion of the community-based pneumonia control intervention to reach at least 14 districts of the country by the year 2002; expansion of the NVAP so that children aged 6-60 months of age in all 75 districts can receive a high dose Vitamin A capsule twice per year by the year 2002; coordination of the “combined” child health package with the IMCI initiative in selected districts.

B. Introduction of the Field Offices

To support the MOH’s programs, JSI has fielded 5 teams of experienced staff to work from Regional Field Offices to support logistics and specific child health interventions in each Region. The Regional offices are located in Biratnagar, Hetauda, Pokhara, Nepalgunj and Dhangadhi. Contact information for these Regional Offices is given in Annex 2. The purpose of this report is to highlight the results of the child health program monitoring activities carried out from these Field Offices during the second year of the LCHSSP, from July 1998 - June 1999 (NFY 2055/56). Reports of logistics activities are prepared separately.



JSI conducts semiannual review meetings which provide an opportunity for all child health staff from the regional field offices and Kathmandu to meet at one of the regional offices to exchange information, review program progress over the past six months and plan for future activities.

C. Role of Field Offices

From the base of the Regional Field Office, the JSI Child Health Field Staff (CHFS) have responsibility for monitoring specific programs within their region and for reporting back to health facility, district, regional and Central level MOH program managers on their findings. Their major role is to assist the District Health Office staff in program management for ARI, CDD, Vitamin A and other child health related programs (Nutrition, Family Planning, support for the National Immunization Day (NID) and the FCHV program). The CHFS utilize standard checklists for monitoring of the programs and the data collected is analyzed not only at the Regional Field Office but also in the JSI office in Kathmandu. Copies of all current checklists are included as Annex 3 of this report.

In addition Child Health Field Officers also:

Provide technical support to the district level staff for the planning and implementation of child health related trainings and assist in the conduct of training to improve the skills of the health workers in the appropriate management of diarrhea and pneumonia cases in children under 5 years of age.

Assist Health Facility (HF) staff in program management for all child health programs including supervision and monitoring up to the community level health workers (FCHVs, VHWS/MCHWs). Motivate the HF staff toward the preventive and promotive aspects of their work.

Monitor the availability of essential child health and FP commodities and supplies and problem solve as needed (in coordination with MOH and JSI's Logistics staff) to improve availability.

Conduct monitoring visits to FCHVs, VHWS and MCHWs and provide on-the-spot refresher training and essential supplies as needed.

Motivate District Development Committee (DDC) and Village Development Committee (VDC) members to support and participate in child health related activities.

Liaise with I/NGOs working in selected districts for the monitoring and support of FCHVs involved in the community-based program for the treatment of pneumonia.

D. Process of CHFS' Visits to the Districts

To conduct their field activities, the CHFS follow a series of "steps" to ensure that all visits are conducted in a uniform way and that the MOH partners know what to expect from the JSI monitoring support. The "steps" in the process are summarized below:

1. Develop regional/individual workplans

2. Visit district health office and brief DHO staff about purpose of visit
3. Prepare HF visit schedule with DHO staff
4. Monitor HFs with DHO supervisor
5. Monitor VHWs, MCHWs, and FCHVs at their working station with DHO/HF staff
6. Provide verbal feedback to DHO and HF in charge on findings
7. Send written report to all concerned
8. Followup as needed immediately and on subsequent visits

E. Child Health Activities

I. General: This part of the report will summarize the results of the monitoring visits conducted by JSI's CHFS during Year 2 of the LCHSSP (July 98 - June 99). The results will be presented according to the level of the monitoring visit: district level; health facility level; VHW/MCHW level; and FCHV level. In addition, results related to monitoring of nutrition program activities will be presented. Where appropriate, comparisons will be made between results of monitoring visits conducted in Year 1 (July 1997 - June 1998) and Year 2 (July 1998 - June 1999) of the LCHSSP.

In subsequent sections, results of monitoring of the community-based pneumonia control program (formerly referred to as the ARI Strengthening Program) in 11 districts will be presented separately and there will be additional sections on training activities and special studies conducted to support the Child Health Programs during the year 1998/99 (Nepali fiscal year 2055/56).

The number of field visits and interviews conducted are summarized in Tables G1 and G2 below. During this year, JSI's CHFS visited 45 different districts, and made a total of 111 district level visits. They visited 618 health facilities, 299 of which were in the community-based pneumonia control program districts (formerly ARI Strengthening Districts). See section E.II for specific results of these ARI monitoring visits. Thirty-one Primary Health Care Centers, 242 Health Posts and 345 SubHPs were visited. Four hundred and ninety-two general child health interviews were conducted with Health Facility staff.

Table G #1: Number of Visits to the District and Health Facility Level by Region

Region	# Dist Visits	# Dist Level Visit	Total # HF Visits	Interview Conducted			Type of Facilities		
				ARI + General	ARI Only	General Only	PHC	HP	SHP
Eastern	4	15	91	44	23	24	7	20	64
Central	12	40	299	129	85	85	14	140	145
Western	14	19	75	-	-	75	-	37	38
Mid-Western	7	22	60	-	-	60	4	17	39
Far-Western	8	15	93	-	18	75	6	28	59
Total	45	111	618	173	126	319	31	242	345

A total of 547 VHW/MCHW level interviews were conducted during monitoring visits with 447 VHWs/MCHWs. Two hundred and sixty-nine of these were in the community-based pneumonia (ARI) control program (formerly ARI strengthening) districts. Two thousand, four hundred and seventeen program specific interviews were conducted with 1,453 FCHVs (716 on regular program issues, 983 on ARI Program issues and 718 on National Vitamin A program issues).

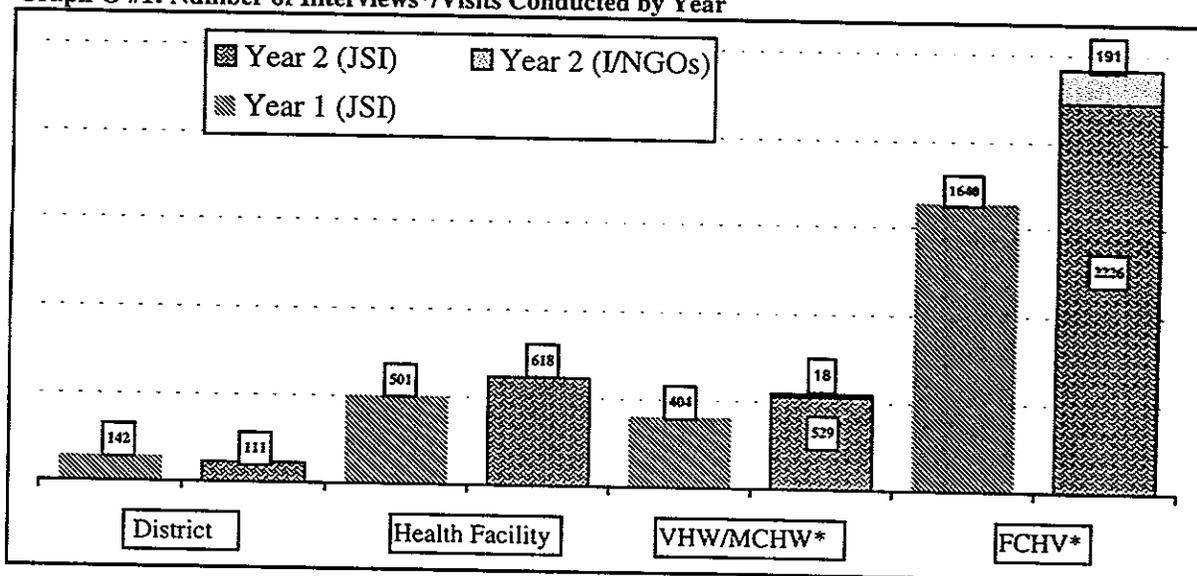
Different checklists are used for different types of program monitoring. These figures are summarized in Table G #2.

Table G #2: Number of Community Level Visits by Region

Region	VHW/MCHW Level Visits				FCHV Level Visits				
	Total # Persons Interviewed	Total # Interview	Regular Program	ARI Program	Total # Persons Interviewed	Total # Interview	Regular Program	ARI Dist	Vit A Dists
Eastern	101	166	80	86	460	862	211	434	217
Central	210	245	80	165	586	746	152	480	114
Western	56	56	56		130	247	130		117
Mid-Western	27	27	27		77	153	77		76
Far-Western	53	53	35	18	200	409	146	69	194
Total	447	547	278	269	1453	2417	716	983	718

Graph G #1 compares years 1 and 2 and shows that the number of interviews conducted by JSI's Child Health Field Staff at both health facility and community level increased during the second year of the project.

Graph G #1: Number of Interviews*/Visits Conducted by Year

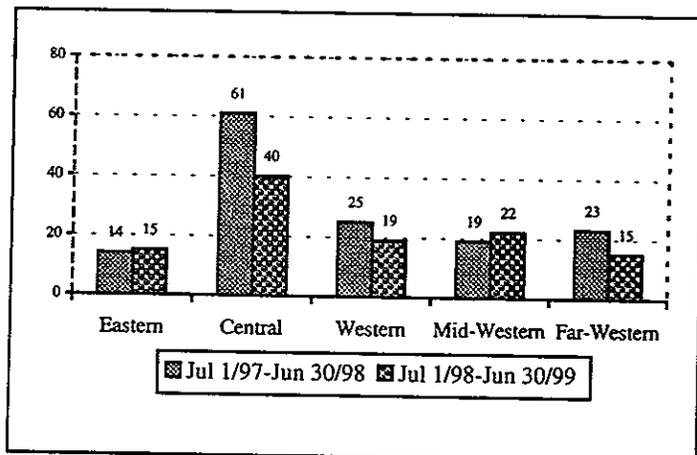


Two hundred and nine interviews with Community Health Workers (VHW/MCHWs (18) or FCHVs (191)) were conducted by I/NGO staff utilizing the ARI checklist.

I. General

1. District Level

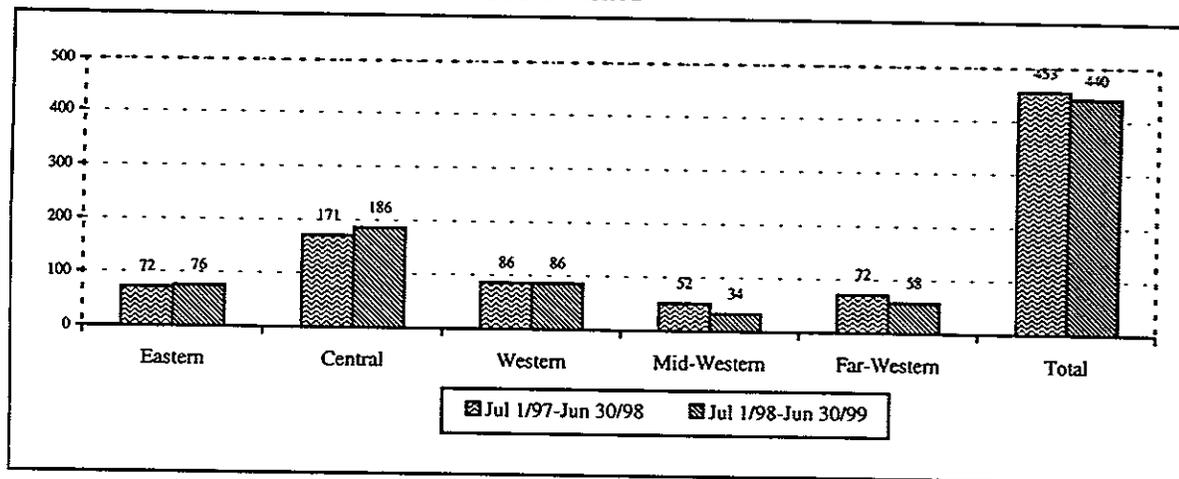
Graph D#1: Number of District Level Visits



JSI's Child Health Field Staff (CHFS) carried out a total of 111 district level visits to 45 different districts during the year. This represents monitoring visits to 60% of the total districts in the country. Graph D #1 gives a region-wise comparison of visits conducted in Years 1 and 2. The number of different districts visited increased from 41 to 45, but the total number of district-level visits decreased from 142 to 111 from Year 1 to Year 2.

During district level visits, the CHFS plan the supervision visit schedule with the district staff and also review any progress made since their previous visit. They also monitor the availability of particular commodities and supplies (ORS, Vitamin A capsules, cotrimoxazole, ferrous sulphate, blue plastic cups, ORT corner materials, Family Planning supplies such as oral pills, condoms, Depo Provera). If they identify a shortage of any essential supplies/materials they request the DHO to order them immediately, and then the CHFS follow-up with the JSI Regional Logistics Management Team and with JSI/Kathmandu as necessary. In addition, the CHFS monitor the availability or shortage of essential supplies at Health Facilities and report to the DHO any shortages identified.

Graph D #2: Number of VAC Distribution Sites Visited



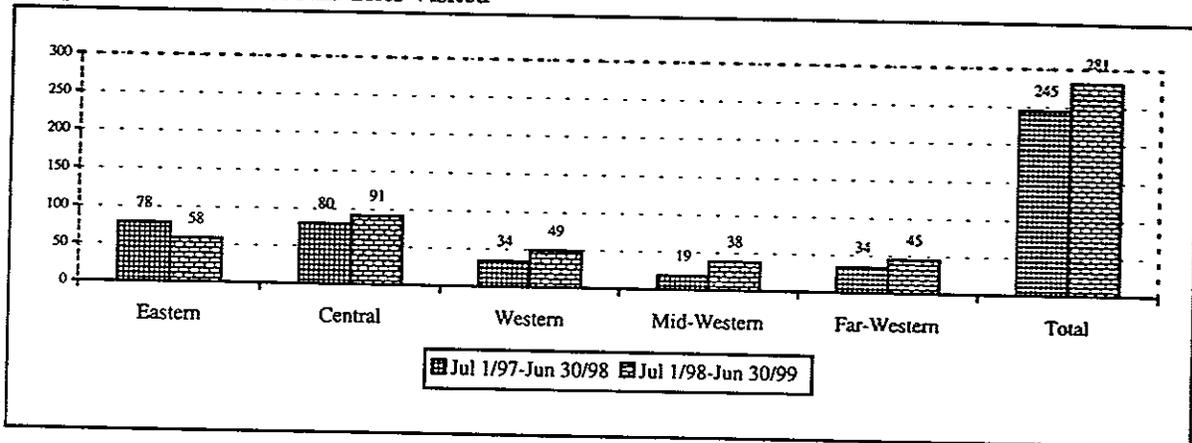
In addition to the regular program monitoring activities, JSI staff also assisted with the monitoring of the April and October Vitamin A capsules (VAC) distribution rounds. In Year 1 they monitored a total of 453 distribution sites in 31 districts; in year 2 they monitored 440 sites in 40 districts. The results, by Region, are compared in Graph D #2.



▲ FCHVs dosing children with Vitamin A Capsules

JSI staff also assisted with the monitoring of the National Immunization Days (NID) during the first and second rounds. In Year 1 they monitored 245 sites in 24 districts, as compared to 281 sites in 29 districts in Year 2. Regionwise breakdown of the NID sites visited is shown in Graph D #3.

Graph D #3: Number of NID Sites Visited



2. Health Facility Level

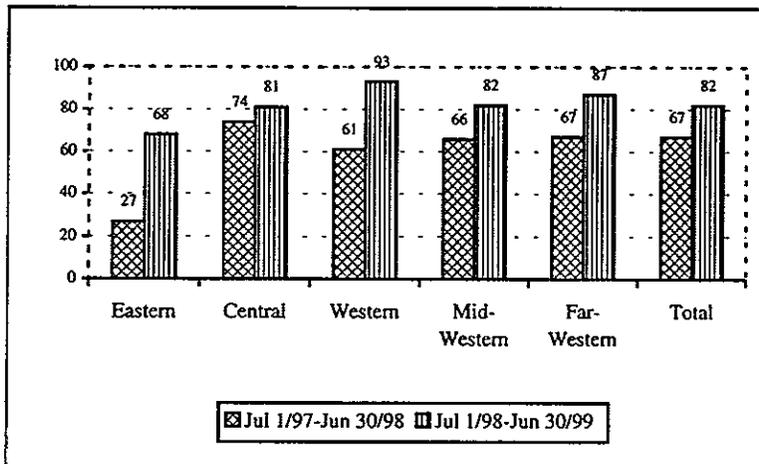
In all 5 regions, JSI's Child Health Field Staff conducted a total of 492 interviews at the health facility level during the period July 1/98–June 30/99 as compared to 499 health facilities visited in the period of July 1/97–June 30/98. The breakdown, by Region and period is shown in Table HF#1.

Table HF #1: Number of HFs Visited by CH Staff

Period	Eastern	Central	Western	Mid-Western	Far-Western	Total
Jul 1/97-June 30/98	37	192	90	56	124	499
Jul 1/98-June 30/99	68	214	75	60	75	492

The CDD Program of the MOH promotes the establishment of Oral Rehydration Therapy (ORT) Corners in all health facilities, to enable staff to treat dehydrated patients on-the-spot in the health facility and also to encourage the demonstration of the preparation and utilization of Oral Rehydration Solution (ORS) in the health facility as a health education opportunity with mothers and caretakers.

Graph HF #1: ORT Corners Available in HFs

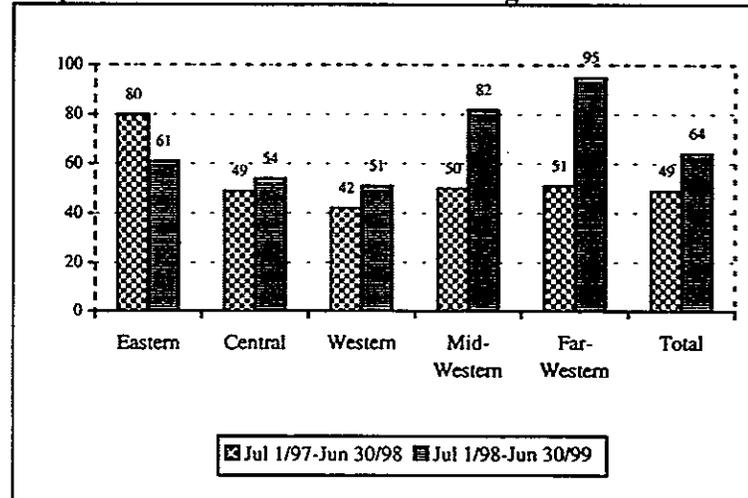


Child Health Field Staff monitor the availability of ORT corner equipment in health facilities and their readiness for use. If they find the equipment set up and ready for use, this is described as a “functioning” ORT corner. Graph HF#1 shows that in Year 2, CHFS found 82% of HFs had ORT corner materials available, as compared to 67% in Year 1. Best availability was in the

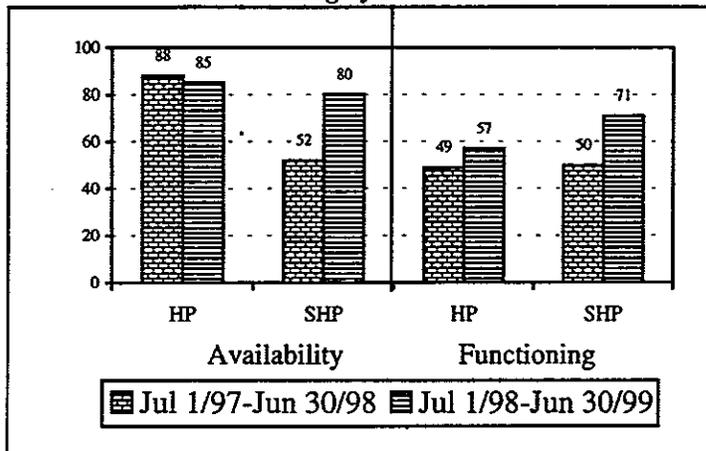
Western and Far Western Regions in Year 2.

In Year 1 of the LCHSSP, Child Health Field Staff found that only 49% of the available ORT corner sets were ready for use, or “functioning”. In Year 2, there was improvement with 64% ready for use, with the best results in the Far-Western and Mid-Western Regions.

Graph HF #2: ORT Corners Functioning in the HF



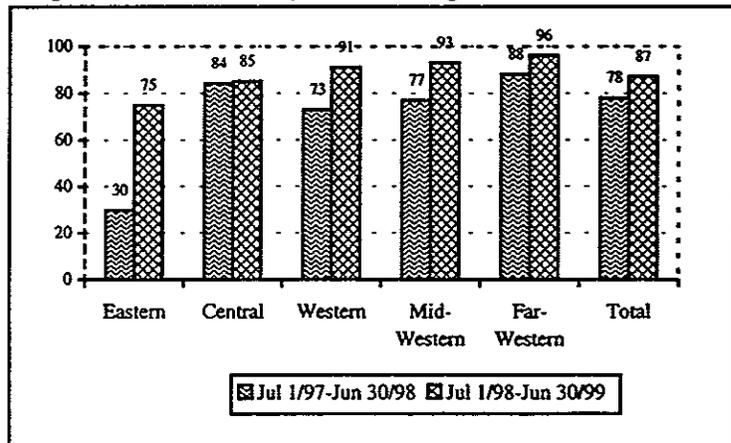
Graph HF #3: ORT Corners Availability and Functioning by Level of HFs



A comparison was made between Health Posts (HPs) and Sub-Health Posts (SHPs) to determine if there was any difference in the availability and “functioning” of the ORT corner sets at the different levels. Graph HF#3 shows that availability of ORT sets increased most at the SHP level between Year 1 and 2, and the ORT corner sets were more likely to be set up and ready for use at a SHP.

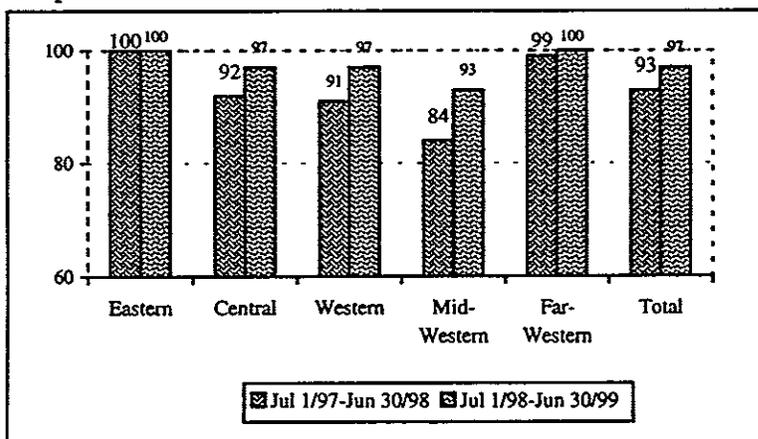
In preparing ORS, it is important that the correct volume of water be utilized so that the solution prepared is neither too dilute and therefore no more beneficial than water, nor too concentrated and potentially harmful. In the health facilities, a standard measuring device of some kind should be available, to ensure that the correct volume of water is measured when preparing ORS and when teaching caretakers.

Graph HF #4: Availability of Measuring Utensil



The HF may have a liter measure, manna, a blue plastic cup, as provided to the FCHVs or some other graduated measure. Graph HF#4 shows overall improvement in the availability of a standard measuring device at the health facilities, with 87% of 492 facilities having an appropriate utensil in Year 2 as compared with 78% of 499 facilities in Year 1.

Graph HF #5: Measurement of Correct Volume of Water

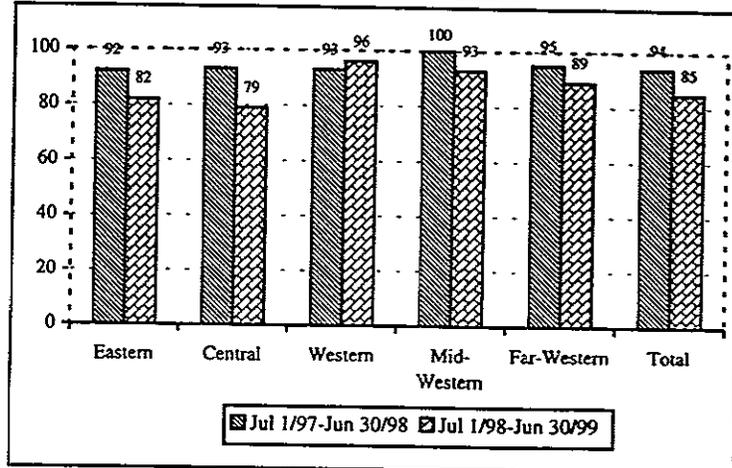


The WHO approved volume of water to be added to one packet of ORS powder is between 950 mls and 1200 mls. When the HF staff were asked to prepare one liter of ORS using the available utensil, there were varying degrees of accuracy in the volume of water measured. Overall there was improvement from 93% to 97% correct preparation including correct volume of water between Year

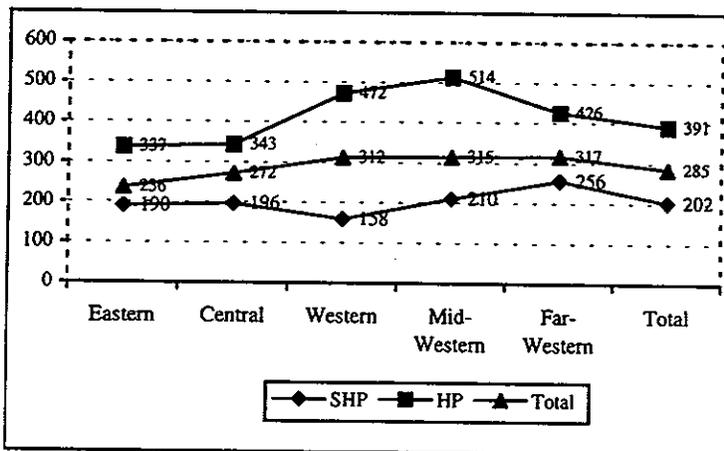
1 and 2. Best performance was in the Eastern and Far-Western Regions.

The National CDD Program, in coordination with the Logistics Management Division, tries to ensure year-round availability of ORS packets in all health facilities of the country. Of the 492 health facilities visited in this year, 85% were found to have ORS on hand on the day of visit. This was decreased from the previous year; due mainly to delays in procurement of ORS through the tender process at the national level and therefore delays in distribution to health facilities.

Graph HF #6: ORS Packets in Stock in HFs



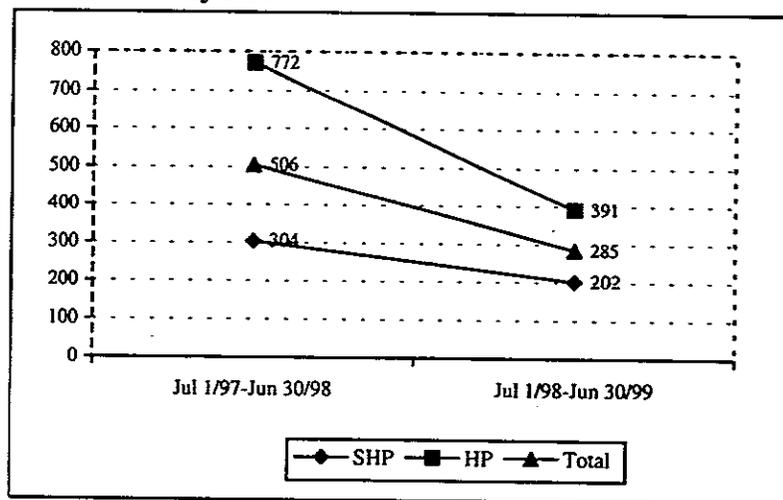
Graph HF #7: Average Number of ORS Packets Available in HFs



A comparison was made between the average number of ORS packets available at HPs and SHPs and the results are shown in Graph HF# 7. The average SHP had 202 ORS packets in stock as compared to an average of 391 per HP, with an overall average availability of 285 ORS packets per Health Facility on the day of visit.

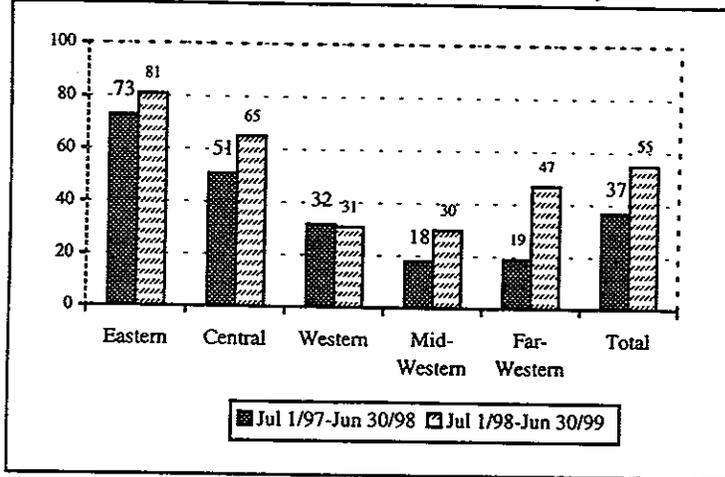
Graph HF #8: Average Number of ORS Packets Available in HFs by Year

Graph HF #8 shows graphically how ORS packet availability per HF dropped significantly between Year 1 and 2 with the average Health Facility having 506 packets in Year 1, as compared with only 285 packets in Year 2. Similarly the average HP availability fell from 772 to 391 packets, and the average SHP availability went from 304 to 202 ORS packets.



The availability of other essential child health and nutrition supplies was also monitored in health facilities: pediatric and adult Cotrimoxazole tablets, iron (ferrous sulphate). Vitamin A availability is shown later in Graph HF #14.

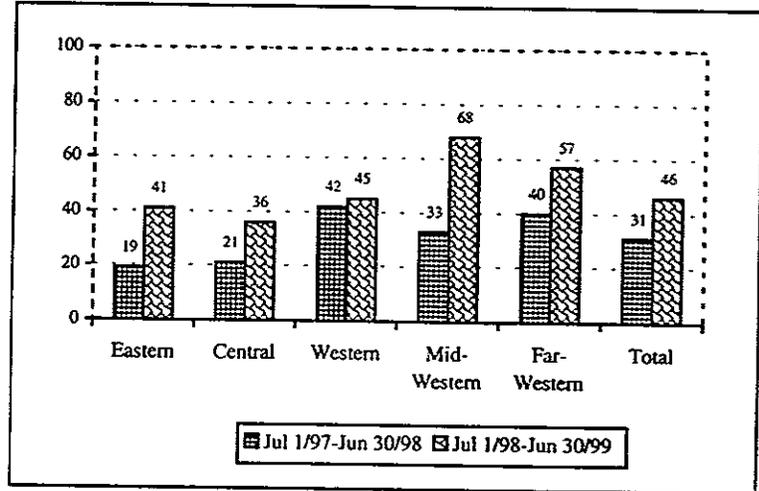
Graph HF#9: Cotrimoxazole (Pediatric) Availability



Graph HF#9 compares the availability of pediatric cotrimoxazole tablets by Region between Years 1 and 2. All regions showed an improvement with an overall increase from 37% to 55% availability in the health facilities.

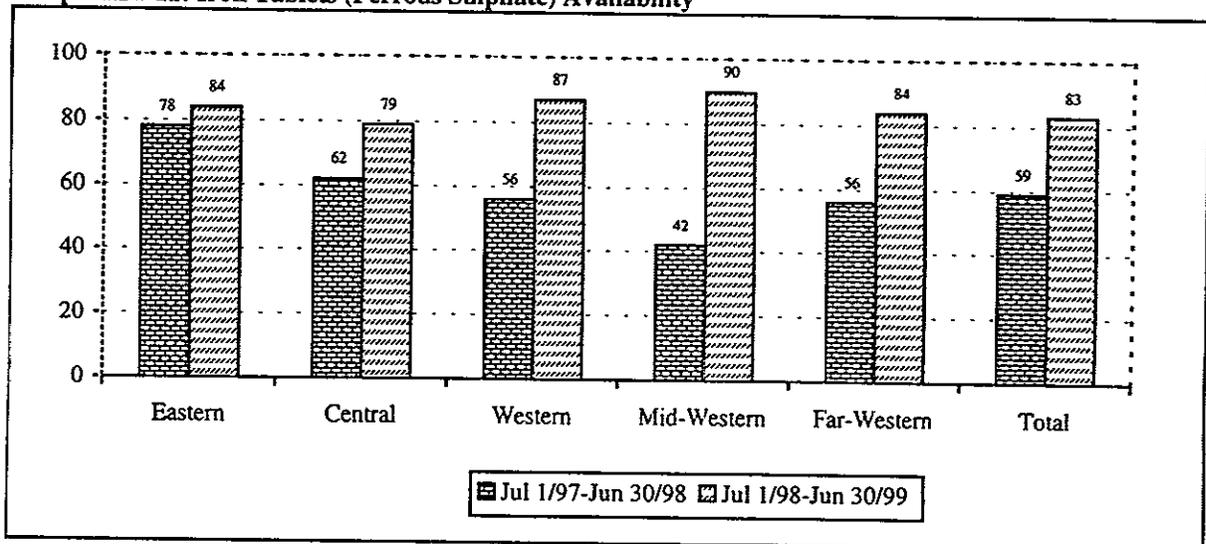
Similarly the availability of adult cotrimoxazole tablets also increased in all Regions between Year 1 and Year 2. Graph HF#10 shows that overall availability increased from 31% to 46% of HFs having adult cotrimoxazole tablets available on the day of visit.

Graph HF #10: Cotrimoxazole (Adult) Availability



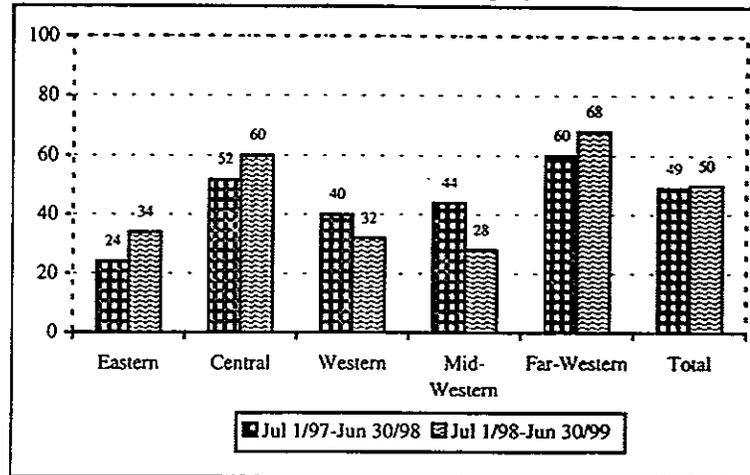
Similarly, Graph HF #11 shows that iron tablet availability at health facilities increased from 59% to 83%, overall, with all regions showing improvement.

Graph HF# 11: Iron Tablets (Ferrous Sulphate) Availability

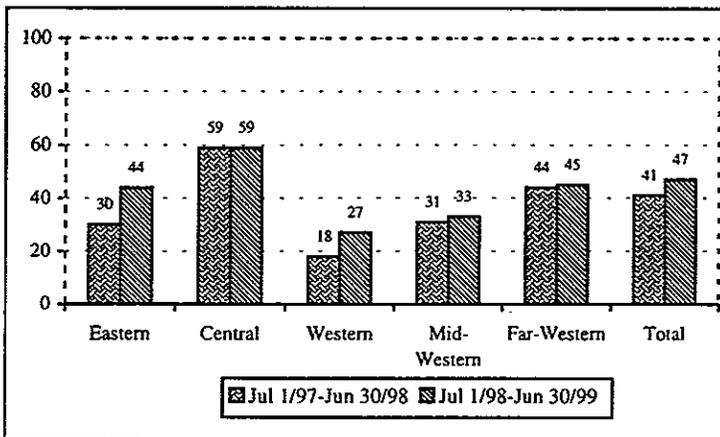


The National CDD/ARI Program and partners working in Child Health programs have produced wall charts in Nepali outlining the WHO-approved guidelines for standard case management of CDD and ARI cases and distributed them to health facilities. CHFS monitored the availability and display of these materials as shown in Graph HF#12 and 13.

Graph HF #12: CDD Treatment Chart Displayed



Graph HF# 13: ARI Treatment Chart Displayed



CDD treatment chart availability improved in health facilities in the Eastern, Central and Far-Western Regions while decreasing in the Western and Mid-Western Regions with overall availability unchanged at about 50%. ARI treatment chart availability improved slightly overall, but still was only available in 47% of the visited health facilities.

During monitoring visits, CHFS provide some materials and supplies on the spot when shortages are identified. A summary of materials distributed by region is shown in Annex 4. LMIS (logistics management information system) reports track availability of some essential supplies at central, regional, district and HF level. Overviews of ORS, Vitamin A and cotrimoxazole availability as reported through LMIS are provided in Annex 5.

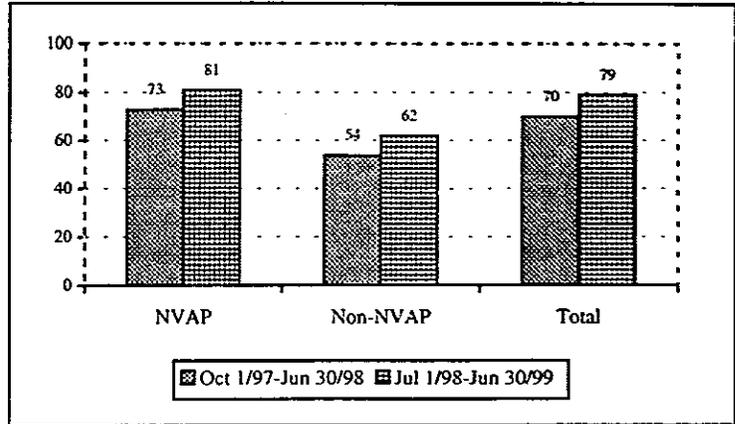
Over a period of 21 months (October 1997 - June 1999), JSI's Child Health field staff has been monitoring the registers in health facilities for case treatment practices and documenting the availability and use of protocols and Vitamin A capsule availability. The differences between NVAP (National Vitamin A Program) and non-NVAP districts, and between October 1/97-June 30/98 and July 1/98 - June 30/99 have been analyzed.

From October 1997 through June 1998, Child Health field staff visited 492 Health Facilities (Health Posts/Sub-Health Posts/Primary Health Care Centers) spread over the 5 Development Regions, 337 in NVAP districts and 56 in non-NVAP districts.

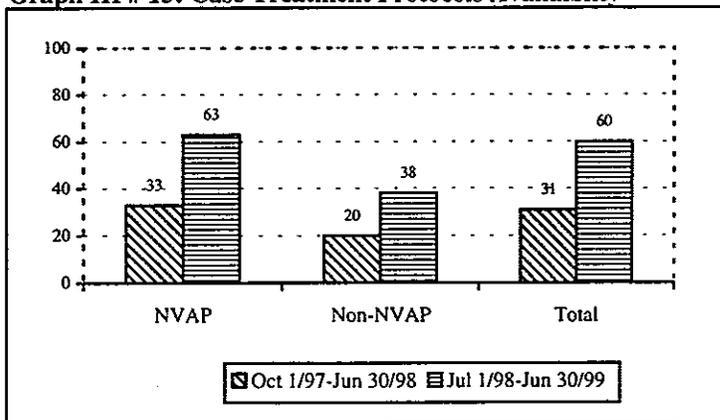
From July 1998 through June 1999, Child Health field staff visited 492 Health Facilities spread over the 5 Development Regions, 437 in NVAP districts and 55 in non-NVAP districts.

In Year 2, on the day of visit 79% of 492 health facilities had high dose Vitamin A capsules (VAC) available as compared with 70% availability in 393 health facilities in Year 1. This year VAC availability increased not only in health facilities in NVAP districts but also in health facilities in non-NVAP districts. These results are shown in Graph HF#14.

Graph HF #14: Vitamin A Capsules Availability



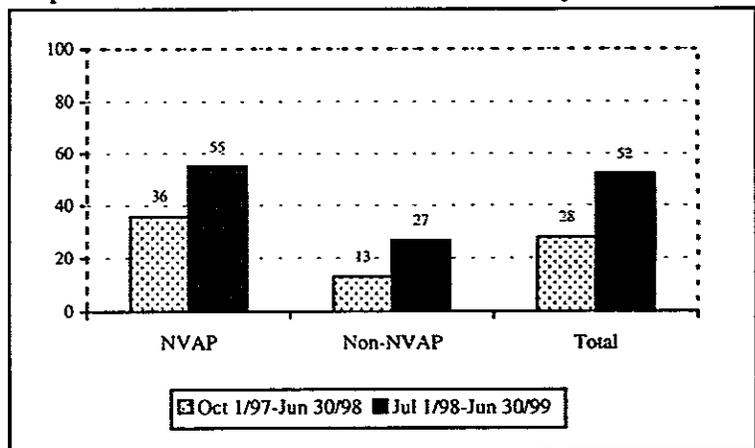
Graph HF# 15: Case Treatment Protocols Availability



Vitamin A Case Treatment protocols should be available in HFs to remind staff of the conditions requiring treatment with VAC and the correct dosages. Availability increased from 31% in Year 1 to 60% in Year 2, with increase availability in HFs in both NVAP and non-NVAP districts. However, availability remained better in NVAP district facilities.

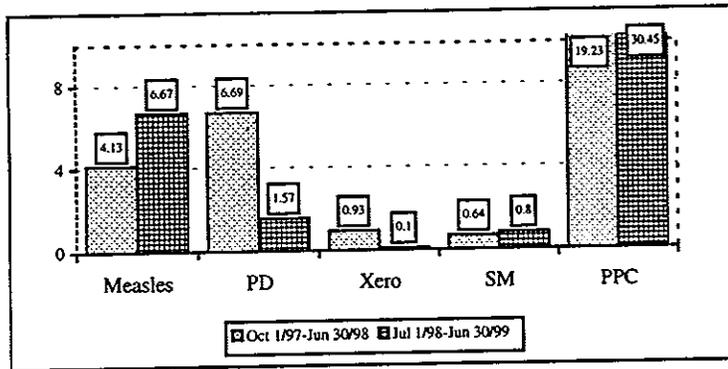
The availability of post-partum dosing protocols increased in health facilities in districts as shown in Graph HF# 16. In Year 2, these protocols were available in 52% of HFs, as compared with 28% in Year 1.

Graph HF #16: Post-Partum Protocols Availability



On review of the Outpatient Register in the Health Facility, Child Health field staff collected information on the number of measles, prolonged diarrhea, xerophthalmia, severe malnutrition and post partum cases recorded as having been treated with high dose Vitamin A capsules within the past one month. As the HMIS still did not have a specific place for recording such information, the best source of this treatment data is from the OPD register review. The data for one month was extrapolated for one year to give an average number of measles and other cases being treated per health facility visited. The results are shown in Graphs HF #17 and HF #18 below. The former shows results in NVAP districts for the 2 years and the latter for the non-NVAP districts.

Graph HF #17: Estimated Number of Cases Treated with High Dose VAC per Health Facility Over a One Year Period in NVAP Districts

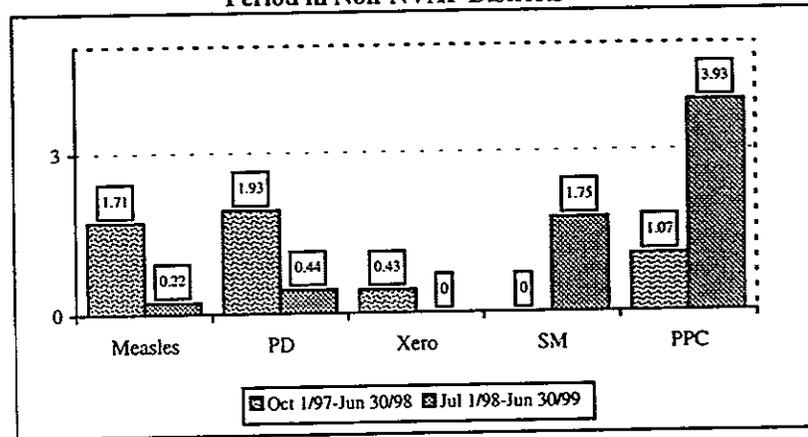


The results in NVAP districts show an increase in the average number of measles, severe malnutrition and postpartum cases treated with VAC per HF in year 2 as compared to year 1. The number of xerophthalmia and prolonged diarrhea cases treated decreased. There could be fewer cases as a result of inclusion of these districts in the NVAP;

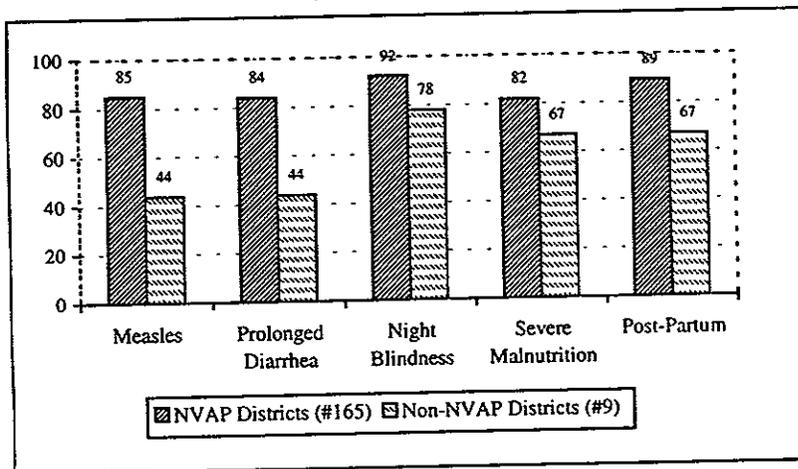
increased measles treatment could also be a result of increased awareness among HF staff about the need to use VAC for measles cases.

Graph HF #18: Estimated Number of Cases Treated with High Dose VAC Per Health Facility Over a One Year Period in Non-NVAP Districts

In non-NVAP districts there was a decrease in the number of measles, prolonged diarrhea and xerophthalmia cases treated, with an increase in the number of severely malnourished and postpartum cases. No clear explanation for these differences is forthcoming.



Graph HF #19: HF Staff Knowledge About Conditions Which Should Receive High Dose Vit A Capsules (VAC) (Mar - Jun 99)



During the JSI Child Health Review Meeting in February 1999 it was decided that a question should be added to the interview with HF staff to determine how familiar they were with the conditions which require treatment with VAC. Results in NVAP and non-NVAP districts are compared in Graph HF #19. Knowledge was good in NVAP districts,

with over 80% of staff knowing the 5 conditions requiring VAC; in non-NVAP districts results were considerably poorer, with only 44% of staff knowing that measles and prolonged diarrhea cases require treatment with VAC. These topics need stress, particularly in the districts which have not yet been included in the National Vitamin A Program.

3. Village Health Worker (VHW)/Maternal Child Health Worker (MCHW) Level

In Year 2 of the project (July 1998- June 1999) JSI's Child Health Field Staff conducted a total of 278 general interviews with either VHWs or MCHWs. This represents a slight increase from Year 1, when 274 VHWs/MCHWs were interviewed. The comparison is shown in Table VM #1 above. The most interviews were conducted in the Eastern and Central Regions.

Table VM #1: Number of VHWs/MCHWs Monitored by CH Staff

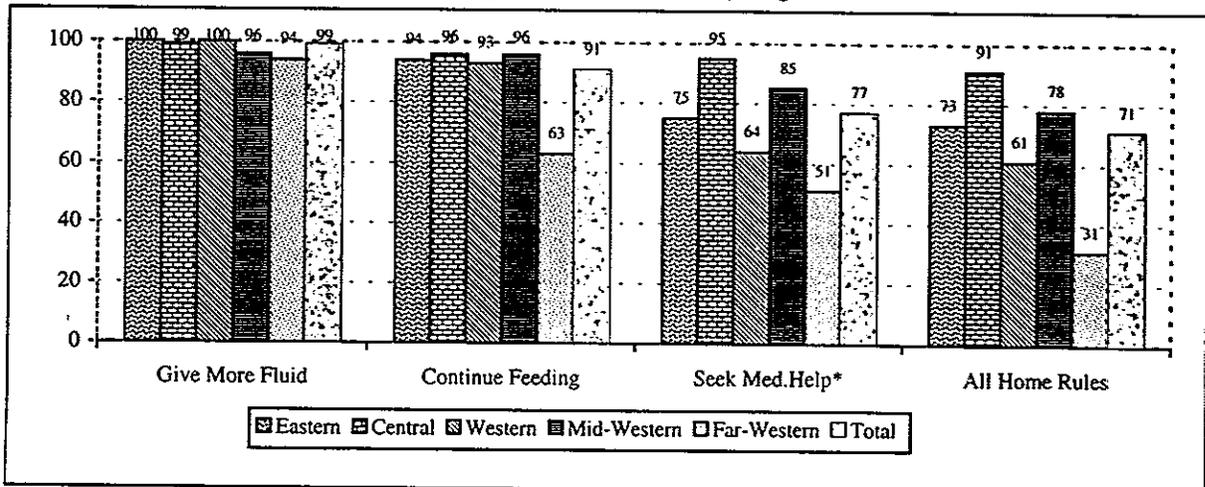
Period	Eastern	Central	Western	Mid-Western	Far-Western	Total
July 1/97-June 30/98	23	68	72	17	94	274
July 1/98-June 30/99	80	80	56	27	35	278

General interviews with VHWs/MCHWs include questions to determine their knowledge about AIDs, FP, diarrheal disease, signs of pneumonia and vitamin A deficiency, nutrition and questions about the activities they conduct including support for the FCHVs. Not all analyses are included in this report but those relating to diarrhea, pneumonia, and general activities are included.

The CDD Program stresses the importance of knowledge about the 3 home rules for care of children with diarrhea for all health workers and caretakers. These 3 rules, which are to be followed at home whenever a child gets diarrhea, are:

1. Increase the volume of fluids that the child receives. This means any kind of fluid: water; juice; liquid from preparing rice, lentils or vegetables; ORS.
2. Continue to feed the child throughout the episode and after recovery.
3. Watch for danger signs and take the child to a health facility if they have one of the following danger signs: many watery stools; repeated vomiting; marked thirst; eating or drinking poorly; fever; blood in the stool.

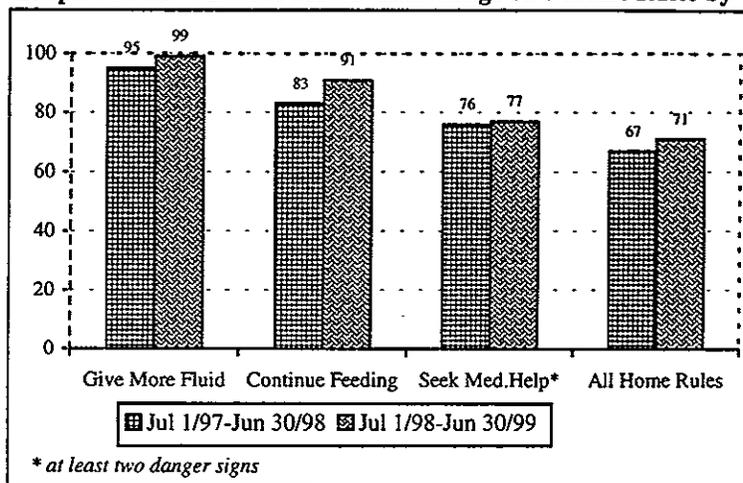
Graph VM # 1: VHW/MCHWs' Knowledge on 3 Home Rules by Region



*At least two danger signs

Graph VM #1 above compares VHW/MCHW knowledge by Region about these 3 home rules. VHWs and MCHWs in the Far-Western Region had poorer knowledge in all areas. The first home rule, increase fluids whenever the child has diarrhea, showed the best results with an average of 99% of these health workers giving the correct response; 91% stated that the child should continue to be fed; 77% were aware of at least two conditions which require the child to be referred to the nearest health facility. Overall 71% knew all three home rules.

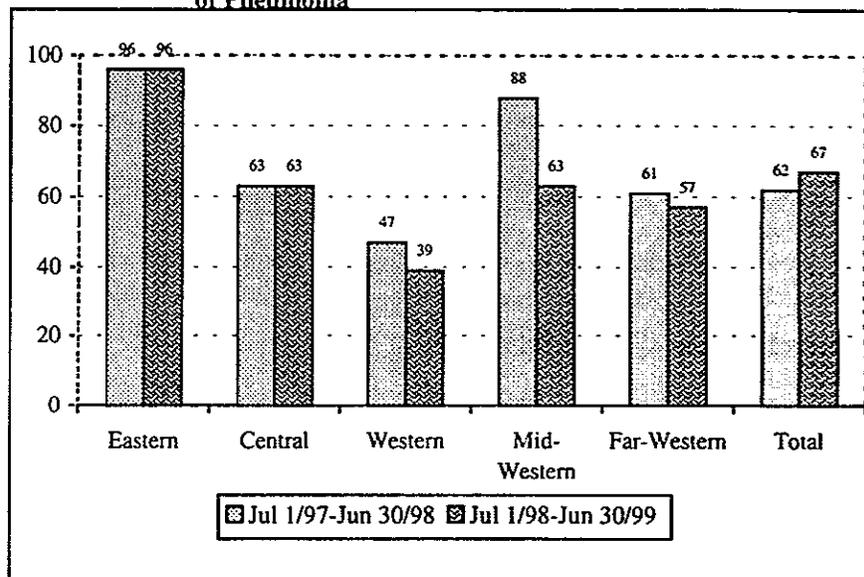
Graph VM #2: VHW/MCHWs' Knowledge on 3 Home Rules by Year



Graph VM #2 compares the overall results between Year 1 and 2 of the project. There was slight improvement in all areas with an increase in knowledge of all 3 home rules from 67% to 71%. There is still room for improvement in all areas, except "increasing fluids".

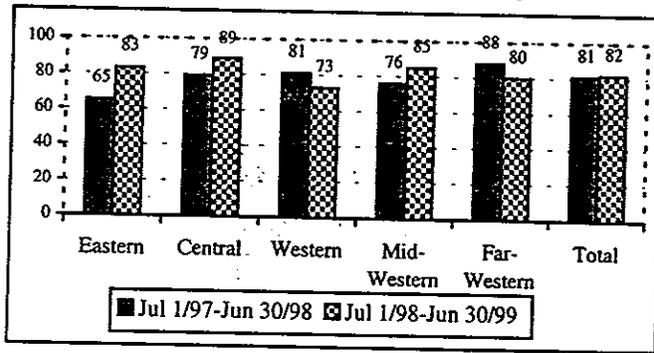
Graph VM #3: VHW/MCHWs' Knowledge on 3/more than 3 Danger Signs of Pneumonia

VHWs and MCHWs need to be aware of the danger signs of pneumonia and dehydration in order for them to advise FCHVs and caretakers about when to seek further help for sick children. Graph VM #3 shows the comparison by Region between Year 1 and 2 of the VHW/MCHW



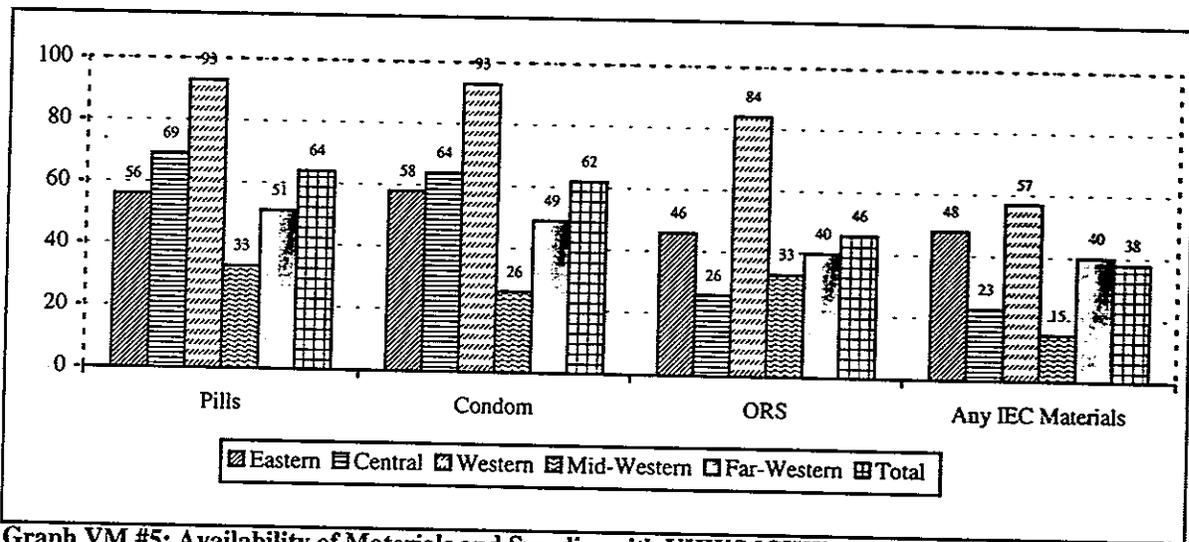
knowledge about 3 or more than 3 danger signs for pneumonia. While there was no overall change in the Eastern and Central Regions, there appeared to be some decrease in knowledge in the other 3 regions. In the overall assessment, there appeared to be a slight increase as the number of VHW/MCHWs interviewed in the Central and Eastern regions was much higher than in the other regions. No targeted training was given to this level of health worker during these two years in any districts in the Western, Mid-Western and Far-Western Regions with the exception of Bajura.

Graph VM #4: VHW/MCHWs' Knowledge on 3/more than 3 Danger Signs of Dehydration



Similarly for diarrheal disease, VHWs and MCHWs need to be aware of the danger signs of dehydration in order to be able to advise FCHVs and caretakers about when to seek help for sick children. Graph VM #4 shows the comparison of their knowledge on 3 or more danger signs of dehydration. Knowledge improved in the Eastern, Central and Mid-Western Regions,

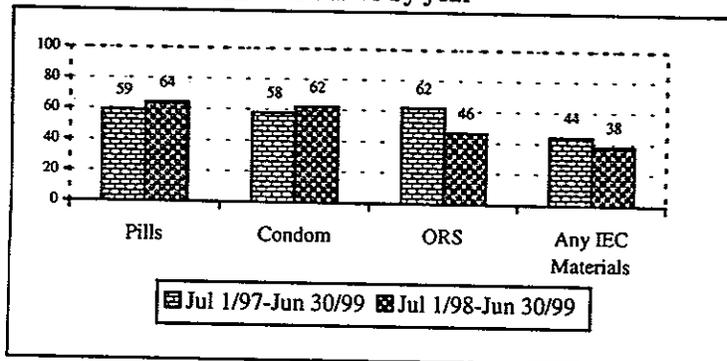
while there was some decrease in the other two regions with overall very little change between year 1 and 2. Still, the level of knowledge is quite good and encouraging if these health workers are passing on their knowledge to FCHVs and caretakers.



Graph VM #5: Availability of Materials and Supplies with VHW/MCHWs

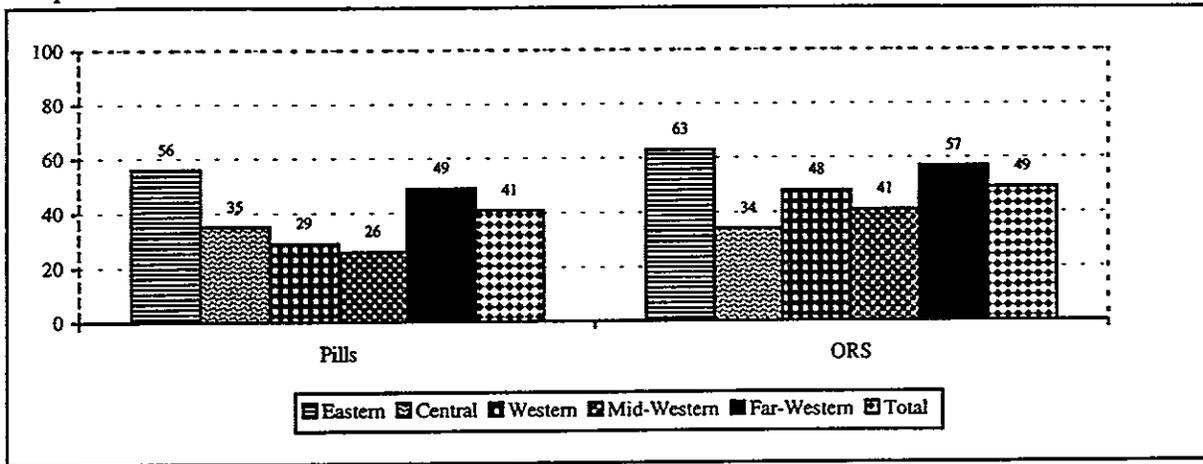
VHWs and MCHWs are provided with some materials and supplies and their availability is monitored by CHFS. In Graph VM#5 availability of specific items is compared by Region. The Western Region showed the best availability for all commodities - birth control pills, condoms, ORS packets and IEC materials. The Mid-Western Region was poor in all areas. Overall, 64% of VHW/MCHWs had pills, 62% had condoms, 46% had ORS packets and 38% had any IEC materials.

Graph VM #6: Availability of Materials and Supplies with VHW/MCHWs by year

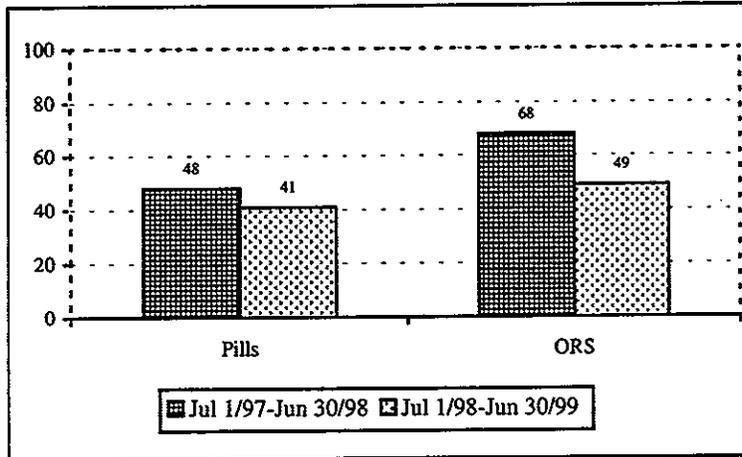


Graph VM #6 compares these results between Years 1 and 2 of the project. Pill and condom availability slightly increased in Year 2; ORS and IEC materials decreased. The ORS shortage is related to the general shortage of ORS at health facilities.

Graph VM #7: Pills and ORS Distribution to FCHVs and Clients (in last month)



Graph VM #8: Pills and ORS Distribution to FCHVs and Clients (in last month) by Year

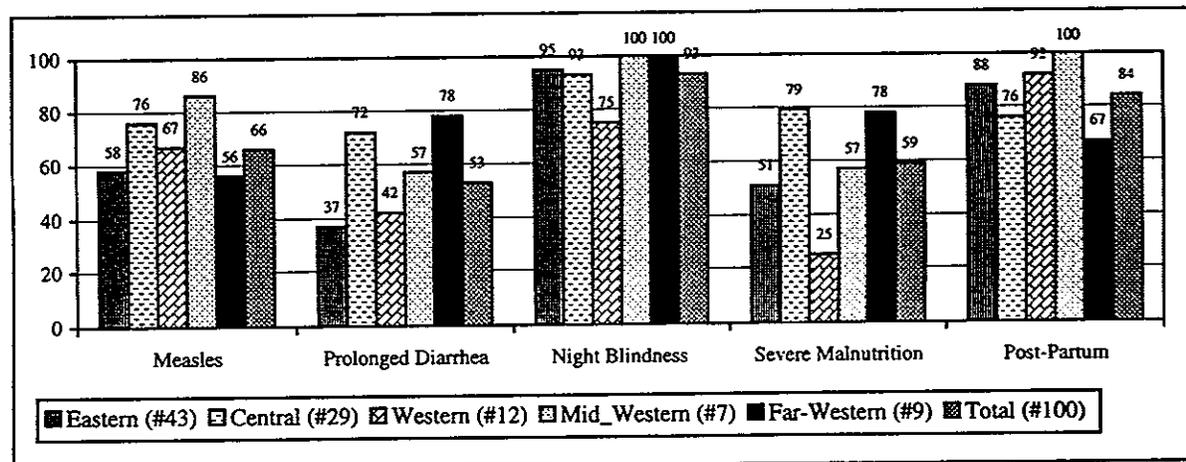


VHWs/MCHWs were asked about their distribution of pills and ORS packets to FCHVs and to clients during the past one month. Graph VM #7 shows the results by Region; overall 41% had distributed pills and 49% had distributed ORS packets during the past one month. When comparing these results with those of the previous year, Graph VM #8 shows that both activities decreased in Year 2.

Pill distribution decreased from 48% to 41% and ORS distribution fell from 68% in Year 1 to 49% in Year 2.

From March 1999, VHWs/MCHWs were asked to name (unprompted) conditions which require treatment with high dose VAC. Graph VM #9 shows their responses by region. Night blindness and postpartum were stated most frequently.

Graph VM #9: VHW/MCHWs' Knowledge on Conditions to Receive High Dose Vitamin A (Mar - Jun 99)



4. FCHV Level

Table F #1: Numbers of FCHVs Visited by Child Health Staff

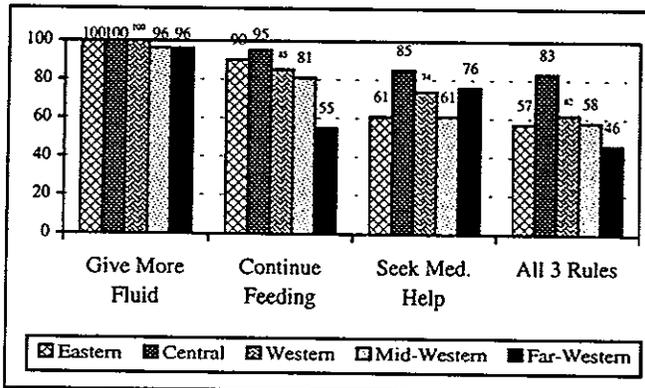
Period	Eastern	Central	Western	Mid-Western	Far-Western	Total
July 1/97-June 30/98	87	163	171	64	242	727
July 1/98-June 30/99	211	152	130	77	146	716



▲ Child Health Staff Interviewing FCHV

In the year July 1998 through June 1999, JSI's Child Health Field Staff conducted a total of 716 general interviews with FCHVs. In the previous year, 727 FCHV interviews were conducted. The content of these interviews can be determined from review of the checklist in Annex 3 of this report. The most interviews (211) were conducted in the Eastern Region. In this year, fewer FCHVs were interviewed in the Western and Far-Western Regions as compared to the previous year. The reason was that the Child Health Field Officers devoted more of their time to the community-based pneumonia/ARI control program activities in Rasuwa and Bajura (respectively).

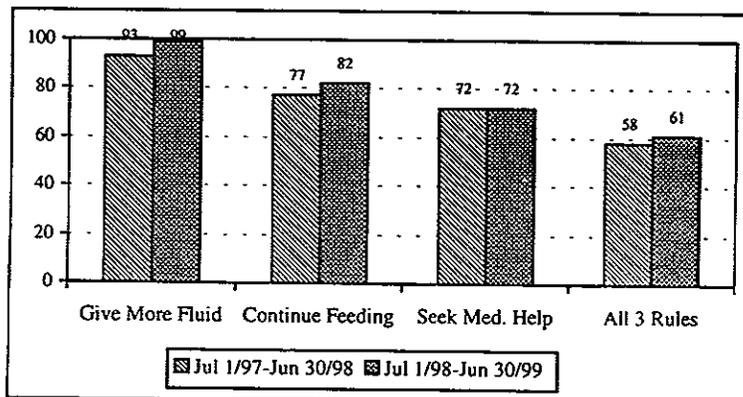
Graph F #1: FCHV's Knowledge on 3 Home Rules



FCHVs were asked about their knowledge of the three home rules for care of children with diarrhea. The results are compared by region in Graph F #1. In all regions, FCHV knowledge on rule number 1, "give increased fluids" was very good. Fewer FCHVs said that the child should continue to be fed throughout the illness and after, but the poorest knowledge was in the Far-Western Region. Awareness of reasons to seek medical help varied between

regions, with the poorest results obtained from the Eastern and Mid-Western Regions. It is interesting to note that FCHVs in the Central Region, which was the only region in which the CDD Reactivation training and follow-up activities reached to the FCHV level, had better knowledge of rules 2 and 3 and all 3 home rules than their counterparts in other regions.

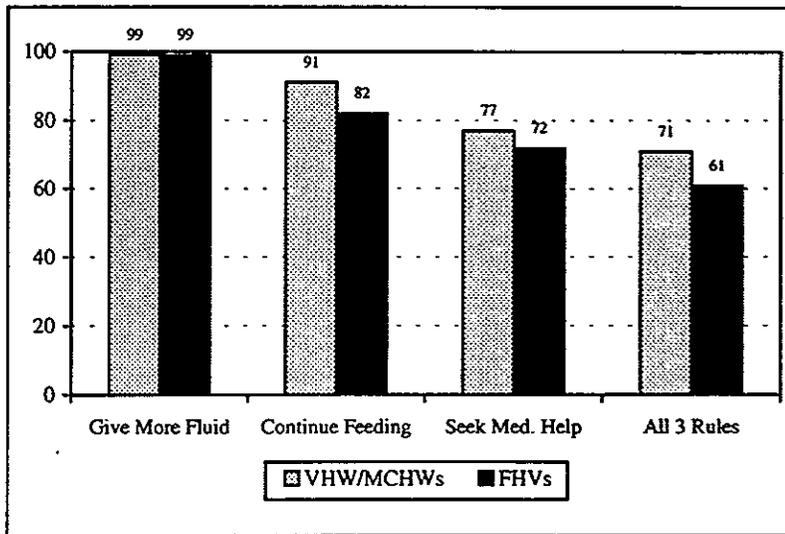
Graph F#2: FCHVs' Knowledge on 3 Home Rules by Year



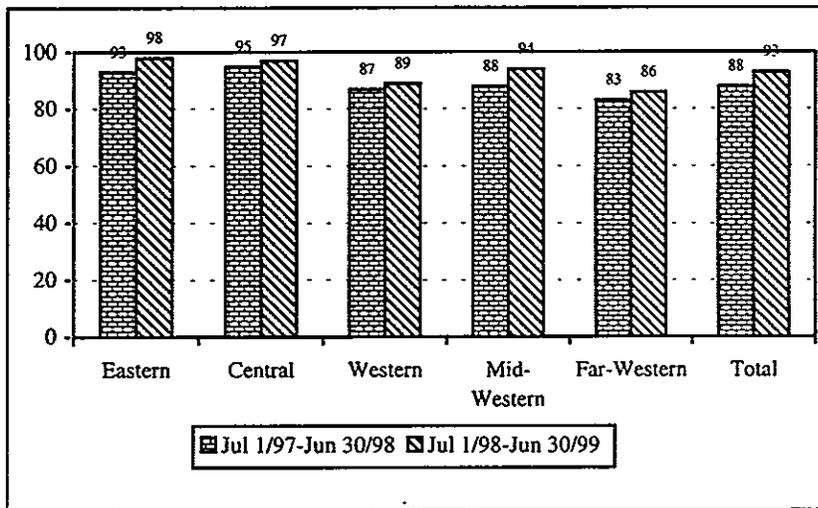
Graph F #2 compares the FCHVs' knowledge by year and shows slight improvement overall between Year 1 and Year 2, with 61% of FCHVs knowing all three home rules in Year 2.

Graph F #3: Comparison between VHWMCHWs and FCHVs' Knowledge on 3 Home Rules

The knowledge of FCHVs was compared with that of VHWMCHWs and is shown graphically in Graph F #3. It is interesting to note that the FCHVs, who are often illiterate and/or have not had opportunities for formal education had almost the same level of knowledge as the VHWMCHWs. This was also observed during the analyses of the Year 1 data.



Graph F #4: FCHVs' Knowledge on 2/more than 2 Dangers Signs of Dehydration by Region

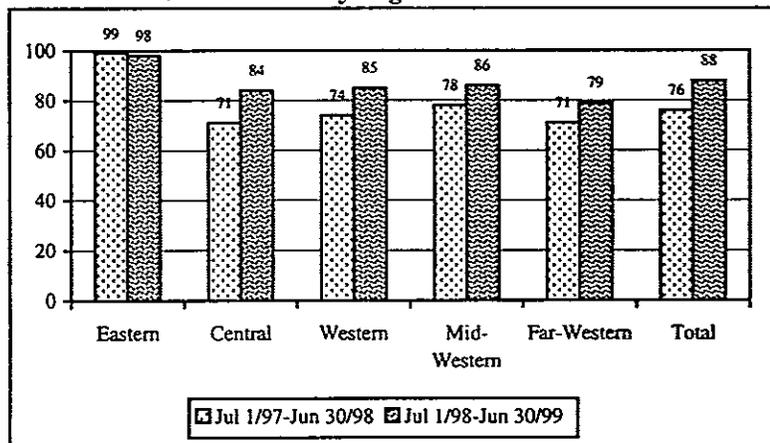


Graph F #4 summarizes by region and year the results of monitoring to determine the FCHVs' knowledge of at least 2 danger signs of diarrheal dehydration. Overall, 93% of FCHVs in Year 2 could name at least 2 danger signs, as compared with 88% in Year 1. Some improvement was seen in all regions, which may be due to several factors: emphasis during FCHV

review/refresher meetings; radio messages and posters targeting these messages.

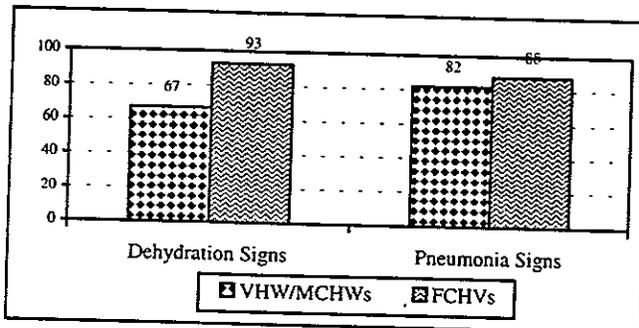
Graph F #5: FCHVs' Knowledge on 2/more than 2 Dangers Signs of Pneumonia by Region

FCHVs must also be aware of the danger signs of pneumonia so they can appropriately advise caretakers and refer sick children. Graph F #5 compares FCHVs' knowledge of at least 2 danger signs of pneumonia by region and year. Eastern region showed excellent knowledge as all interviews were conducted in districts where the community-based pneumonia



control program has been implemented; all other regions showed improvement probably for similar reasons to those stated above, emphasis during trainings and targeted IEC messages both on radio and printed material.

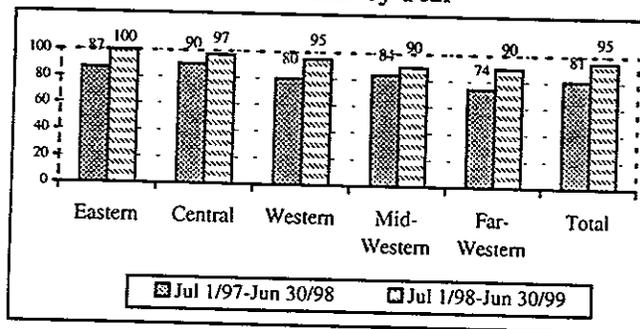
Graph F #6: Comparison of VHWMCHWs' and FCHVs' Knowledge on Danger Signs of Pneumonia and Dehydration



Comparison was made between VHWMCHWs' and FCHVs' knowledge of danger signs for dehydration and pneumonia and the results are shown in Graph F#6. The comparison may not be completely fair, as the former are asked to state 3 danger signs, while FCHVs are only asked to state two. However, it is very interesting to note that FCHVs

outperformed paid, literate health workers. Ninety-three percent of FCHVs stated the danger signs of dehydration as compared to 67% of VHWMCHWs; 88% of FCHVs knew the danger signs for pneumonia as compared to 82% of VHWMCHWs.

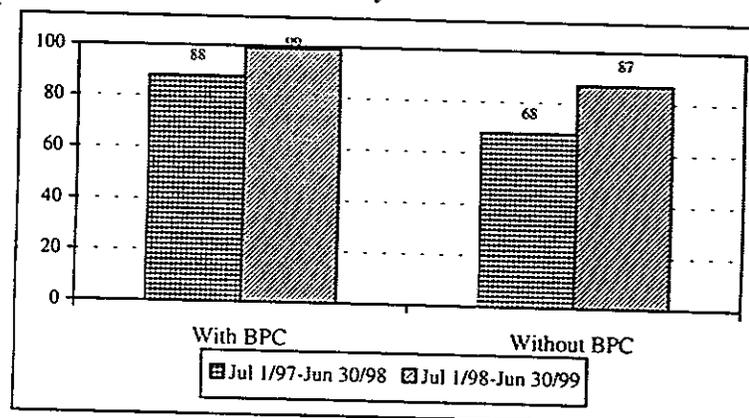
Graph F #7: FCHVs' Skill on Measurement of Correct Volume of Water by Year



During monitoring visits with FCHVs they are always asked to demonstrate the preparation of ORS and the volume of the solution prepared is measured by the Child Health Field Staff using a graduated cylinder. This helps to reinforce for the FCHVs that correct volume is important and that they too must ensure that they are teaching correct

preparation to caretakers of sick children. Graph F #7 shows that there has been an improvement in correct preparation in all regions between Year 1 and 2 with an overall increase in correct preparation from 81% to 95% in interviews with 716 FCHVs.

Graph F #8: FCHVs' Measurement of Correct Volume of Water for ORS Preparation by Blue Plastic Cup (BPC) Availability



The National Control of Diarrheal Diseases (CDD) Program has tried to provide a blue plastic cup (BPC) to all FCHVs in the country, to ensure that they will have a standard measuring device to teach the correct preparation of ORS. JSI's CHFS monitored the availability of the BPC and correlated availability with the ability to measure the correct

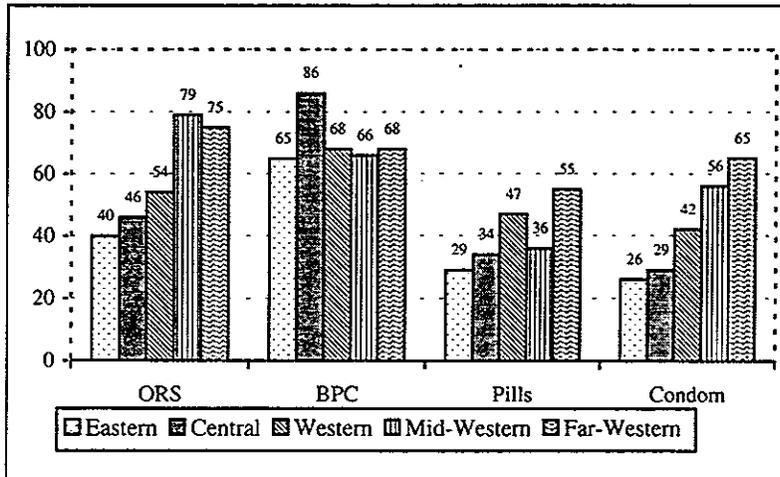
volume of water. Results are shown in Graph F #8. Ninety-nine percent of FCHVs who had a



▲ CHFO measuring ORS prepared by FCHV

BPC in year 2 were able to correctly prepare ORS; 87% of those who did not have the BPC also measured the correct volume of water. The number of FCHVs who did not have a BPC was low. There was an improvement in both groups' performance between Year 1 and 2.

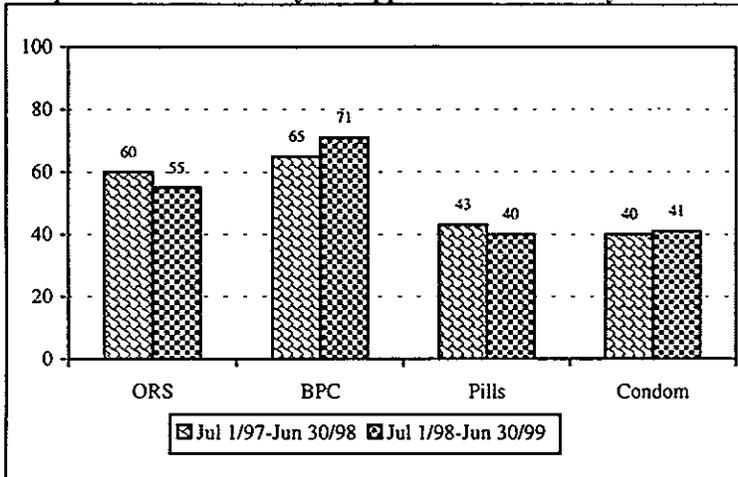
Graph F #9: Availability of Supplies with FCHVs



In order to provide services in her community, the FCHV is provided with some supplies from her nearest health facility. The availability of some specific items was monitored and is shown in Graph F #9. ORS packet availability varied greatly, from a high of 79% in the Mid-Western Region to a low of only 40% in the Eastern Region. Blue Plastic Cups (BPCs) were available with

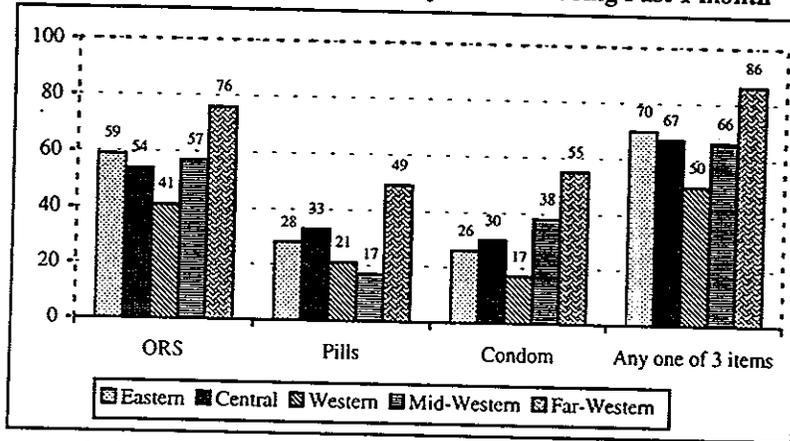
between 65 and 68% of FCHVs in the Eastern, Western, Mid and Far Western Region, but with 86% of FCHVs in the Central Region. This again reflects the community-based focus of the CDD Reactivation Program in the Central Region. Availability of pills (oral contraceptives) was low in all regions, ranging from 29% in the Eastern Region to 55% in the Far West. Condom availability ranged from 26% in the East to 65% in the Far West. When asked, FCHVs often stated that they had few clients for pills and condoms and therefore did not see any need to keep a stock on hand.

Graph F # 10: Availability of Supplies with FCHVs by Year



Graph F #10 compares the availability of these supplies with FCHVs over two years. While the availability of Blue Plastic Cups increased from 65% to 71%, ORS and pill availability went down slightly and condoms remained almost unchanged.

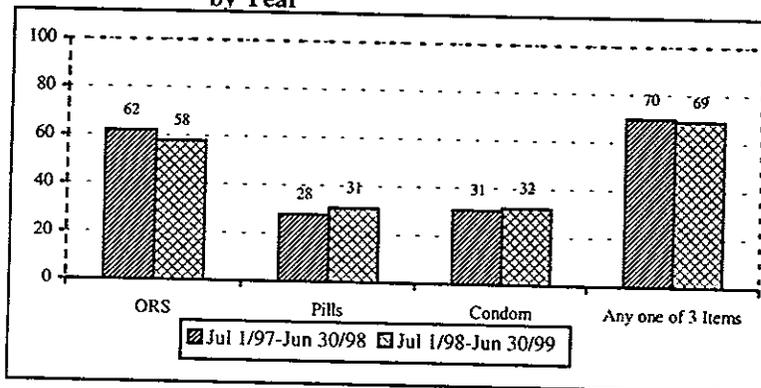
Graph F#11: Supplies Distributed by FCHVs During Past 1 month



As with the VHW/MCHWs, FCHVs were also asked what supplies they had distributed during the past one month to clients. Whenever possible, FCHV record books were reviewed to determine which services had been provided. However, if records were not updated in those cases the CHFS also noted the FCHVs' verbal reports of services

provided. From the year 1999/2000 onwards the HMIS will also be collecting information about these services provided by the FCHVs so records should be available for review. Graph F #11 shows that FCHVs in the Far Western Region were most active in providing ORS, pills and condoms to clients. Eighty-six percent of interviewed FCHVs reported providing at least one item in the past one month. Activity varied in other regions, with the lowest activity (50%) reported from the Western Region.

Graph F #12: Supplies Distributed by FCHVs During Past 1 Month by Year



Graph F #12 compares distribution of supplies between Years 1 and 2 of the project and overall there is very little difference, with 70% in Year 1 and 69% in Year 2 reporting provision of at least one service within the past one month. ORS distribution dropped slightly, and pills and condom distribution increased slightly.

The drop in ORS distribution is linked to decreased availability and therefore some hoarding at the health facilities. The latter is not linked with any shortage of supplies but more with the perception that there are few clients. A change in these attitudes will be encouraged over the next year through support from the Central and District levels, and with direction going to the HFs and VHWs/MCHWs to provide supplies to the FCHVs for distribution to clients in their wards.

FCHV Level – National Vitamin A Program Districts (NVAP)

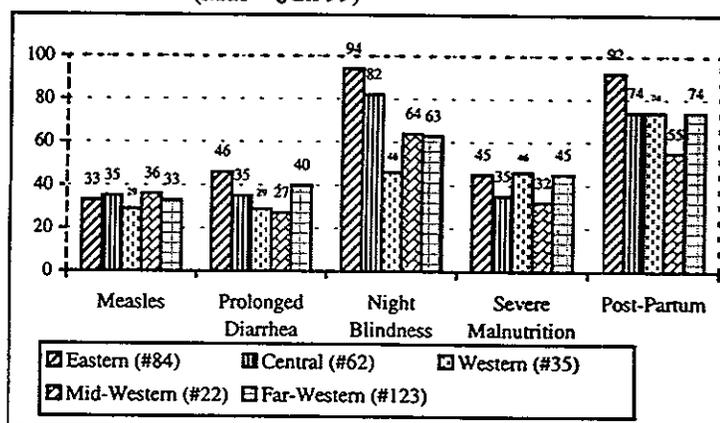
Table Fvit#1: Number of FCHVs Interviewed by CH Staff

Period	Eastern	Central	Western	Mid-Western	Far-Western	Total
Oct 1/97-June 30/98	88	50	117	52	223	530
July 1/98-June 30/99	217	114	117	76	194	718

Responsibility for support to the National Vitamin A Program (NVAP) was added to the JSI portfolio in mid-1997 under the LCHSSP. A new checklist was developed in September 1997 and revised in subsequent meetings to assist CHFS in monitoring some specific areas related to the NVAP. The table above compares the number of FCHVs interviewed on their Vitamin A knowledge and activities in Year 1 (530 in 9 months) and Year 2 (718). The largest number of interviews was conducted in the Eastern Region (217) followed by the Far Western Region (191) during Year 2.

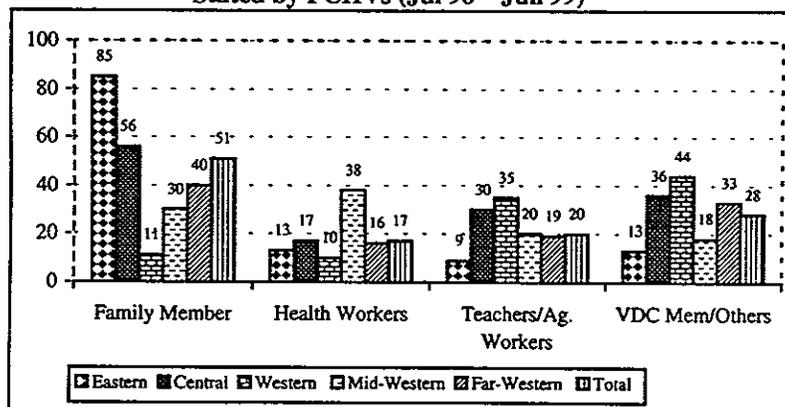
Graph Fvit #1: FCHVs' Knowledge on Conditions to Receive High Dose Vit A in the NVAP Districts (Mar – Jun 99)

As the availability of Vitamin A capsules (VAC) has greatly increased in HF's, reaching 79% in Year 2 of the project, it has now become important to increase awareness and demand from the community side to ensure that children who require treatment with VAC are brought to the HF's. Therefore, the FCHV-Vitamin A checklist was revised in February 1999 to include a



question about their awareness of the conditions requiring treatment with VAC. Graph Fvit #1 compares the knowledge of 326 FCHVs, by region, about the main conditions requiring treatment. Overall 33% of FCHVs knew that measles cases should be given VAC; 39% stated "prolonged diarrhea"; 73% stated "night blindness"; 43% knew "severe malnutrition"; and 77% stated that "post-partum" women should be given VAC. The FCHV review/refresher meeting curriculum will be revised for next year, to ensure that this important information is disseminated through their regular meetings.

Graph Fvit #2: Source of Assistance Provided to the FCHVs During the Time of the Last VAC Distribution by Region as Stated by FCHVs (Jul 98 – Jun 99)

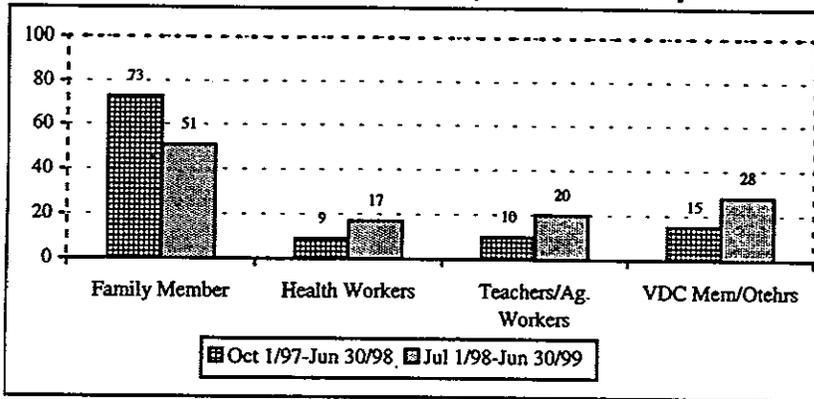


FCHVs in NVAP districts were asked who had helped them during the last Vitamin A distribution round. Results for Year 2 are shown in Graph Fvit #2.

There was a lot of variation between Regions; family members were more likely to help in the Eastern and Mid-

Western Regions; VDC members, teachers and agriculture workers were more active in the Western Region; health workers were most active in the Mid-Western Region.

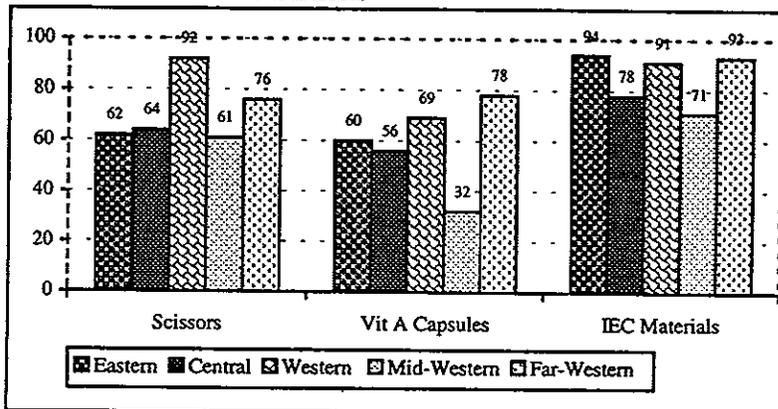
Graph Fvit #3: Source of Assistance Provided to the FCHVs During the Last VAC Distribution By Year as Stated by FCHVs



Graph Fvit #3 compares the results for Year 1 and 2. FCHVs reported that assistance received from their own family members had decreased from 73% of the FCHVs getting support in Year 1 to 51% in Year 2. In other categories, support increased from Year 1 to Year 2. Initially only 9% of

FCHVs reported getting assistance from health workers, but this increased to 17%; similarly support from teachers or agriculture workers increased from 10% to 20%; and support from VDC members/others increased from 15% to 28%. These trends are encouraging as a wider group of community members are providing needed assistance during distribution days.

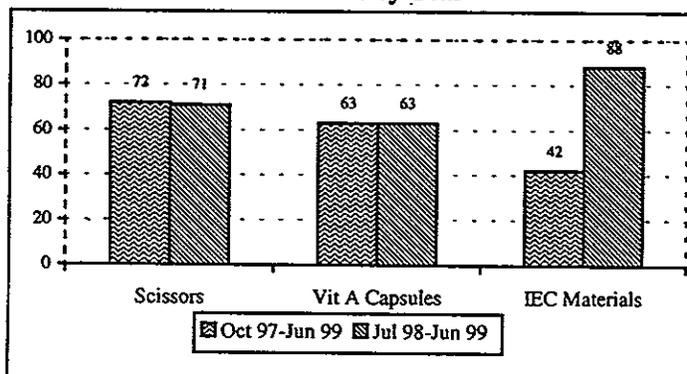
Graph Fvit #4: Vit A Materials Available with FCHVs by Region in the NVAP Districts



FCHVs require some specific materials to carry out their Vitamin A related activities and the availability of these materials with FCHVs in the NVAP districts was monitored. Results are shown in Graph Fvit #4. Scissors were available with 61% to 92% of FCHVs with best availability in the Western Region; Vitamin A capsules

were available with 32% (Mid West) to 78% (Far West) of the FCHVs; Vitamin A related IEC materials were available with 71% (Mid West) to 94% (East) of FCHVs interviewed.

Graph Fvit #5: Vit A Materials Available with FCHVs in the NVAP Districts by Year



Graph Fvit #5 compares the availability of these materials in NVAP districts between Year 1 and 2. Availability of scissors and VAC did not change but there was a great increase in the availability of Vitamin A related IEC materials, from only being available with only 42% of FCHVs in Year 1 to 88% of FCHVs having materials in Year 2. UNICEF, USAID, NTAG and the MOH all

contributed to this improvement in IEC material availability.

5. Nutrition Monitoring

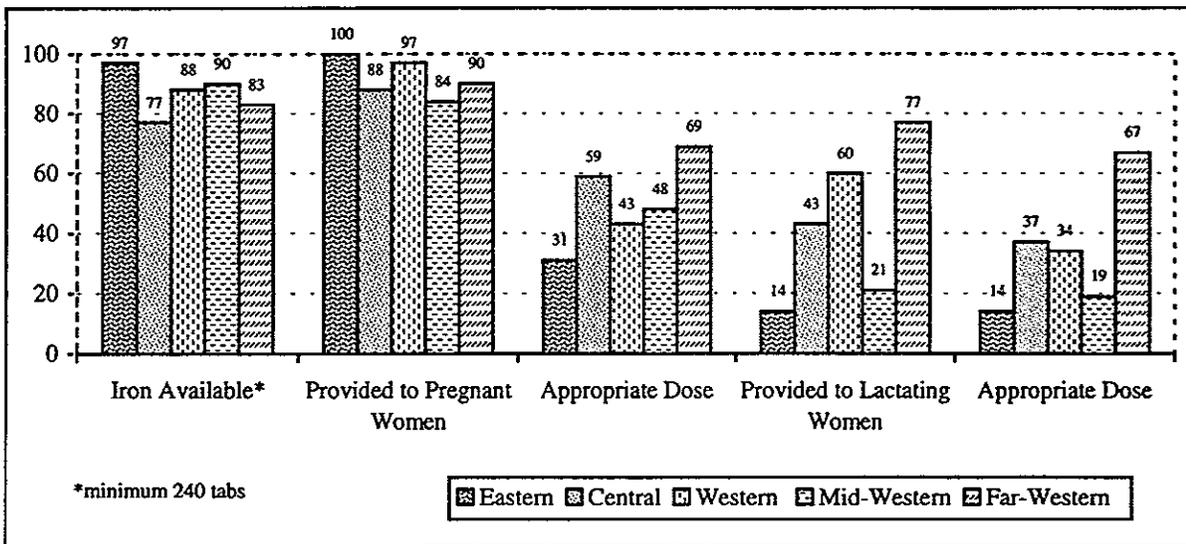
The Nutrition Section, Child Health Division, MOH requested JSI's CHFS to monitor some specific aspects of the nutrition program during regular supervisory visits. The Program Manager was particularly interested in reports on the following: iron availability and utilization at health facilities and iodine content of salt samples anywhere. The results of these monitoring visits are summarized in Sections E.I.5. and E.I.6. of this report.

Table NM#1: Number of Nutrition Monitoring Visits Conducted by CH Staff

Period	Eastern	Central	Western	Mid-Western	Far-Western	Total
Oct 97-Jun 98	36	73	79	44	99	331
Jul 98-Jun 99	29	147	68	58	70	372

To determine iron availability and utilization a total of 372 health facilities were visited and the distribution of visits by Region is given in the above Table NM #1. A comparison is also made between the number of visits conducted in Year 1 and Year 2 by Region.

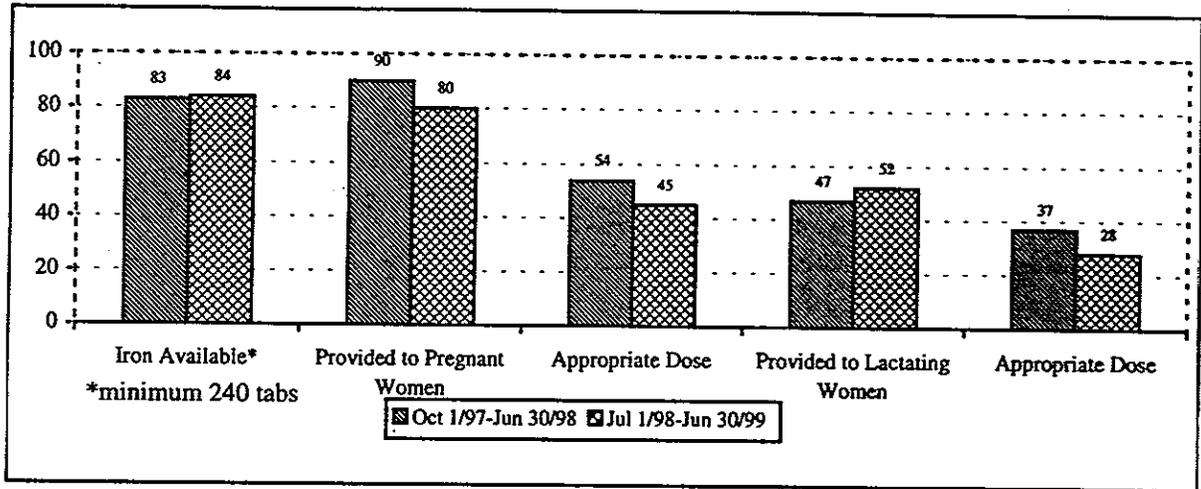
Graph NM# 1: Iron Distribution and Appropriate Dose by Region



Graph NM #1 shows a breakdown by Region of the following: iron availability and utilization. Iron tablets were found available on the day of visit in 84% of health facilities. To report "available" there had to be at least sufficient tablets available to give one complete course to one woman, that is a minimum of 240 tablets. Regarding reporting of provision of iron tablets to pregnant women, there was some variation ranging from a low of 83% reporting provision in the Mid-Western Region to 100% in the Eastern Region. The Nutrition Section defines "appropriate" dose as 60 mg elemental iron per day. This should be given to a pregnant woman for the last 6 months of pregnancy and during the first two months post partum. According to this definition, 31% of health facilities in the Eastern Region reported giving an appropriate dose. The highest reported was 69% in the Far-Western Region.

Again for lactating women, reporting varied, with the staff of HFs in the Far-Western Region reporting that 77% of lactating women were given iron, with 67% of them receiving the appropriate dose. The Eastern Region reported lowest for this at 14% and other Regions varied between the two extremes.

Graph NM# 2: Iron Distribution and Appropriate Dose by Year



Graph NM #2 compares these results between Year 1 and 2 of the LCHSSP and all areas show a decrease in provision and appropriate dosing. Iron availability was unchanged.

6. Iodine Content of Salt Samples

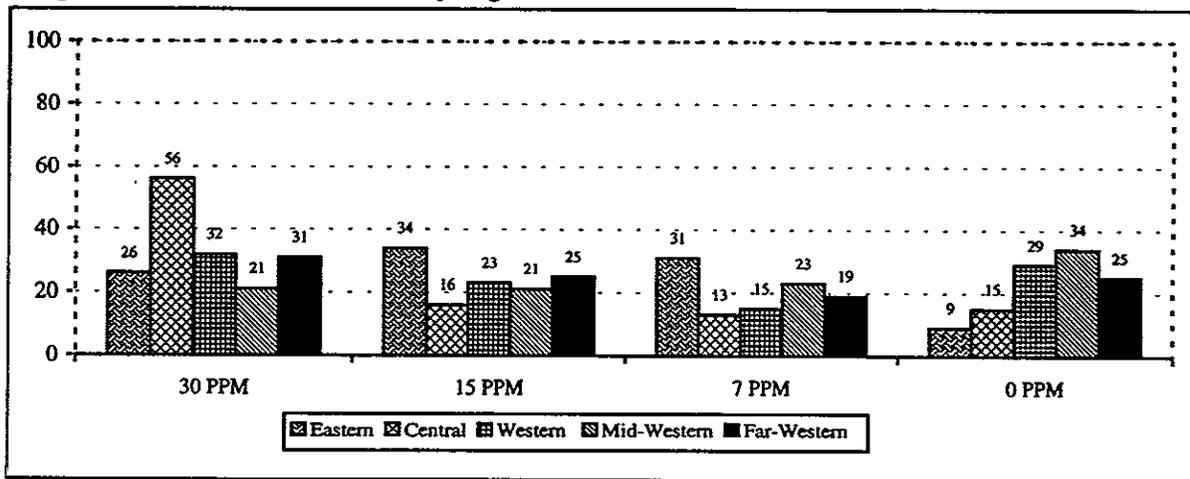
The Nutrition Section requested JSI's CHFS to monitor the iodine content of salt samples encountered anywhere during their field visits. A total of 539 samples were tested in Year 1 and 1,084 in Year 2. The number of sites where testing was done by Region is shown in Table Io #1.

Table Io #1: Number of Sites Where Testing Was Done by CH Staff

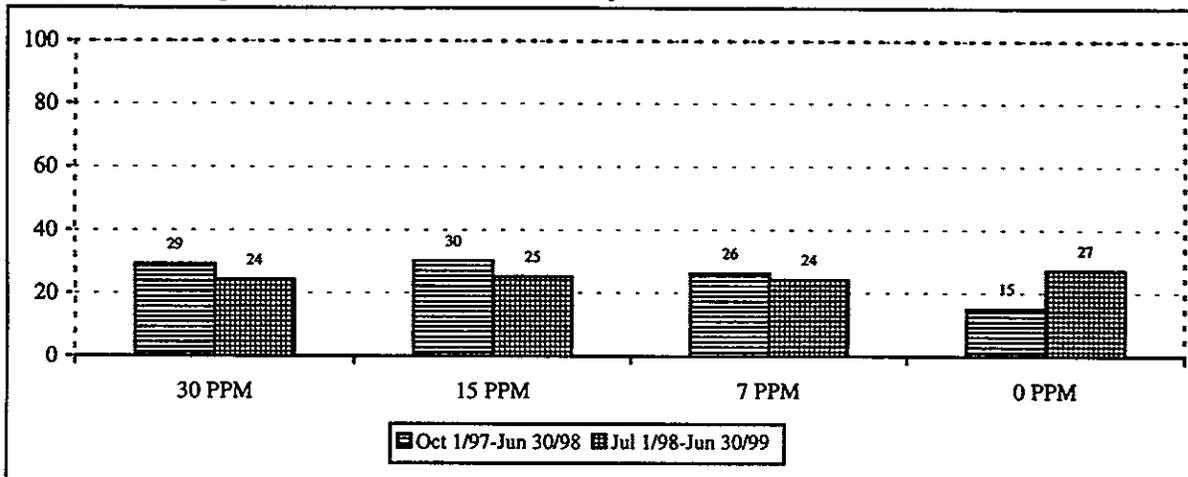
Year	Eastern	Central	Western	Mid-Western	Far-Western	Total
Oct 97-Jun98	55	65	103	105	211	539
Jul 98-Jun 99	717	61	47	65	194	1084

A test kit, provided by UNICEF through the Nutrition Section was used to test the salt samples. Color changes in the salt were used to estimate the iodine content and divide them into 4 possible categories: 30 parts per million (PPM), 15 PPM, 7 PPM and 0 PPM. The results of the analyses of salt samples by Region are shown in Graph Io #1. It was surprising how many salt samples tested 0 PPM, with the most in the Mid Western Region where 34% of the 65 tested samples showed no iodine content at all.

Graph Io #1: Iodine Content of Salt by Region



Graph Io #2: Comparison of Iodine Content of Salt by Year



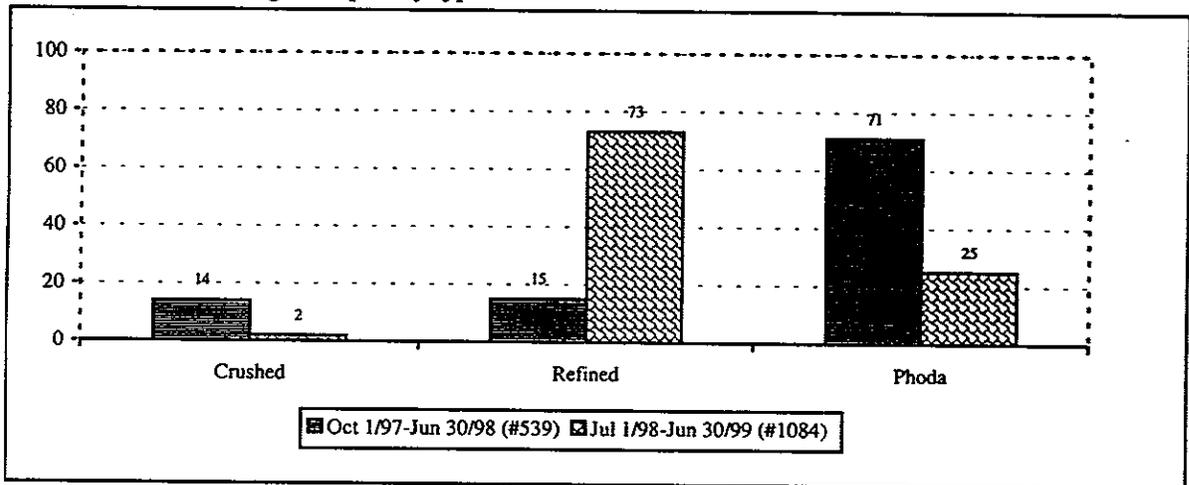
Graph Io #2 compares the overall percentage of samples found with different iodine contents in the 2 years of the project. There is an increase from 15% to 27% of the tested samples found to have 0 PPM and a slight decrease in all other categories from Year 1 to 2.

Several different types of salt are available in the market in Nepal: "phoda", crushed and refined. "Phoda" is the large porous type of salt, which cannot be packed into 1 kg bags. "Crushed" is the smaller crystal salt which is packed in plastic bags under the brand names of "Bhanu" (which is distributed in remote districts only as part of a transport subsidized scheme) and "Shakti". "Refined" salt is fine table salt which has a low moisture content, averaging less than 1%. This is packed by the Salt Trading Corporation (STC) in 1 kg bags and sold under the brand names of "Tata" and "Ionoon".

Of all 1,084 salt samples tested by the CHFS in Year 2, 24 (2%) were crushed, 271 (25%) were phoda and the remaining 789 (73%) were refined.

This is summarized in Graph Io #3 along with a comparison of the findings from Year 1.

Graph Io #3: Percentage Samples by type of Salt



II. Community-Based Pneumonia Control Program in 11 Districts

Firstly, some clarification of terminology is needed. During the first year of the LCHSSP, there were 6 districts (Makwanpur, Chitwan, Sunsari, Morang, Jhapa and Parsa) in which not only health facility staff but also VHWs, MCHWs and FCHVs were trained to diagnose and treat pneumonia. These latter three cadres of health workers received the same kind of training, although the VHWs and MCHWs had some additional orientation on how to support their FCHVs. All three cadres were combined for some analyses and referred to collectively as Community Health Workers (CHWs).

Starting in 1995, a “pilot” ARI program called the ARI Strengthening Program had been conducted in 4 districts, in which two different intervention models for taking pneumonia treatment closer to the community were tested. In Makwanpur and Chitwan, CHWs had been trained to diagnose and treat “pneumonia only” cases with cotrimoxazole and to refer more seriously ill children to the nearest HF. This was referred to as the “treatment” model. In Morang and Sunsari CHWs had been trained to diagnose pneumonia in the same way, but they were to refer all cases of pneumonia regardless of the degree of severity. This was called the “referral” model.

In 1997 an external evaluation was conducted by WHO and UNICEF in collaboration with JSI/USAID and the MOH and it was determined that the FCHVs and other CHWs in the “treatment” districts were adequately diagnosing and managing pneumonia cases and referring appropriately. In addition, this intervention was bringing treatment to twice as many children with pneumonia as the “referral” model. Therefore cautious expansion of the “treatment” model was recommended by the evaluation team and accepted by the MOH and partners.

In 1997/98 the two “referral” districts were converted to “treatment” districts and two new districts, Jhapa and Parsa were added bringing the total number of community-based pneumonia control districts to 6. The results of JSI monitoring in those 6 districts was reported in the 1997/98 annual report.

During the fiscal year currently being reported, 1998/99, a further 5 districts were added in which not only HF staff but also CHWs were trained in the diagnosis and treatment of pneumonia. Some changes were made to the program including the combination of the ARI/pneumonia component with other key child health programs so the name of the program was changed to “CBAC- Community Based ARI/CDD” Program. Because of the huge numbers of health workers to be trained, community members to be oriented and supervision and monitoring to be conducted, the prospect of adding five new districts at once was daunting. Therefore, the MOH sought new partner organizations to assist with many aspects of the expansion, with particular attention for the monitoring of the community-level health workers.

Four I/NGO organizations agreed to work with the MOH and existing partners to expand the program as follows: CARE - Bajura; PLAN -Bara, Rautahat; ADRA - Rasuwa; SCF/US - Siraha. I/NGO field staff attended practical training sessions conducted jointly by JSI and MOH staff to orient them to the use of the standard checklists for monitoring of the community level workers and reporting mechanisms were established. USAID requested that for the purpose of maintaining a standardized format and comparable data a copy of all

I/NGO monitoring reports should be sent to JSI/Nepal for data analyses and collation. This is in addition to whatever analysis the I/NGOs carry out on their own reports.

Training activities were conducted in all 5 of these new districts during the 1998/99 year and details of training activities are included in Section III of this report. Monitoring in the new implementation districts by the I/NGO partners began late in Year 2 and some results will be reported in this section of the report.

It was expected that there might be some difference in monitoring findings between “old” and “new” districts and it was decided that they would be grouped for easy reference as “A” and “B” districts as follows:

A districts - Makwanpur, Chitwan, Jhapa, Parsa, Morang, Sunsari

B districts - Bajura, Siraha, Rasuwa, Bara, Rautahat

In this report, some comparisons will be made between the monitoring results found in the two different groups of districts. Other comparisons will be made between monitoring results from Year 1 and Year 2 and between data collected by JSI CH staff and I/NGO staff. Since this section refers specifically to results related to pneumonia control in the districts where CHWs are diagnosing and treating pneumonia cases, this section is referred to as: “Community-Based Pneumonia Control Program in 11 Districts”.

1. Health Facility Level

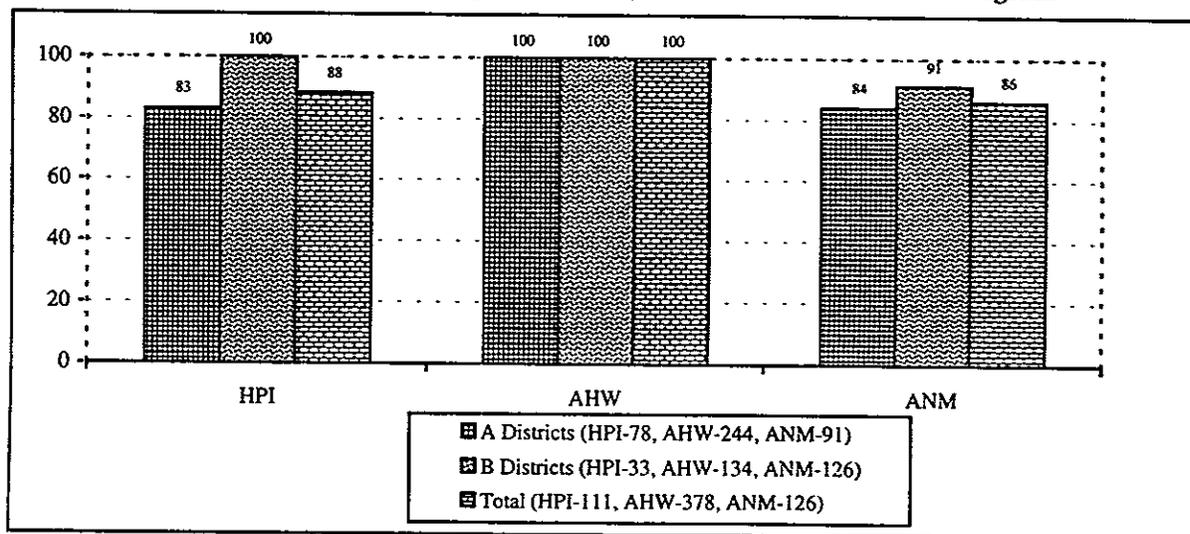
Monitoring visits were conducted at 299 health facilities - 196 in A districts and 103 in B districts during the year. Twenty-eight interviews were conducted by I/NGO staff; the

Interviewed by	# HF
I/NGOs	28
JSI	271
Total	299

remaining 271 were conducted by JSI CHFS. For the implementation of many programs, the problem of the frequent transfer of MOH staff often hinders smooth program functioning. Child Health Field Staff and I/NGO staff, during interviews with staff in 299 facilities

determined how many of the staff currently working in the health facilities in the 11 community-based pneumonia control districts had received the training provided through the CDD/ARI Section specifically for this program.

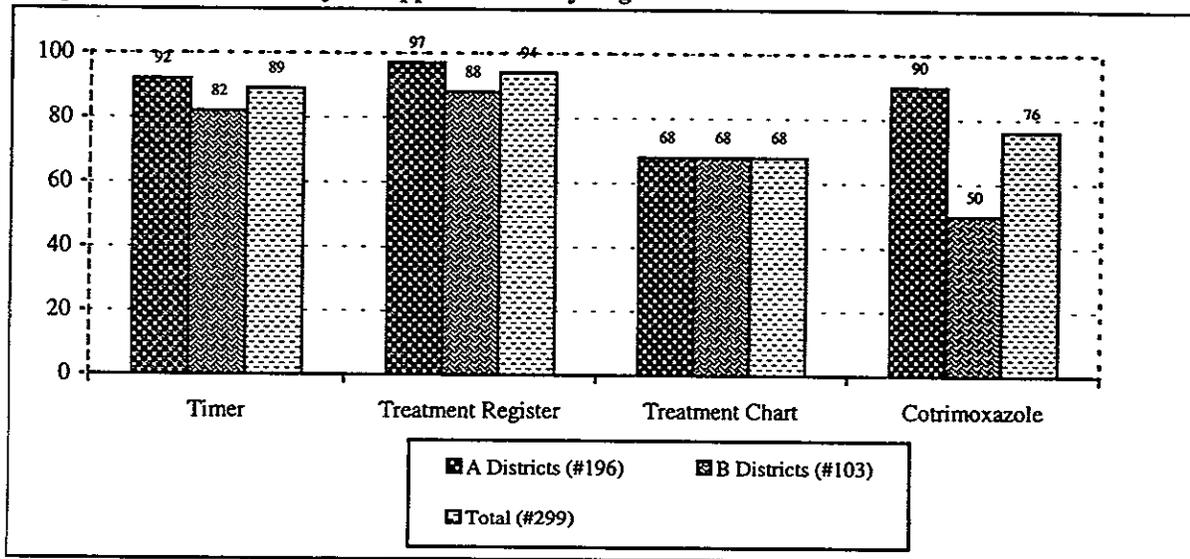
Graph AHF #1: HF Staff Trained through Community-Based Pneumonia Control Program



The results are shown in Graph AHF #1 and very encouraging. In A districts, 83% of 78 HPIs had been trained through the program; in B districts 100% of 33 HPIs had been trained and overall 88% of interviewed HPIs had received specific training. Similarly 100% of a total of 378 AHWs in the 11 districts had been trained; and overall 86% of 126 ANMs had been trained.

At the HF level, CHFS monitor the availability of some essential supplies. The results of their review is shown in Graph AHF #2 and a comparison is made between A and B districts. Timer availability was better in A districts, 92% compared to 82% with overall 89% of facilities having a timer available on the day of visit. ARI Treatment Register availability was high in both types of districts, over 88%. Wall treatment charts were more scarce with only 68% of facilities having one displayed. There was not much difference between A and B districts for these three items. However, there was a significant difference in the availability of cotrimoxazole pediatric tablets at HF's in the different districts. Availability was very good at 90% in A districts, but only 50% in B districts. One reason for this large discrepancy was that in new district resupply of cotrimoxazole from district stores to HF's was not prompt.

Graph AHF #2: Availability of Supplies at HF's by Region



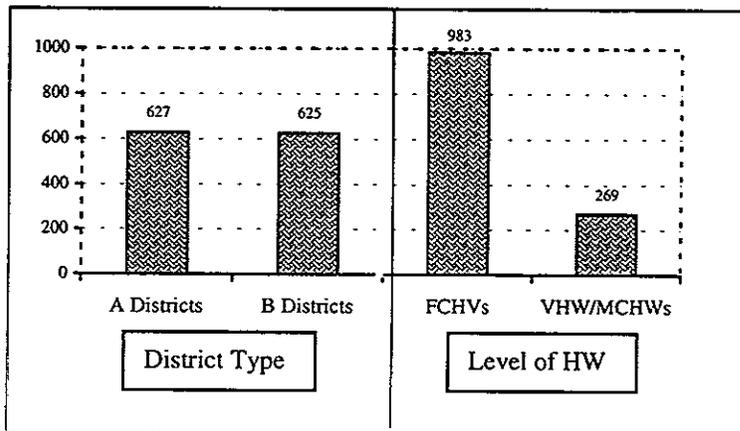
2. Community Level



▲ USAID Director Observing FCHV's ARI activities in Makwanpur with JSI Sr. CHFO

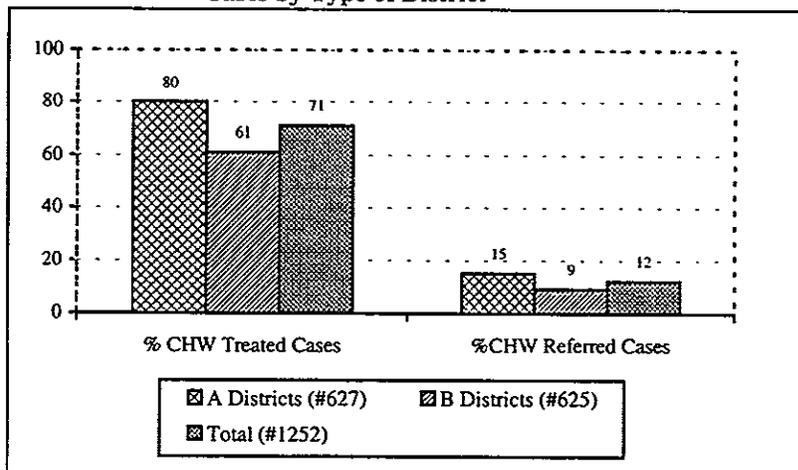
The majority of the monitoring effort for the community-based pneumonia control program is targeted to the community level to ensure that the VHWs/MCHWs/FCHVs are correctly diagnosing, treating and/or referring pneumonia cases. During Year 2 (July 1998 - June 1999) CHFS interviewed a total of 1,252 CHWs (269 VHWs/MCHWs and 983 FCHVs) in districts where pneumonia treatment is being conducted at the community level. In the previous year they had interviewed a total of 513 CHWs (130 VHW/MCHWs and 383 FCHVs).

Graph AC #1: Number of CHW (VHW/MCHW and FCHV) Interviews Conducted



Graph AC #1 shows the number of CHW interviews conducted with 627 interviews conducted in A districts and 625 interviews conducted in B districts. In B districts 191 FCHVs and 18 MCHW/VHWs were interviewed by I/NGO staff.

Graph AC #2: Comparison of Percentage of CHWs (MCHW, VHW, FCHV) Who Treated/Referred* Pneumonia Cases by Type of District



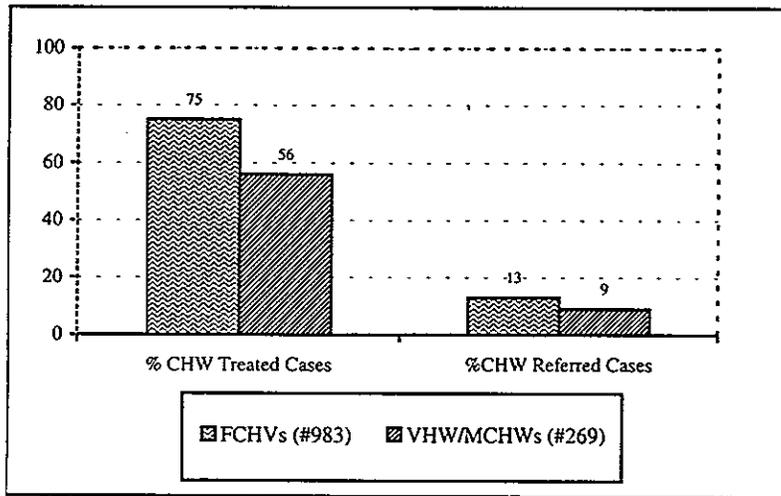
In addition to utilizing a standard checklist to ask questions to determine CHWs' knowledge and skill in diagnosing pneumonia, the CHFS conduct a record review in order to be as objective as possible and to standardize the monitoring procedures. They review the information that is recorded in the CHWs' treatment and referral books and do not

rely on verbal information only to determine treatment practices. They conduct a record review for the 10 most recent treated and referred cases and this data is utilized in the analyses presented here and to USAID in our quarterly reports. Graph AC #2 compares the

* 10 most recent cases

percentage of CHWs who had treated or referred any pneumonia cases by district type. For both treatment and referral a smaller percentage of CHWs had been active in the B districts. Eighty percent of 627 interviewed CHWs (501 CHWs) had treated pneumonia cases in A districts, while only 61% of 625 (383 CHWs) had treated in B districts. Fifteen percent of 627 CHWs (92 CHWs) had referred cases in A districts as compared to 9 % of 625 (58 CHWs) in B districts. This is probably a reflection of the “newness” of the program and since the CHWs rely on self referral to bring the sick children, it may take caretakers a while to realize that the FCHVs can help their children right in the village. A similar pattern was seen when the A districts were first included in the program.

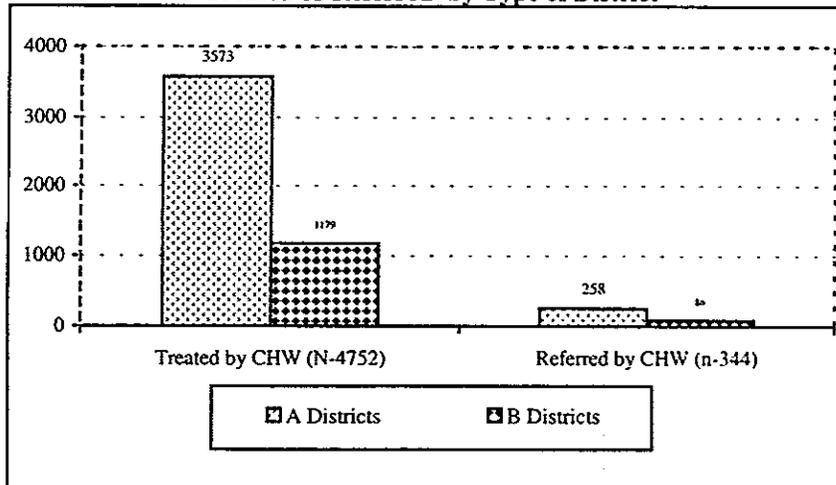
Graph AC #3: Comparison Between Percentage of VHW/MCHWs and FCHVs Who Treated/Referred* Pneumonia Cases



Graph AC #3 looks at the same data in another way, comparing whether FCHVs or VHW/MCHWs are more active in treating and referring cases. We can see that FCHVs are more active in both areas, with 75% of 983 FCHVs (737 FCHVs) treating cases as compared to 56% of 269 VHW/CHWs (151 VHW/CHWs). Similarly a higher percentage of FCHVs had referred cases; 13% of 983 or

128 FCHVs referred as compared to 9% of 269 or 24 VHW/MCHWs .

Graph AC #4: Comparison of Number of Pneumonia Cases Treated or Referred* by Type of District



In Graph AC #4, the actual number of cases treated or referred taken from the CHWs' record books is compared by district type. In A districts, the 501 CHWs who reported treating cases had treated a total of 3,573 cases, an average of 7.1 cases each when interviewed. From March 1999 to June 1999, in B districts, the

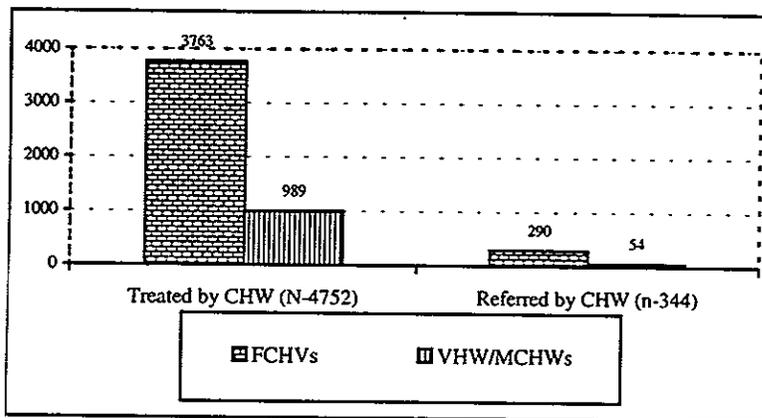
383 active CHWs had treated 1,179 cases, an average of 3.1 cases each. Similarly, the 92 CHWs in A districts who reported referring cases had referred 258 children, an average of 2.8 children per CHW. In B districts, 58 CHWs reported referring 86 children, an average of 1.5 children referred per CHW. This analysis is summarized in Table AC #1.

* 10 most recent cases

Table AC #1: Average Number of Cases Treated/Referred* by Type of Districts

Type of Dist	# CHWs Who treated cases	Total # of Cases Treated*	Average # of Cases Treated/ CHW	# of CHW Who Referred Cases	Total # of Cases Referred	Average # of Cases Referred/ CHW
A	501	3,573	7.1	92	258	2.8
B	383	1,179	3.1	58	86	1.5
Total	884	4,752	5.4	150	344	2.3

Graph AC #5: Comparison Between Number of Pneumonia Cases Treated/Referred* by FCHVs and VHWMCHWs By Level of CHW



Graph AC #5 compares the number of cases treated and referred by the level of CHW. Seven hundred and thirty-four FCHVs treated 3,763 cases of pneumonia, an average of 5.1 cases each. One hundred and fifty VHWMCHWs treated 989 cases, an average of 6.6 cases each. "Active" FCHVs who had referred cases, referred an average of 2.3 each as did

"active" VHWMCHWs. These figures are shown in Table AC #2. Because of the large number of FCHVs trained the overall number of pneumonia cases they can identify and treat is greater, but on an individual basis the "active" VHWMCHWs treat and refer close to the same number of children.

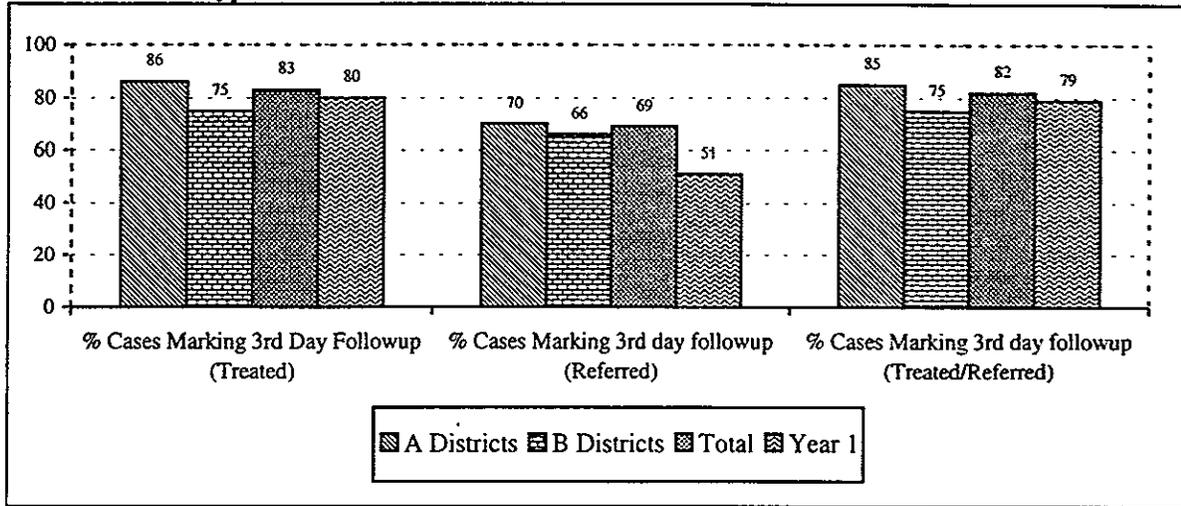
Table AC #2: Average Number of Cases Treated/Referred* by Level of CHW

Type of CHW	# CHWs Who Treated Cases	Total # of Cases Treated*	Average # of Cases Treated/ CHW	# of CHW Who Referred Cases	Total # of Cases Referred	Average # of Cases Referred/ CHW
FCHV	734	3,763	5.1	126	290	2.3
VHWMCHW	150	989	6.6	24	54	2.3
Total	884	4,752	5.4	150	344	2.3

Graph AC #6 compares the results obtained from the record review of the 10 most recent treated and referred cases to determine percentages of cases where third day follow-up and outcome of follow-up were clearly recorded in the CHWs' registers. These indicators are presented for both A and B districts separately, then combined for a Year 2 result and compared to the result of monitoring conducted in Year 1.

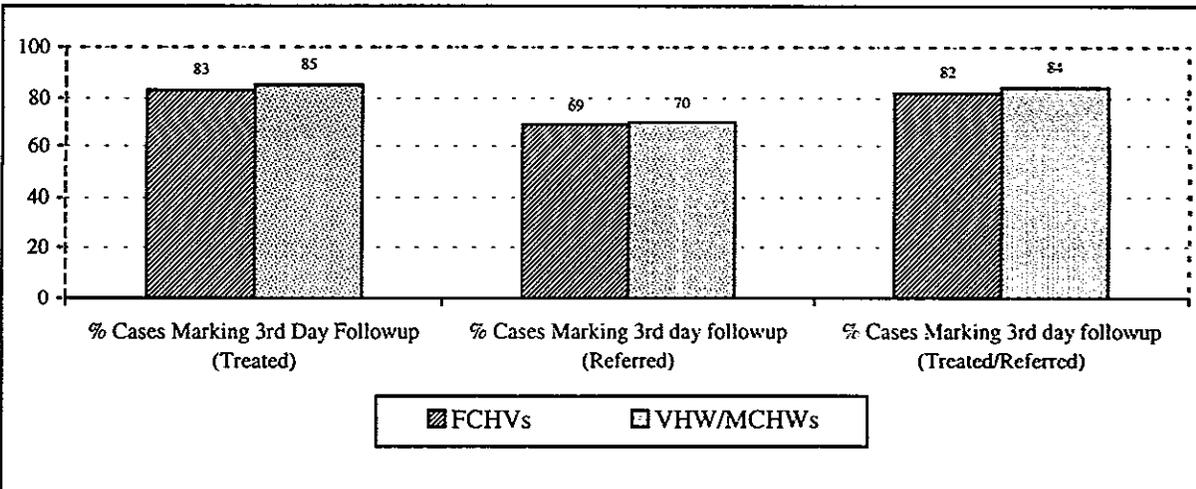
* 10 most recent cases

Graph AC #6: Comparison Between Percentage Followup of Pneumonia Cases Treated/Referred* by Type of District



Firstly, looking at the percentage of treated cases marking third day follow-up, 86% of treated cases in A districts had a follow-up visit as compared with 75% in the B districts for an overall 83% of treated cases being followed-up in 1998/99. In 1997/98, 80% of treated cases received a follow-up visit. For referred cases, 70% were followed-up in A districts, 66% in B districts, with an annual Year 2 average of 69%. This was much improved from the Year 1 indicator when only 51% of referred cases had a follow-up visit. The combined results for follow-up of all treated and referred cases together, shows 85% in A districts, 75% in B districts and a Year 2 average of 82%. The year one indicator, as reported to USAID, was 79%.

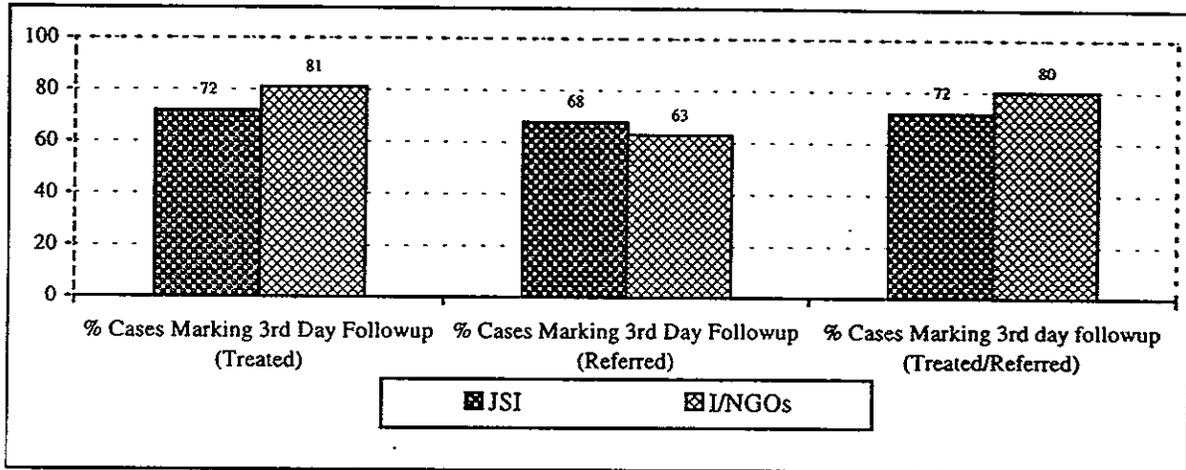
Graph AC #7: Comparison Between Percentage Followup of Pneumonia Cases Treated/Referred* by FCHVs and VHWMCHWs



Graph AC #7 compares the same indicators by level of CHW. FCHVs followed-up 83 % of the cases they treated, whereas VHWs/MCHWs followed-up 85%. FCHVs followed-up 69% of the cases that they referred; VHWs/MCHWs followed-up 70% of the cases they referred. Overall FCHVs followed-up 82% of all the cases they treated and referred; VHWs/MCHWs followed up 84% of treated and referred cases.

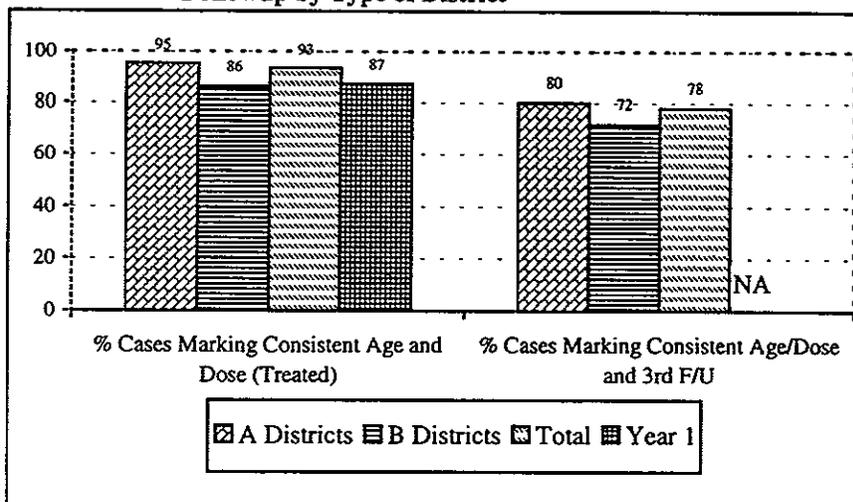
* 10 most recent cases

Graph AC #8: Comparison Between Percentage Followup of Pneumonia Cases Treated/Referred* as Collected by JSI and I/NGOs in B Districts



Graph AC #8 compares the same information collected from 2 different sources: JSI CHFS reports and I/NGO staff reports for B districts only, as the I/NGOs are only supporting monitoring in B districts. JSI CHFS record reviews found 72% of cases treated by FCHVs received follow-up visits as compared to 81% of treated cases were found followed-up from I/NGO monitoring reports. Sixty-eight percent of referred cases were followed-up in JSI monitoring areas as compared to 63% where I/NGOs monitored. Overall, the collation of JSI CHFS reports showed that 72% of treated and referred cases in B districts were followed-up whereas I/NGO reports showed 80% follow-up. Differences may be due to the geographic areas monitored and the other support and supervision that the CHWs have received in maintaining their registers, but should not be due to observer bias, as the report is only based on objective data collection not on any subjective information obtained from personal interviews.

Graph AC #9: Comparison of Percentage of Pneumonia Cases Treated* by CHWs Marking Consistent Age/Dose and 3rd day Followup by Type of District



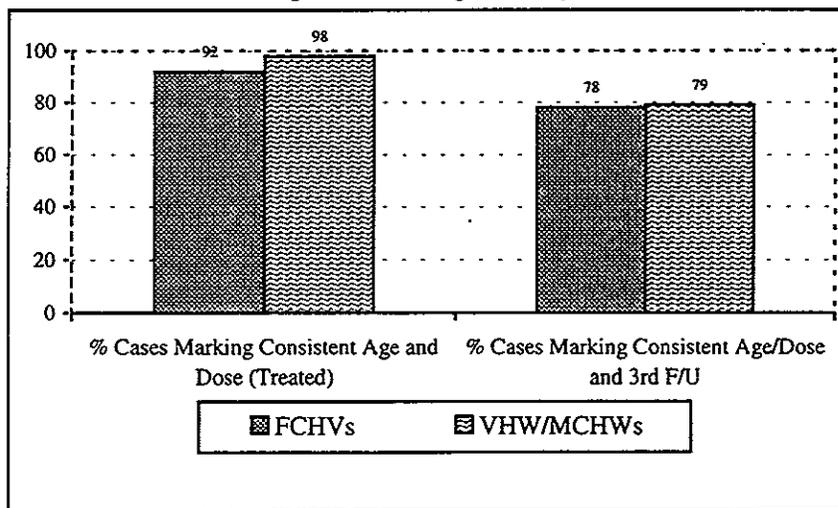
Other indicators of the quality of case management provided by the CHWs can be obtained from the record reviews, and some of these are summarized and compared in the next 3 graphs. Graph AC #9 compares the percentage of treated cases where the CHWs marked the consistent

age and dose of cotrimoxazole in the treatment register and the percentage of cases that not only marked consistent age and dose but also marked third day follow-up. This graph compares these results by district type and also compares results between the two years. Ninety-five percent of cases had age and dose marked correctly in A districts in 1998/99

* 10 most recent cases

compared to 86% in B districts for an overall 93% of cases having consistent age/dose recorded. In A districts last year this figure was 87% correct. The second part of AC #9 shows that 80% of treated cases had both consistent age/dose recorded in the register and a third day follow-up visit in A districts, as compared to 72% having both in B districts, with an overall average of 78% of cases having both recorded correctly in the FCHV treatment register. There is no comparable figure for last year as this was not analyzed.

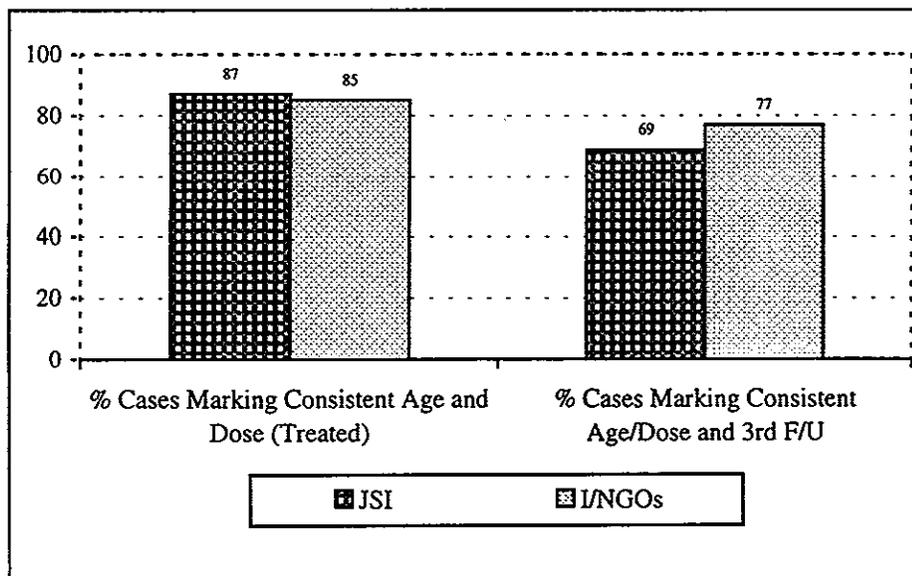
Graph AC #10: Comparison of Percentage of Pneumonia Cases Treated* Marking Consistent Age/Dose by Level of CHW



Looking at the same data in a different way, Graph AC #10 compares these results by level of CHW. FCHV records showed consistent age/dose recorded for 92% of cases as compared to 98% in the VHWMCHW records. Seventy-eight percent of cases treated by FCHVs had both consistent age/dose and third day follow-up

recorded in the treatment register; VHWMCHW registers revealed 79% of cases with both consistent age/dose recorded and third day follow-up.

Graph AC #11: Comparison Between Percentage of Pneumonia Cases Treated* by CHW Marking Consistent Age/Dose in B Districts as Collected by JSI and I/NGO Interviewers

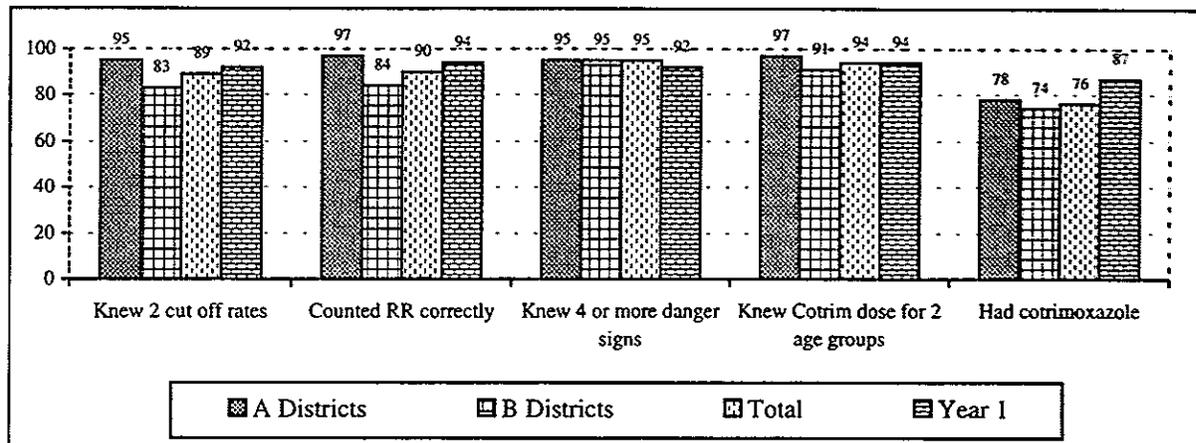


Graph AC #11 compares these same indicators as determined from JSI and I/NGO monitoring reports for B districts only in the year 1998/99. JSI reports found 87% of cases with consistent age and dose marked in the CHW registers as compared to 85% from the I/NGO records. For third

day follow-up and consistent age/dose JSI CHFS reported 69% of cases had both recorded in the treatment registers as compared to 77% in the I/NGO reports. JSI and I/NGO field trips were conducted independently, in different areas of the districts and the results are comparable.

* 10 most recent cases

Graph AC #12: Comparison of CHWs' (FCHV/VHW/MCHWs) Knowledge and Skills in the Program Districts



JSI CHFS and I/NGO staff also ask CHWs questions to determine their general knowledge about pneumonia diagnosis and treatment, observe them counting respiratory rate and check availability of cotrimoxazole pediatric tablets. Errors are corrected on the spot at the conclusion of the interview. The results are shown graphically in Graph AC #12. A comparison is given between findings in A and B districts and then a comparison is made between Year 1 and 2 results.

Overall, in Year 2, 89% of FCHVs knew 2 respiratory cut off rates, with 95% correct in A districts and 83% correct in B districts. In Year 1, 92% of CHWs knew 2 cut off rates. Similarly, 90% of FCHVs in Year 2 could count respiratory rate correctly (A districts - 97%, B districts - 84%). This difference is probably due to the extra experience, practice and review that CHWs in A districts have had since their initial training. In Year 1, 94% of FCHVs could count respiratory rate correctly.



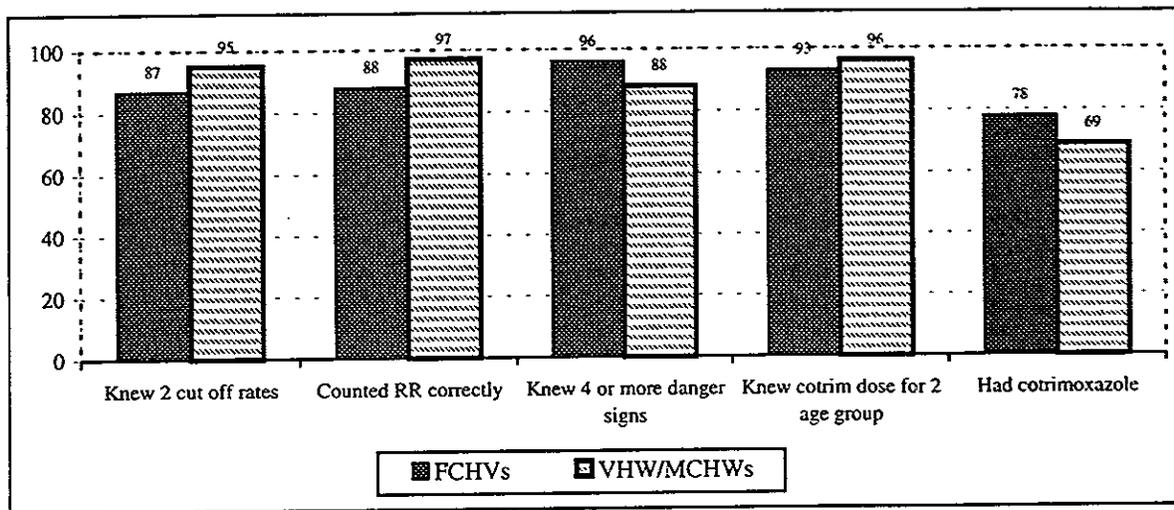
▲ FCHV Counting RR in Bajura

In training CHWs learn the danger signs of pneumonia, and during interviews FCHVs are permitted to look at the memory card, if needed, to name the danger signs. VHWs/MCHWs are expected to know the danger signs without looking at the memory card. Overall their knowledge was very good, with no difference between A and B districts, with 95 % of CHWs knowing at least 4 danger signs. Last year the result was 92%.

Knowledge of the cotrimoxazole dose for two age groups was also very good; 97% of CHWs in A districts and 91% of CHWs in B districts knew the 2 dosages, with overall 94% of CHWs getting the dosage correct for the 2 different age groups. The result was the same in the Year 1 monitoring report.

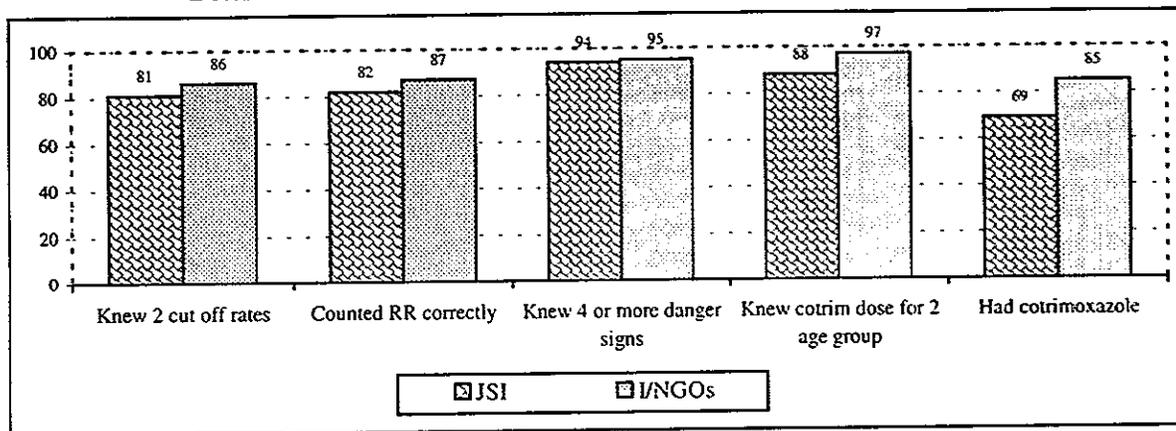
One concerning result is the finding that cotrimoxazole availability with CHWs was only 78% in A districts, 74% in B districts and overall 76% for Year 2. In Year 1, when there were fewer districts and fewer CHWs participating in the program, 87% of CHWs had cotrimoxazole available. Mechanisms for improving and sustaining supply of cotrimoxazole year-round are needed.

Graph AC #13: Comparison of CHWs' (FCHV/VHW/MCHWs) Knowledge and Skills by Level of CHW



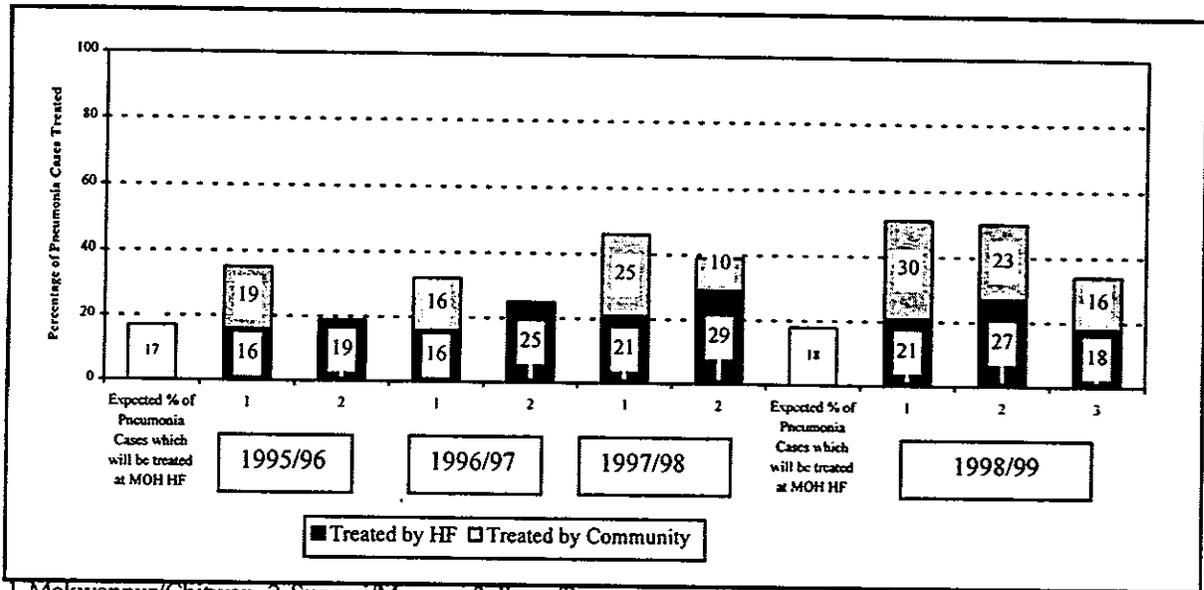
Graph AC #13 looks at the same information by level of health worker, comparing FCHVs with VHWs/MCHWs. Although VHW/MCHW knowledge of 2 cut off rates and 2 cotrimoxazole dosages is somewhat better than the FCHVs, the results for all are very good. FCHVs in these program districts may need some refresher in counting respiratory rate (RR), but still 88% were correct in counting. Availability of cotrimoxazole pediatric tablets was better with FCHVs (78%) when compared with VHW/MCHWs (69%).

Graph AC #14: Comparison of CHWs' (FCHV/VHW/MCHWs) Knowledge and Skills in B Districts as Determined in Interviews Conducted by JSI and I/NGO Staff



Graph AC #14 compares the results of monitoring knowledge and skill of the CHWs in the B districts and compares monitoring results from JSI and I/NGO reports. JSI CHFS found that 81% of CHWs knew two cutoff rates; I/NGO staff found 86% knew 2 cutoff rates. Eighty-two percent of CHWs interviewed by JSI staff counted RR correctly; 87% were correct when monitored by I/NGO staff. Ninety-four and ninety-five percent knew at least 4 danger signs. The I/NGO staff found that 97% of CHWs knew two cotrimoxazole dosages for 2 different age groups; JSI staff found 88% correct knowledge. Cotrimoxazole availability was also better (85%) according to the I/NGO monitoring report, as compared to 69% availability in the JSI monitored areas. A possible reason for the improved availability is that most of the I/NGO monitoring reports included in this analysis were submitted by PLAN, and they are providing cotrimoxazole pediatric tablets in their program VDCs in Bara and Rautahat districts.

Graph AC #15: Comparison of Percentage of Pneumonia Cases Treated in A Districts



1-Makwanpur/Chitwan, 2-Sunsari/Morang, 3-Jhapa/Parsa

The community-based pneumonia control program has been implemented in Makwanpur and Chitwan districts as a “treatment” model since 1995/96 and data is available about the total numbers of pneumonia cases being treated over 4 years of the program. Morang and Sunsari started as “referral” districts in 1995/96, remained “Referral” districts in 1996/97 and in mid-1997/98, following the release of the assessment results, were converted to “treatment” districts. Jhapa and Parsa started as new “treatment” districts in 1997/98.

In addition to documenting that CHWs are correctly diagnosing and managing pneumonia cases, it is important to try to document how many children with pneumonia are being reached by the program. Graph AC # 15 compares the numbers of pneumonia cases treated over 4 years of the program in the earliest program districts. In 1995/96, HMIS data showed that 17% of expected pneumonia cases (based on estimated prevalence of 300 cases/1000 children under 5/per year) were treated in the static health facilities in Nepal. In that same year, in Makwanpur and Chitwan, the first 2 “treatment” districts 35% of the expected pneumonia cases were treated, with 19% getting treatment at the community level from CHWs and 16% getting treatment from HFs. In the same year (1995/96), 19% of expected pneumonia cases were treated in the “referral” districts of Morang and Sunsari. In year 2 (1996/97), 32% of expected cases were treated in the “treatment” districts with equal proportions treated by CHWs and HFs, while 25% of expected cases were treated at HFs in the “referral” districts. In year 3 (1997/98), 46% of expected cases were treated in the original “treatment” districts, with 25% treated by CHWs and 21% by HFs. In that year, the “referral” districts were converted to “treatment” and they treated 39% of the expected cases, with 29% treated at HFs and 10% treated at the community level, as the training was only conducted mid-year. In 1998/99, in non-program districts, According to HMIS, 18% of expected pneumonia cases were treated at government facilities; in the original “treatment” districts 51% of expected cases were treated, with 30% of the expected cases treated at the community level. In the same year, 50% of expected cases were also treated in the original “referral” districts of Morang and Sunsari, with 23% of the expected cases treated at the community level. In that same year, Jhapa and Parsa also started as new “treatment” districts and in that first year 34% of the expected cases were treated, with 16% of expected cases treated by the community health workers.

The evolution and maturing of this program over several years has been exciting to watch and document. If the shortages of cotrimoxazole can be corrected, through local cost recovery, then the potential for the program to be sustained at the community level is high, as more and more people are self referring to the CHWs for treatment and learning to trust her assessment, advice and treatment.

III. Training

JSI Child Health Field and Central Level staff provided technical support for the conduct of trainings and orientations for the Community-Based ARI/CDD (CBAC) Program in 5 new (B) districts during the fiscal year 2055/56 and assisted with the conduct of monitoring meetings/refresher trainings in 6 old (A) districts. The results of these training activities are summarized below.

1. Community-based ARI/CDD (CBAC) Program

During the fiscal year 2055/56 (1998/99), the Child Health Division expanded the program through which the community level health workers (VHWs, MCHWs, FCHVs) are trained to diagnose and treat pneumonia under the new name of CBAC Program. They selected 5 new districts (Rasuwa, Bajura, Bara, Rautahat, Siraha) in which district level health staff and DDC officials were initially oriented to the program and involved in planning for subdistrict level activities. These 5 districts are referred to elsewhere in this report as “B” districts.

The CBAC program had a number of strategies to strengthen the overall child survival activities:

- Combined child health approach with pneumonia, diarrhea, nutrition and EPI all included in trainings at all levels;
- Training for all health facility staff and community-level health workers on the combined child health package;
- Partnership with I/NGOs already working in the five districts for support for monitoring and supervision, particularly of the community-level health workers;
- Orientations for DDC and VDC representatives to explain the program activities and to encourage active support from the locally elected leaders for the community-level health workers;
- Mothers’ Group Meetings were held where FCHVs explained about the dangers of pneumonia, demonstrated how to count respiratory rate and check for danger signs and actually examined children under 5 brought by their mothers with cough and cold;
- Orientation for traditional healers (dhami/jhankris) on the danger signs of pneumonia and diarrheal dehydration to encourage them to act as referral agents;
- Testing of cost recovery for cotrimoxazole in Siraha district with SCF/US support.

The following tables summarize the training activities conducted in 1998/99 in B districts. Table T #1 shows the number of health workers trained or oriented in the 5 districts. Overall, 112 district assistants and Health Post Incharges and 438 SubHP incharges, AHWs and ANMs were trained in the combined child health package. In addition, 480 VHWs and MCHWs were trained and 3,096 FCHVs were given the first phase of training, which consisted of 3 and a half days of in-depth training on pneumonia, a half-day VDC/ward level orientation which the FCHV also attended, and a one-day Mothers’ Group Meeting which the

FCHVs conducted in their own wards. "Second phase" training was a 2-day course, in which the pneumonia/ARI content was reviewed, and CDD, nutrition/Vitamin A and EPI components were added. This second phase was not conducted in Bara and Rautahat as all FCHVs in those two districts had received similar training in fiscal year 2054/55 through the CDD Reactivation Program.

Table T #1: Number of Health Workers Trained in the B Districts

Districts	HPI/Dist Asst.	SHPI/AHW/ ANM	VHW/ MCHW	FCHV 1 st Phase	FCHVs 2 nd Phase	Dhami/ Jhankris
Rasuwa	18	12	26	150	159	47
Bajura	15	39	43	238	227	69
Bara	23	128	128	869	-	371
Rauthat	21	125	109	856	-	366
Siraha	35	134	174	983	973	407
Total	112	438	480	3096	1359	1260

In the new strategy to train dhامي/jhankris, health posts were asked to identify 3-4 traditional healers per VDC who were known to be specialists in pediatric illness for inclusion in the orientation program. A total of 1,260 dhامي/jhankris received the half-day orientation.

Table T #2 summarizes the numbers of people reached through other orientation programs that were conducted as part of the CBAC activities. One hundred and eight officials were reached during district-level orientations; 3,283 locally elected leaders were reached through VDC-level orientations.

Table T #2: Number of Persons Reached Through Orientations/Meetings in the B Districts

Districts	Dist.* Orient'n	VDC Orientation	Mother Group Meeting	Total < 5 Children Examined	Pneumonia Cases Detected	
					Treated	Referred
Rasuwa	24	210	2391	2259	53	29
Bajura	29	410	*	-	-	-
Bara	20	890	13953	8634	356	63
Rauthat	15	665	6285	462	12	24
Siraha	20	1108	10825	2600	194	58
Total	108	3283	31063	11696	562	145

*Not received

A very exciting aspect of the program was the conduct of Mothers' Group Meetings at the end of Phase 1 of the FCHV-level training. FCHVs were asked to call together at least 15 mothers in their wards, and to ask them to bring with them any children under 5 years of age who had symptoms of cough and cold. The FCHVs (often with help from the SHP staff) conducted a meeting describing the danger signs of pneumonia, what she had learned at her training, how to count respiratory rate and what treatment and advice she had to offer. Although data on the number of mothers reached in Bajura was not available, in the other 4 districts a total of 31,063 mothers attended these meetings; 11,696 children were examined and 562 cases of pneumonia were detected and treatment started on the spot. An additional 145 children were ill enough to be referred to the nearest health facility. This was a very effective means of communicating to mothers the potential role of the FCHVs and reinforced her skills through practice with supervision.

2. Monitoring Meeting/Refresher Training in Old 6 districts

During this fiscal year, JSI's Child Health staff also assisted in the conduct of various activities in the "A" districts (Chitwan, Makwanpur, Parsa, Jhapa, Morang, Sunsari) to strengthen recording/reporting and support of the community-level program activities. These are summarized in Table T #3 below. In all 6 districts, 2-day district level monitoring meetings were conducted with a total of 339 health facility and district level staff attending. In one district (Chitwan), 13 HPIs attended a one day monitoring meeting in conjunction with the Vitamin A program expansion into that district. VHWs and MCHWs in all 6 districts had a one-day monitoring meeting in which they presented the results of their monitoring of the FCHVs in their VDCs and their own treatment data. Five hundred and forty-eight VHWs/MCHWs were included in these meetings.

In four districts (Jhapa, Morang, Sunsari and Parsa), 394 VHWs/MCHWs and 2,112 FCHVs received a 2-day refresher training in which the following areas were stressed on: 1) knowledge of danger signs, 2) cotrimoxazole doses for 2 age group, 3) knowledge of respiratory cut off rates, 4) recording and reporting.

Table T #3: Number of Health Workers Who Received Refresher Training

Type	HPI/SHPIs/ Dist Asst.	HPI	VHW/MCHWs	FCHV
2 Days Dist Level Monitoring Meeting (6 districts)	339	-	-	-
1 Day HPI Level Monitoring Meeting During Vitamin A (1 district)	-	13	-	-
1 Day VHW/MCHW Monitoring Meeting (6 districts)	-	-	548	
2 Days VHW/MCHW/FCHV Refresher Training (4 districts)	-	-	394	2112

JSI's Child Health Staff assisted the Child Health Division, CDD/ARI Section in the conduct of these activities, to support the local and district staff to conduct these activities and to monitor the quality of the trainings/orientations/meetings. MASS (Management Support Services) staff provided logistical support for the conduct of many of these activities in all districts.

IV. Special Studies

1. Raising Awareness About Household Management of Diarrhea Through Community Action: A Study of the Blue Plastic Cup Distribution Activity, Chitwan District, Nepal

This report summarizes the findings of a study conducted in selected wards in Chitwan district to assess the impact of the distribution of blue plastic cups (BPC) at the household level for the purpose of measuring the proper amount of water when making oral rehydration solution. The study was carried out over four days in February 1999 by two researchers: an independent consultant and a JSI Child Health Field Officer. The study consisted of semi-structured interviews, with many questions open-ended to allow the researchers to probe into subjects alluded to by respondents in their answers.

Persons interviewed included representatives of the DHO in Chitwan who are primarily associated with this activity, health post and sub-health post In-Charges, VDC chairpersons and members, FCHVs, representatives of local clubs or NGOs which participated in past distribution activities, mothers from BPC distribution areas and from outside these areas, and fathers in BPC distribution areas. During interviews with FCHVs and mothers, their ability to correctly make ORS was assessed by having them demonstrate how to do so, using packets of ORS provided by the research team. Parents interviewed were randomly selected by the independent consultant in the field. FCHVs were also selected at random, with two exceptions. The two FCHVs who were not selected at random were notified by the in-charges at their health post or sub-health post that persons from JSI were arriving on a specified date to speak with them. They were not informed of the topic of discussion.

CDD Reactivation Program

In January 1993, HMG/N initiated a "Reactivation Program" to strengthen the existing National Diarrheal Disease Control Program in Nepal which commenced in 1983. The reactivation was designed to follow-up on the elements included in the original Diarrheal Disease Control Program and increase the knowledge level of government health facility personnel to improve diarrheal case management through extensive training activities. It also aimed to improve access to ORS at both the health facility and community level.

The "Reactivation Program" was implemented sequentially in each of the five regions of Nepal between 1993 and 1996 with support from the United Nations Children's Fund, the World Health Organization and the United States Agency for International Development.



Through a USAID-funded contract, John Snow Incorporated provided technical assistance to the Ministry of Health for some aspects of program implementation and follow-up.

One of the Reactivation Program's strategies for improving awareness about diarrhea and its correct management was to distribute BPCs to each health facility and to all FCHVs within the district. The BPCs facilitate accurate measurement of water when preparing ORS, since six glasses (the number of "tea" glasses to be used when measuring water for ORS preparation, according to the directions on the packets) measure out approximately one liter (1000 ml.) of water, the correct amount for making ORS. However, in Chitwan district, unlike in other areas of Nepal where the CDD Reactivation Program was carried out, BPC distribution was eventually extended to the household level, with extremely positive results. Four different groups were mobilized for BPC purchase and/or distribution: VDCs, clubs/non-governmental organizations (NGOs), FCHVs and households. As of June 1998, BPCs were distributed to a total of 9,171 households (approximately 14 percent of the total number of households) in 52 wards in Chitwan (15 percent of the total number of wards).

The *objectives of the BPC distribution activity* in Chitwan are:

- *To mobilize local resources to support the CDD Reactivation Program;*
- *To create awareness among mothers to use ORS and home-made fluids during episodes of diarrhea (home-made fluids include vegetable stock, rice stock and other nutritious fluids);*
- *To allow mothers to measure the correct volume of water when preparing ORS; and,*
- *To create awareness among mothers about the management of diarrhea.*

Findings

The findings of the research team were overwhelmingly positive regarding the impact of BPC distribution at the household level in Chitwan. Individuals from each group interviewed spoke highly of the efficacy of BPCs in raising awareness regarding diarrheal diseases in general, and the correct preparation of ORS to manage episodes of diarrhea in the home in particular. Some of the key findings are given below:

- Health staff posted in areas where distribution has been carried out, including FCHVs, have reported that the level of understanding among the community regarding how to prepare ORS has improved markedly. This understanding has led, in their opinion, to a higher demand for ORS, as people increasingly manage diarrhea in their own homes, as reflected in fewer and fewer diarrhea patients reporting to health posts for consultation and care.
- The BPCs have proven to be a powerful tool for increasing general awareness of diarrheal disease. Mothers who received a BPC demonstrated a clear knowledge of where ORS is available and how to make ORS correctly, and no longer need to burden the health posts during episodes of simple diarrhea.
- The BPCs were kept in safe places where they could be easily accessed when needed and in good condition in the homes visited during this study, indicating their importance in those households.
- Among mothers who did not receive BPCs, their understanding and confidence regarding diarrhea management was not as strong. Each mother interviewed who had not received a BPC made fundamental mistakes (all added an incorrect amount of water, one mother added salt and sugar) when demonstrating how to make ORS for the interview team.

- Schools, local clubs and/or NGOs and, most importantly, VDCs, are all key to generating community support, carrying out the distribution in a well-publicized way so that all are informed of the purpose and value of the activity, and, with the exception of schools, providing funding so the activity may take place. Successful distribution is not as likely to happen if these groups are not involved.
- The BPC distribution can have other positive effects on the communities in which it is carried out. It may lead to other community initiatives to improve public health. Also, the high degree of visibility the distribution provides local FCHVs, who are often involved in the distribution process, allows household members to more easily understand the role of FCHVs, and gives FCHVs and local community members a chance to meet and get to know each other.
- Many informants stressed that BPCs in households are meaningless without an adequate supply of ORS, which was in short supply at the time of the interviews. Up until now, HMG/N has managed the supply of ORS to health facilities throughout Nepal, but communities must also begin to take measures to ensure that enough ORS is on hand so that it is available to all households throughout the year.
- Though the DHO in Chitwan has been supportive of the BPC distribution activities in principal, it has made little effort thus far to follow-up, either to document lessons learned or to reinforce or expand on what has been carried out. Health posts and health staff throughout Chitwan need the active encouragement of the DHO to reinforce their initiatives to support the expansion of BPC distribution to households. The active support of the DHO would also lead to increased motivation among health service delivery personnel in Chitwan to take the extra steps necessary to successfully accomplish BPC distribution at the household level.

Recommendations

The recommendations of the study include the following:

- 1) *The BPC distribution activity should be expanded to cover all households in Chitwan, then moved to other districts;*
- 2) *The DHO in Chitwan must increase its involvement in the BPC distribution activity;*
- 3) *An adequate supply of ORS must be ensured in all communities in Chitwan (and Nepal) through the efforts of both communities and HMG/N; and,*
- 4) *Measures should be taken to "market" the BPCs to increase the percentage of households in Chitwan who have them. This may be done through sales schemes whereby a BPC is given away with the purchase of a fixed number of ORS packets, or the logo of a specific brand is stamped on the BPCs.*

2. Assessment of Dhami/Jhankri Orientation

Diarrhea and acute respiratory infections, particularly pneumonia, continue to be the major causes of morbidity and mortality in children under the age of five in Nepal. In order to take treatment of pneumonia cases closer to the community, in 1995, the Ministry of Health launched a program to train Female Community Health Volunteers (FCHVs) on the treatment and/or referral of pneumonia cases in four districts of Nepal. An assessment of this program in 1997 revealed that, in addition to the FCHVs, traditional healers, or *dhami/jhankris* (D/Js), play an important role in the treatment of cases of pneumonia in the community. Based on the recommendations of this evaluation, in 1997/98, CDD/ARI Section, MOH, in collaboration with UNICEF, WHO, and JSI/USAID, conducted an orientation for D/Js. *Dhami/Jhankris* from six districts in Nepal, Jhapa, Morang, Sunsari, Parsa, Makwanpur and Chitwan were

oriented to recognize the referral signs of ARI and diarrhea, and to learn about home therapies for both diseases.

This study is an evaluation of the effectiveness of the D/J orientation in two districts, Makwanpur and Jhapa, 14 months after its implementation. A total of 144 interviews were conducted with both oriented and non-oriented D/Js. Forty-five of the 105 originally oriented D/Js from Makwanpur and 33 of the 76 from Jhapa were randomly selected for interview. Thirty-five non-oriented D/Js were interviewed in Makwanpur and 31 in Jhapa. The interviews were conducted primarily to compare the knowledge and practice of the oriented D/Js, pre- and post- orientation, as well as to compare the oriented and non-oriented D/Js. The assessment included questions about the D/Js' knowledge and practice in regard to the referral signs of ARI and dehydration, danger signs of ARI and diarrhea, ability to correctly prepare Oral Rehydration Solution, and knowledge about home therapies for these diseases. Comparisons were also made between the D/Js of Makwanpur and Jhapa, and between literate and illiterate D/Js. Health facility staff were interviewed in both districts to get their impressions of the effectiveness of the orientation. Finally, caretakers of children with ARI and/or diarrhea who had visited an oriented D/J within the two weeks prior to the study were interviewed with the intent of documenting the oriented D/Js' management of these diseases.



A total of six Village Health Workers and one Auxiliary Health Worker were trained as interviewers for the two districts. JSI staff and the study co-ordinator carried out supervision of the interviewers. Interviews were conducted using a standardized questionnaire which was written in Nepali and field tested in Makwanpur.

The primary objective of the orientation was to educate the D/Js about ARI and diarrheal disease to the extent that they would learn when to make referrals to the FCHVs or health facilities when necessary. Ninety-six percent of the oriented D/Js stated that they referred ARI cases to the health facilities after receiving the orientation, whereas only 35% of them reported referring prior to receiving orientation. The non-oriented D/Js' referral rate was 44%. These results indicate that the orientation program had a positive impact on the D/Js' treatment pattern.

The oriented D/Js' knowledge about home therapies for ARI was better than that of the non-oriented D/Js. Thirty-three percent of the oriented D/Js advised home therapy for their cough and cold (no pneumonia) patients, whereas 20% of non-oriented D/Js advised home therapy. Although a slightly higher percentage of oriented D/Js recognized the danger signs of ARI, ("fast breathing", "chest indrawing", "fever", "malnutrition", "unable to eat/drink", and "difficulty in waking up"), knowledge about these danger signs was overall poor among both oriented and non-oriented D/Js. One reason for the poor recall among the oriented D/Js could be that the ARI orientation was not of long enough duration. This finding suggests that future orientations may need to be longer and that refresher courses and study aids may be necessary.

A higher percentage of oriented D/Js recognized all six of the signs of dehydration, (“general condition”, “tears”, “thirst”, “skin elasticity”, “sunken eyes”, and “dry mouth and tongue”), compared to the non-oriented D/Js. The oriented D/Js had an overall better knowledge of the seven referral signs for diarrhea, (“frequent watery stools”, “repeated vomiting”, “marked thirst”, “unable to eat/drink”, “fever”, “blood in stool”, and “child not getting better”), however, both groups performed poorly in the categories of “unable to eat/drink” and “fever”. Finally, the oriented D/Js had better knowledge about the three home rules for treating diarrhea, (“increase fluids”, “continue feeding”, and “knows at least one reason for referral”). Future orientations clearly need to place more emphasis on some aspects of diarrheal disease.

When comparing the two districts, the D/Js of Makwanpur had better knowledge about the danger signs of ARI, ARI home therapies, and the signs of dehydration. This may be attributed to the ARI Strengthening Program which has existed longer in Makwanpur than in Jhapa. In addition, Makwanpur has had the benefit of the CDD Reactivation Program since 1996/1997. The CDD Reactivation Program, which reached the community level, is a combined child health program which includes diarrhea, ARI, nutrition, vitamin A, and Expanded Program on Immunization (EPI) as its components. Therefore, the health facility staff in Makwanpur may have been better prepared to orient the D/Js in comparison to those in Jhapa. The ability of both oriented and non-oriented D/Js to correctly prepare ORS (Oral Rehydration Solution/Salt) was poor in both Makwanpur and Jhapa, (46% and 28%, respectively).

A higher percentage of literate D/Js recognized the danger signs of ARI and dehydration, knew about ARI home therapies, and were able to demonstrate the correct preparation of ORS. These findings indicate that the literate D/Js may be more capable of learning about ARI and diarrheal disease by the methods employed during the orientations. In light of these results, future orientations should be tailored to meet the educational requirements of the illiterate D/Js.

In order for the D/J referral process to be successful, the D/Js need to know the FCHV of their ward and be aware of her treatment of childhood pneumonia and diarrheal disease. A higher percentage (81%) of oriented D/Js knew the FCHV of their ward, as compared to non-oriented D/Js (58%). Of those who knew their FCHV, more oriented D/Js also knew of her treatment of pneumonia. A comparison of the two districts showed that in Makwanpur, where the ARI Strengthening Program has been in existence longer than in Jhapa, a higher percentage of D/Js knew the FCHV of their ward and her treatment of pneumonia.

Although the results of this study indicate that the ARI orientation was effective in improving the D/Js' knowledge, skills and practice in assessment and treatment of cases of ARI and diarrhea, there are several aspects of the program which require improvement. Based on the findings of this study, the following recommendations are proposed:

- Target and reinforce specific messages in future orientations.
- Improve the linkage between the *dhamiljhankris* and the FCHVs.
- Develop new ways to orient illiterate *dhamiljhankris*.
- Utilize experienced trainers.
- Increase the duration and frequency of subsequent orientations for *dhamiljhankris*

Results of this study are encouraging in that they show the ARI orientation had a positive effect on the D/Js' knowledge about ARI and diarrheal diseases. Referral of ARI cases by the D/Js to the health facilities increased after the orientation, which was the primary objective of the orientation. *Dhami/Jhankris*, without question, play an important role promoting the health of the community because many villagers place a great amount of faith and trust in their treatments. In addition, the D/Js seemed eager to learn current medical practices. Therefore, the D/Js should not be alienated, but rather included in the future health plans of Nepal.

3. Peons' Training in Bardiya District

A peon is an HMG staff member who receives the lowest pay and has the lowest status. S/he has no written job description but remains always busy carrying out instructions from his/her supervisors. Recruitment criteria are the same for all peons in governmental organizations.

Peons working in the MOH health facilities have been conducting many activities either through their own interest or at the request of their superiors. S/he has highest chance of interpersonal communication with the patient or clients. Peons are usually local people and are rarely transferred, which is a common occurrence for other health staff. Thus s/he is available most of the time in health facilities even in remote locations. They understand the local people, their language and their problems and are often the first contact with the health system that villagers have. It will be no exaggeration to say that s/he remains the available service/care provider in many remote areas and health facilities.

In the health sector there is always a need to get updated information and there are many training opportunities for all health facility staff, except peons.

HMG/N CDD program has targeted to establish ORT corners (ORT/C) in all HFs. Materials were supplied and HF staff were trained for that purpose, but still in many institutions the ORT/Cs are not in a functional state.

JSI's CHFO in the Mid-Western Region thought that if health facility peons were trained on the importance of correct ORS preparation and appropriate care for children with diarrhea then they could assist both in HFs and in the community to improve management of diarrheal dehydration. He also felt that the responsibility for maintaining functioning ORT/Cs could be handed over to the peons following training, under the guidance of their supervisors, to ensure that HFs always have an ORT/C ready for use.



▲ Participants of the Peons' Training in Neulapur

The CDD/ARI focal person and DHO in Bardiya were interested in piloting this idea in their district. They took the suggestion very positively and a training program was carried out with JSI /USAID technical and financial support during the month of June 1999.

This training program had the following objectives and received immediate returns.

Training Objectives were:

- To provide knowledge on the importance of clean environment within the health facility working areas;
- To encourage peons to maintain good working relationships with HF In-Charge and other staff;
- To discuss the peon's role in prevention and treatment of diarrhea and Vitamin A deficiency cases;
- To make them knowledgeable and able to impart health education to mother/caretakers about 3 rules of Home Care Management for children with diarrhea;
- To develop the peons' skill on ORS preparation and **make** them responsible for keeping the ORT/C set always functional.

Immediate Benefits from the Training:

- 33 HFs in Bardiya are now equipped with an ORT/C set, CDD/ARI Treatment Chart, Vitamin A treatment protocol, a set of materials for cleaning the health facilities and IEC materials of CDD/ARI;
- 58 Peons were trained and provided with the new mothers' booklet, blue plastic cup (BPC) and small towel for their personal use;
- Under 5 children with diarrhea were treated for dehydration in Neulapur HP during training which gave good exposure to the trainees as well as mothers of the children. Hands-on-training gave the participants more confidence to manage cases. Similarly, the smiling faces of mother and children gave great pleasure to the group.
- The teaching Health Post environs were cleaned well despite the problem of water supply and 3 Pits were made in both training sites for proper disposal of solid waste;
- Peons and other staff were very pleased with the training. Some of the peons said that they also used their learning at home to teach their wives and children to wash their hands. Good singers and managers were also found among the peons;
- This was the first formal training to peons in Bardiya district;
- A peons' job description was prepared with their input and agreement.

A formal follow-up to the training has not yet been conducted, but will be completed during Year 3 of the project and a report prepared.

V. Participation by JSI Child Health Staff in Trainings/ Workshops/Conferences

1. Quality Assurance Conference from October 4 to 11, 1998 - Budapest, Hungary

Kumar Lamichhane was nominated by USAID/N to attend an international conference on Quality Assurance in Budapest, Hungary, to share the materials and experience developed in Nepal through the ARI Strengthening Program and other Child Health Program monitoring activities facilitated by JSI field staff.

2. IMCI Review Workshop from September 20 to 25, 1998 - Kathmandu

Penny Dawson and Kumar Lamichhane attended an MOH/WHO workshop in Kathmandu to review the progress in the implementation of the Integrated Management of Childhood Illness (IMCI) and to discuss future collaboration between the CBAC and IMCI programs.

3. WHO/UNICEF Inter-Country Meeting on IMCI from December 14 to 17, 1998 – Myanmar

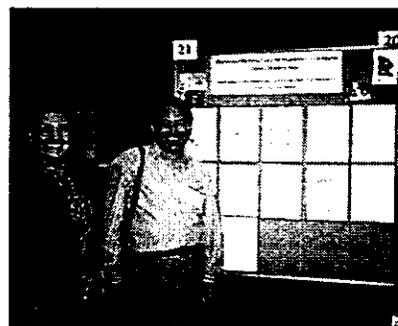
Penny Dawson attended an IMCI workshop in Myanmar organized by WHO/UNICEF. She presented the results of the ARI Strengthening Program activities to-date and Nepal's experiences in taking child health interventions beyond the health facilities.

4. 29th World Conference of International Union Against Tuberculosis and Lung Diseases from November 23 to 26, 1998 – Bangkok, Thailand

Dilip Poudel attended the 29th World Conference of International Union Against Tuberculosis and Lung Disease in Bangkok to present a poster on the ARI Strengthening Program.

6. XIXth International Vitamin A Consultative Group Meeting (IVACG) from March 8 – 12, 1999 – Durban, South Africa

Ram Shrestha, NTAG and Penny Dawson attended XIX IVACG meetings at which Ram presented a poster on Nepal's NVAP.



^ JSI Team Leader and NTAG Director at XIX IVACG Meeting, South Africa

7. Nutrition Program Monitoring and Evaluation Workshop from June 7 to 18, 1999 – Tufts University, Massachusetts

Sushil Karki attended the Nutrition Program Monitoring and Evaluation workshop.

8. Intercountry Workshop on Promotion of IMCI Training for Basic Health Workers, April 27 to 30, 1999 - Chandigarh, India

Hira Tiwari attended the Intercountry Workshop and presented the results of the ARI Strengthening Program and CDD Reactivation Program Activities to-date.

Checklists Used by CH Staff

General (CDD/ARI/Vit A)

- a. Child Health Checklist for Supervision at the District Level
- b. Child Health Checklist for Supervision of the Health Facility
- c. Supervisory Checklist for VHW/MCHW
- d. Supervision Checklist for FCHV Activities

Specific

- a. ARI Strengthening Followup Checklist for Health Facility Level
- b. ARI Strengthening Program Followup Checklist for VHW/MCHW/FCHV
- c. Vitamin A Checklist for FCHV

CHILD HEALTH CHECKLIST FOR SUPERVISION AT THE DISTRICT LEVEL

District: _____ Visit #: _____ (Srawan-Asar) Date of Visit _____
Name of Interviewee: _____ Position: _____
Name of Interviewer: _____ Organization: _____

- A. VITAMIN A**
- | | | | |
|----|---|---|---|
| 1. | District Coordination Committee - formed ? | Y | N |
| | - Meeting? | Y | N |
| 2. | Case Treatment Protocol Available ? | Y | N |
| 3. | Distributed to all HF's
(If not, why not _____) | Y | N |
| 4. | Post Partum Protocol Available? | Y | N |
| 5. | Distributed to all HF's?
(If not, why not _____) | Y | N |
| 6. | Vit A IEC Material Available? | Y | N |
- B. Logistics Observation**
- | | | | |
|-----|--|---|---|
| 7. | Do you have ORS packets now? | Y | N |
| 8. | If no, since when? | | |
| 9. | Do you provide ORS packets to all HF regularly | Y | N |
| 10. | Are the ORS packets properly stored? (Observation) | Y | N |
| 11. | # of ORS packets _____ | | |
| 12. | # of cotrimoxazole - pediatric _____
- Adult _____ | | |
| 13. | Iron tab # _____ | | |
| 14. | Depo Provera (# of vial) _____ | | |
| 15. | Pills # _____ | | |
| 16. | Condom # _____ | | |
| 17. | Vit A Capsules # _____ | | |
| 18. | ORT/Corner Materials Set # _____ | | |
| 19. | BPC # _____ | | |
| 20. | CDD Treatment Chart # _____ | | |
| 21. | ARI Treatment Chart # _____ | | |
| 22. | Did you buy cotrimoxazole ped for this FY.
If yes, Mention manufacture company name _____ | Y | N |
23. What supports/activities do your staff think need to be improved?
- | | |
|--------------------|-----------------------|
| 1) case management | 2) supervision |
| 3) training | 4) supplies/equipment |
| 5) others? | |

Materials Supplied

<u>Name</u>	<u>Quantity</u>
_____	_____
_____	_____
_____	_____
_____	_____

Before leaving the DHO give feedback to the staff and mention the points

CHILD HEALTH CHECKLIST HEALTH FACILITY LEVEL

District: _____ Health Facility: _____ Date: _____
 Name of Health Worker: _____ Designation: _____
 Name of DHO's Supervisor: _____ Designation: _____
 Name of Supervisor: _____ Designation: _____
 Visit # _____ (Srawan - Asar)

A. ORT Corner:

- | | Y | N | Remarks |
|--|---|---|---------|
| 1. Facility has ORT Corner Equipment? | Y | N | _____ |
| 2. Is it functioning?
(Functioning = water, measuring device ORS should be ready to serve at the time of observation) | Y | N | _____ |
| 3. Type of measuring utensil being used (Specify) ? _____ | | | |
| 4. Volume of water correct (950 - 1200 mls is correct) | Y | N | _____ |

B. Vitamin A

- | | | | |
|---|---|---|-------|
| 5. Capsule available (# _____) | | | |
| 6. Case treatment Protocol Available in OPD | Y | N | _____ |
| 7. Post Partum Protocol Available | Y | N | _____ |
| 8. what conditions should receive Vit A high dose ? | | | |
| A. Measles | Y | N | _____ |
| B. Persistent diarrhea | Y | N | _____ |
| C. Night Blindness/Xerophthalmia | Y | N | _____ |
| D. Severe Malnutrition | Y | N | _____ |
| E. Post Partum (Mention time frame _____) | Y | N | _____ |
| 9. Recording of case treatment | | | |

Cases Treated	Last 1 month (from OPD Register)	1 month back (From HMIS)	2 month back (From HMIS)
1) Measles			
2) Persistent diarrhea			
3) Night blindness			
4) Xerophth'a/bitot's spot			
5) Severe Malnutrition:			
6) Post Partum			
Total			
Cases given preventive dose of Vitamin A			
Cases (Baisakh, Kartik, NID)			

Example: Last 1 month = Asar, 1 month Back=Jestha, 2 month Back =Baisakh

- | | | | |
|--|---|---|-------|
| 10. In the HMIS report are you reporting VAC used for prevention and VAC used for treatment separately | Y | N | _____ |
| 11. Vit A IEC Materials Displayed | Y | N | _____ |

C. Logistics:

- | | | | |
|---|---|---|-------|
| 12. Do you have ORS packets now? | Y | N | _____ |
| 13. If no, since when? | | | |
| 14. Are they properly stored? | Y | N | _____ |
| 15. When was the last time the HF received ORS packets? | | | |

16. Do you provide ORS to FCHVs (through VHW/MCHW/HF) Y N _____
 17. CDD Treatment Chart Displayed Y N _____
 18. ARI Treatment Chart Displayed Y N _____
 19. Stock Observation During Visit: _____
 ORS #: _____ BPC #: _____ Vit A #: _____ Iron # _____

Cotrimoxazole (pd) # _____ Cotrimoxazole (Adult) # _____

Depo Y/N _____ Pills Y/N _____ Condom Y/N _____

D. Supervision:

From	Y/N
DHO Staff (in last 3 months)	
HF (in last 2 months)	
Others in last 3 months (specify)	

E. What Supports/Activities Do Your Staff Think Need to be Improved?

- Case management
- Supervision
- Training
- Supplies and equipment
- Others

F. Supplies Provided During the Visit:

CTP # _____ 2. PPP # _____ 3. CDD Treatment Chart/packet # _____

ARI Treatment Chart # _____ ORT Equipment # _____

ORS # _____ BPC # _____

CDD/ARI Posters # _____ Others # _____

G. What Kind of Cases do You Treat with Cotrimoxazole ped ?

Pneumonia _____
 Others _____

H. Iron (Verbal)

Provided to Pregnant Women (Y/N)	Sufficient Dose for 6 months (Y/N) (60 mg 180 Tabs)	Provided to Lactating Women (Y/N)	Sufficient Dose for 2 months (Y/N) (60mg 60 tabs)

File:nonQICDD

CH CHECKLIST FOR VHW/MCHW

District: _____ Date: _____ Visit #: _____ (Srawan-Asar)
 HP: _____ SHP/VDC: _____
 Name of VHW/MCHW: _____ Name of DHO Supervisor: _____
 Name of Supervisor: _____

Activities Last Month:

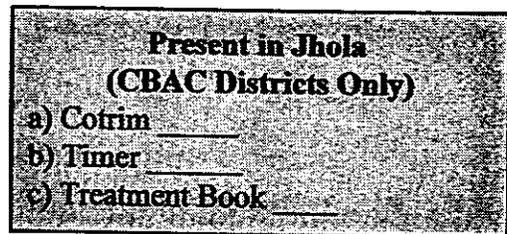
	Yes	No	Remarks
1. FCHVs visited last month If yes, how many FCHVs _____	Y	N	_____
2. Number of mothers group meetings attended: _____			
3. Contraceptive pills given to # of client _____ # of FCHVs _____			
4. Distribution of ORS to # of client _____ # of FCHVs _____			
5. Monthly reports sent to Health Facility	Y	N	_____
6. Referred any children/people with VAD/Other to HF for treatment	Y	N	_____
If yes, a) Measles _____ b) Persistent diarrhea _____ c) Night blindness/Xerop'a _____ d) Severe malnutrition _____ e) Post partum _____			

Knowledge:

7. 2 ways to prevent AIDS	Y	N	_____
8. 2 Signs of pneumonia (Fast Breathing (Y/N) __, Chest Indrawing (Y/N) __, Any other (Y/N) __)	Y	N	_____
9. 3 signs of dehydration: (General condition (Y/N) __ Thirst (Y/N) __ Skin elasticity (Y/N) __, Any other (Y/N) __)	Y	N	_____
10. Explain the three rules for treating diarrhea at home	Y	N	_____
a. increased fluid intake	Y	N	_____
b. Continue feeding	Y	N	_____
c. Reasons for seeking medical help: (If any two of following, the answer will be yes) Many watery stool, - Repeated vomiting; - Mark thirst, - Eating or drinking poorly; Fever, and Blood in stool	Y	N	_____
11. Vit A	Y	N	_____
a. 2 signs of Vit A deficiency (nightblindness, Xerophthalmia, bitot's spot, Cornealulcer, Keratomalacia)			
b. 2 Animal Sources of Vit A	Y	N	_____
a. _____			
b. _____			
12. What conditions should receive Vit A high dose?			
A. Measles	Y	N	
B. Persistent diarrhea	Y	N	
C. Night Blindness/Xerop'a	Y	N	
D. Severe Malnutrition	Y	N	
E. Post Partum (mention time frame _____)	Y	N	

Availability:

13. Jhola available Y/N _____
 14. Present in Jhola
 a. Pills Y/N _____
 b. Condom Y/N _____
 c. ORS Y/N _____
 e. CDD/ARI/Vit A Posters Y/N _____
 15. ORS Received in past 2 months Y/N _____



Supervision:

16. From HF staff Y/N (in last 2 month)
 17. From DHO staff Y/N (in last 3 month)
 18. Others staff Y/N (in last 3 month) Specify _____

Supplied during the visit _____

CH CHECKLIST FOR FCHV ACTIVITIES

Name: _____ Age: _____ Ed: _____ (Lit=1, Illit=2)
 DHO Staff: _____ JSI/Others Staff: _____ Visit # _____ (Srawan-Asar)
 Date # _____ Other involvement: _____

Remarks

ACTIVITIES OF LAST MONTH

- | | | | |
|--|---|---|--|
| 1. Assisted in EPI Center | Y | N | |
| 2. Mothers group meeting conducted | Y | N | |
| a. VHW/MCHW present | Y | N | |
| 3. Distributed: | | | |
| a. Oral contraceptives: | Y | N | |
| b. Condoms: | Y | N | |
| c. ORS to # of client _____ | Y | N | |
| 4. FCHV register available (Ward Register) | Y | N | |
| If available, register up-to-date ? | Y | N | |

KNOWLEDGE OF FCHVs

- | | | | |
|--|---|---|-----------------------------------|
| 5. Exclusive breast feeding | Y | N | |
| 6. 2 Signs of dehydration | Y | N | |
| (General condition Y/N __, Thirst Y/N: __, Skin elasticity Y/N __, Any other Y/N __) | | | |
| 7. Explain the three rules for treating diarrhea at home | | | |
| a. Increased fluid intake | Y | N | |
| b. continue feeding | Y | N | |
| c. Reasons for seeking medical help | Y | N | |
| (If anyone of followings, the answer will be yes) | | | |
| -Many watery stools Y/N __ | | | -Repeated vomiting Y/N __ |
| -Marked thirst Y/N __ | | | -Eating or drinking poorly Y/N __ |
| -Fever Y/N __ | | | -Blood in stool Y/N __ |
| 8. Measured correct volume of Water | Y | N | |
| (950 - 1200 mls is correct volume) | | | |
| (Specify measuring device _____) | | | |
| 9. A sign of pneumonia | Y | N | |
| (Fast breathing Y/N __, Chest Indrawing Y/N __, Anyother Y/N __) | | | |
| 10. Available with FCHV | | | |
| a. Pills Y/N _____ | | | b. Condom Y/N _____ |
| d. BPC Y/N _____ | | | c. ORS Y/N _____ |
| e. Mother Booklet Y/N _____ | | | |
| 11. ORS received during past two months: | Y | N | |
| If yes, source - (VHW/HF/JSI/bought by self/others) | | | |

Supervision:

From VHW/MCHW Y/N (in last 1 month)
 From HF staff Y/N (in last 2 month)
 From DHO staff Y/N (in last 3 month)
 Others Y/N (in last 3 month) Specify

Ask to bring salt for test!!

Supply on the spot by JSI/DHO/Others staff:

- | | |
|---|-----------------|
| 1) Blue glass _____ | 2) ORS: _____ |
| 3) Condom: _____ | 4) Pills: _____ |
| 5) IEC (CDD/ARI/Vit A/Others) Posters _____ | |

ARI FOLLOWUP CHECKLIST HEALTH FACILITY LEVEL

District: _____ PHC/HP/SHP: _____
 Followup by District staff: _____ Visit: _____ (Srawan - Asar)
 JSI Staff: _____ Date: _____

A. Staff Training

Name	Post	ARI Strengthening Training	
		Y/N (Year)	If no, Reason

B. Availability and Use of ARI Materials

Materials	Available (Y/N)	Remarks
OPD Register		
Timer		
Referral Slip Box		
Home Therapy card		
Treatment Card (FCHV/VHW/MCHW)		
Cotrim Dose Card		
Treatment Chart		
Classification Card		
Posters		
Treatment Book # _____ (in stock)		
Referral Book # _____ (in stock)		

C. ARI Medicines Received/Distributed

Medicines	Balance	
	Balance	If no since when
Cotrim Ped Tab # _____		
Chloramphenicol Suspension # _____		
Others	P. Penicillin	Y N
	Amoxycillin	Y N
	Ampicillin	Y N

D. Service Activities

Activities	Total	Remarks
# of Treatment slip received from CHW in HF in last month		

1. Referral slip Received from CHW (last visit or Srawan NFY ___)

Activities	Total	Remarks
# of referral slip received in HF		
# of very severe diseases confirmed by HF		
# of severe pneum. confirmed by HF		
# of pneumonia confirmed by HF		
# of no pneumonia confirmed by HF		

2. Observation of HF ARI Treatment Register (last visit or Srawan NFY ___)

Items observed	#	Remarks
# of ARI cases registered		
# of very severe diseases		
# of severe pneumonia cases		
# of pneumonia cases		
# of no pneumonia cases		
# of cases referred to hospital by HF		
# of revisit (followup) cases at HF		
# of CHWs' referred cases registered in OPD Register		
# of cases treated by cotrimoxazole		
# of cases treated by CHL		
# of cases treated by other medicine		

3. ARI Report

Last month's report sent Y/N ___
 MCHW/VHW's report received Y/N ___

4. Supervision

From	Y/N
DHO ARI Focal Person (in last 3 months)	
HF (in last 2 months)	
Others in last 3 months (specify)	

5. Materials supply During the Visit

Name	Quantity
A. _____	_____
B. _____	_____
C. _____	_____

File:ARIHF

ARI STRENGTHENING PROGRAM FOLLOW UP CHECK LIST VHW/MCHW/FCHV

District: _____ PHC/HP/SHP: _____ VDC: _____
 VHW/MCHW/FCHV: _____ Ward No: _____ Age: _____
 Education: _____ Visit #: _____
 (Literate = 1, Illiterate = 2)
 Follow up by: _____ Date: _____

A. Training and Materials

	Yes	No	Remarks
1. ARI Strengthening Training taken (2054)	_____	_____	_____
2. ARI Timer	_____	_____	_____
3. ARI Referral book	_____	_____	_____
4. Treatment book	_____	_____	_____
5. Treatment card (cotrim dose card)	_____	_____	_____
6. Classification card	_____	_____	_____
7. Home therapy card	_____	_____	_____
8. Reporting form (for VHW/MCHW only)	_____	_____	_____

B. Knowledge and Skill

1. **Respiratory Cut off Rate:**
 - less than 2 month _____
 - rate 2-60 month _____
2. **Danger Signs of Pneumonia (Only FCHV can see classification card during interview)**

Under 2 months	Y/N	2 month to 5 years	Y/N
Fast Breathing	_____	Chest Indrawing	_____
Severe Chest Indrawing	_____	Not able to drink	_____
Stopped Feeding Well	_____	Abnormally Sleepy	_____
Abnormally Sleepy	_____	Severe Malnutrition	_____
Fever	_____		_____
Low Body Temperature	_____		_____

- | | Correct | Incorrect |
|--|---------|-----------|
| 3. a. When to follow up the referred and treated cases | _____ | _____ |
| b. What to do on the day of follow up (Assessment)
(CI _____ RR _____ Cotrim Dose _____ Home Therapy _____) | _____ | _____ |
| 4. Explain the Home Therapy Card (Only FCHV can use Home Therapy Card) | | |
| a. Look for - Fast breathing | _____ | _____ |
| b. Look for - Chest indrawing | _____ | _____ |
| c. Keep young infant warm | _____ | _____ |
| d. Breast feed frequently | _____ | _____ |
| e. Clean the nose | _____ | _____ |
| f. Give more fluid | _____ | _____ |
| g. Give food more frequently | _____ | _____ |
| 5. Counting RR by using timer | _____ | _____ |
| 6. Treatment doses of cotrim 2 to 12 months | _____ | _____ |
| 12 to 60 months | _____ | _____ |

C. Service Activities (Date: From to)

1.a. Pneumonia cases treated*

	<u>Total</u>	<u>Correct Treatment*</u>	<u>Correct Classification</u>
- 2 to 12 months	_____	_____	_____
- 12 to 60 months	_____	_____	_____
(Total # _____ Slip # _____ to _____)			

b. Number of treated cases followed up Total Recorded Verbal

c. Number of cases both correct (correct treatment and 3rd day followed up) _____

d. Number of treated cases who were referred on third day _____

	<u>Total</u>	<u>Correct Classification</u>
2.a. Cases referred	_____	_____
Less than 2 months	_____	_____
(Total # _____ (Slip # _____ to _____))		
2 to 60 months	_____	_____
Total # _____ (Slip # _____ to _____)		

b. # of referral cases revisited (followed up) Total Recorded Verbal

c. # of followed cases referred on third day: _____

Treatment Book Indicators (get from attachment)

# of cases (maximum 10 most recent cases)	# of cases marking consistent age and dose	# of cases marking 3 rd day followup	Both Correct (Consistent Age/Dose and 3rd day followup)

Referral Book Indicators (get from attachment)

Age Group	Total # of cases (maximum 10 most recent cases)	# of cases marking 3 rd day followup
< 2 months		
2 - 60 months		
Total		

D. Supervision (for only ARI)

From VHW/MCHW YES/ NO (in last 1 month) Report collected Y/N _____
 From HF staff YES/ NO (in last 2 month)
 From DHO staff YES/ NO (in last 3 month)
 From others (Specify) YES/NO (in last 3 month)

E. Medicine (Cotrim P.)

Balance: _____ (min 20 tabs). If no, since when _____
 Cotrim received from _____

F. Resupply: Treatment book _____ Referral Book _____

G. Supply on the Spot by JSI/DHO Staff

a. IEC Materials: _____ (specify)
 b. Cotrim P.: _____
 c. Others: _____ (specify)

H. Have any traditional healers referred any case of ARI/Pneumonia to you for treatment Y/N _____

Note:

*Correct treatment = Correct cotrim dose by age.
 Follow up=Reassessed by CHW on 3rd day or CHW verified out come with parent/guardian/caretaker on 3rd day.

Practice with case studies for classification

Correct for < 2 month Y/N _____ Correct for 2 months to 5 years Y/N _____

Vitamin A Checklist for FCHV

District: _____ HP: _____ SHP: _____
 VDC Name: _____ Ward #: _____
 Name: _____ Age: ____ Ed: ____ (Literate= 1, Illiterate = 2)
 Date: _____

Knowledge

- | | | |
|---|---|---|
| 1. 2 Animal Sources of Vit A: | Y | N |
| A. _____ | | |
| B. _____ | | |
| 2. Have you told any mother about the two sources of Vit A? | | |
| A. Animal | Y | N |
| B. Vegetable | Y | N |
| 3. What conditions should receive Vit A high dose ? | | |
| A. Measles | Y | N |
| B. Persistent diarrhea | Y | N |
| C. Night Blindness/Xerophthalmia | Y | N |
| D. Severe Malnutrition | Y | N |
| E. Post Partum (within 6 weeks (45 days) of delivery) | Y | N |
| Time frame _____ | | |

ACTIVITIES

- | | | |
|---|---|---|
| 4. Did you dose children with Vit A in last round?
if Yes how many _____ (If register is available) | Y | N |
| 5. # of children missed last round _____
Reasons: a) Shortage of Capsule _____, b) Others _____ | | |
| 6. Who supported you in pre-distribution and distribution of Vit A in last round _____
(Family member=1, health workers=2, teachers=3, agriculture workers=4
VDC members=5, others = 6 _____ specify) | | |
| 7. Referred any children/people with
VAD/Other to HF for treatment (within last 6 months) | Y | N |
| If yes: a) Measles _____ | | |
| b) Persistent diarrhea _____ | | |
| c) Night Blindness/Xerophthalmia _____ | | |
| d) Severe Malnutrition _____ | | |
| e) Post Partum _____ | | |

Availability

- | | | |
|--|---|---|
| 1. Scissors | Y | N |
| 2. Vit A Capsule | Y | N |
| 3. Vit A Flipchart | Y | N |
| 4. Other Vit A/Nutrition IEC Materials | Y | N |
| 5. Register | Y | N |

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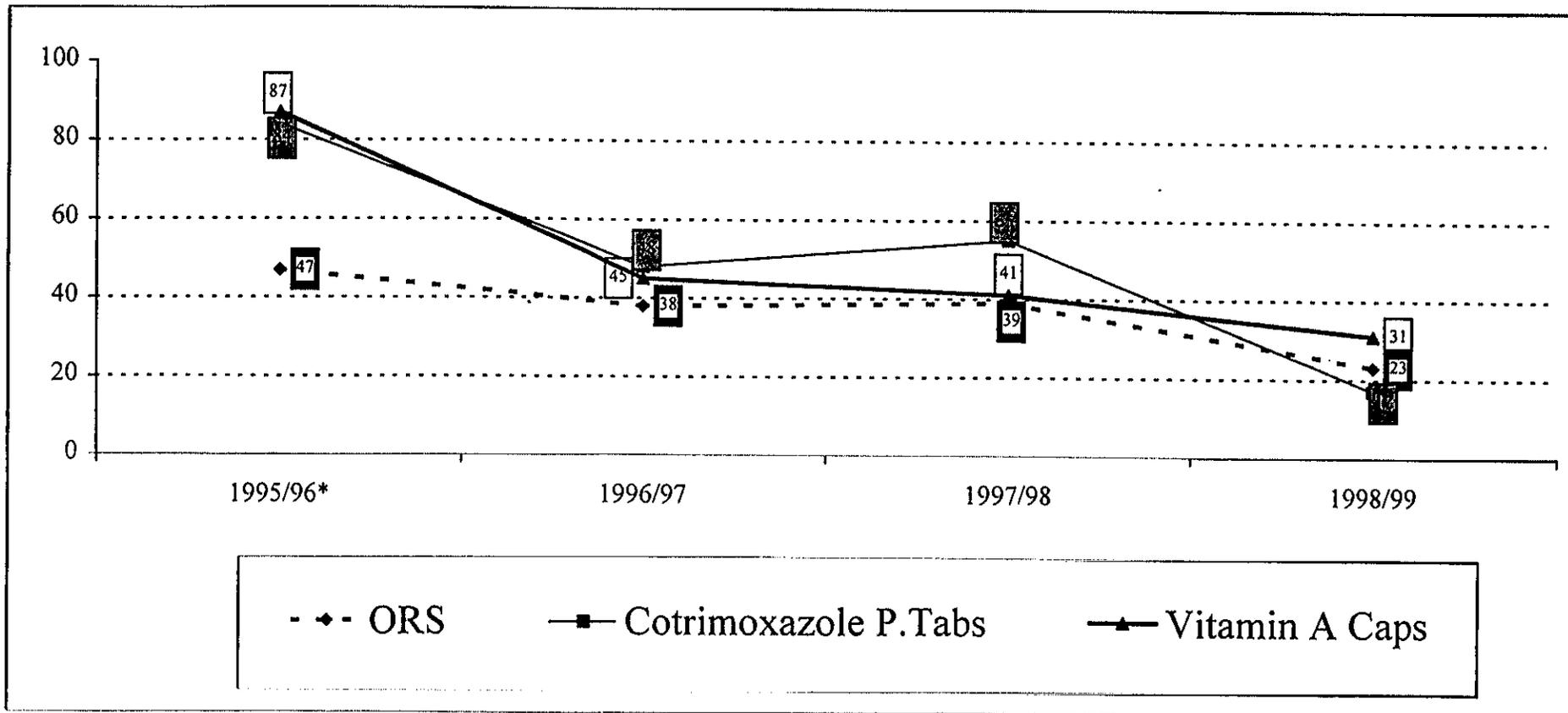
Materials Distributed by CH Staff by Region July 1/98 - June 30/99

Region	ORS	BPC	New CDD/ARI IEC	Other IEC	Others	ORT Corner	Vit A Capsules	Condom/Pills /Depo	Cotrimoxazole	Timer
Eastern	1,836	132	105	97	38	16	1,050	1,770	14,100	21
Central	6,767	112	335	347	12,821	78	4,878	823	77,490	24
Western	2,104	347	512	323	5,078	0	503	48	0	0
Mid-Western	922	88	491	519	164	5	837	786	0	0
Far-Western	2,852	106	304	417	2,244	35	2,476	6,734	2,000	0
Total	14,481	785	1,747	1,703	20,345	134	9,744	10,161	93,590	45

Others: condoms, scissors, ARI Treatment/Classification Cards etc.

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LMIS INFORMATION REGARDING % STOCKOUT OF ORS, VITAMIN A CAPSULES AND COTRIMOXAZOLE PEDIATRIC



* Data from Far-Western Region is not available

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Source of Performance Milestone Data

The LCHSSP is a performance based project, which means that annually specific program performance milestones are documented and reported to USAID. The source of the data for two of the milestones in Year 2 of the LCHSSP (1998/99) is the monitoring reports of the JSI Child Health Field Staff (CHFS). For ease of identification those are summarized here.

1. FCHV Program

Performance Milestone: Percentage of active FCHVs reporting provision of MCH services to their MOH supervisors

Year 2 Performance: 69%
(1998/99)

Source of Data: JSI CHFS field reports from all 5 Regions from interviews with a total of 716 FCHVs

Reference in report of child health monitoring activities:

Page 23: **Graph F#12: Supplies Distributed by FCHVs During Past 1 Month**

Comment: Ideally, this data could be obtained through the MOH's Health Management Information System (HMIS) but at the present time the FCHV service statistics are not reported separately to the Central Level, although they are reported at the Health Facility level.

2. ARI Program

Performance Milestone: Percentage of children 0-60 months of age with pneumonia symptoms referred or treated appropriately by FCHVs, VHWs/MCHWs in target districts

Year 2 Performance: a. 82% of cases treated or referred by FCHVs/VHWs/MCHWs had third day followup marked in the record book.

b. 93% of cases treated by FCHVs/VHWs/MCHWs had consistent age and cotrimoxazole dose marked in the record book.

Source of Data: JSI CHFS field trip reports from 11 districts where the community Level intervention has been implemented; interviews with 1252 Community health workers

Reference in report of child health monitoring activities:

Pages 36:Graph AC #6: Comparison Between percentage Followup of Pneumonia Cases Treated/Referred* by Type of District

Page 37: Graph AC #9: Comparison of Percentage of Pneumonia Cases Treated* by CHWs Marking consistent Age/Dose and 3rd Day Followup by Type of Districts

Comment:

The data which was compiled and analyzed to calculate these figures is summarized below.

# CHWs Interv'd	Treated Cases		Referred Cases		Treated/Referred Cases		Treated Cases	
	# of 10 most recent cases	#/% cases of marking third day followup	# of 10 most recent cases	#/% cases of marking third day followup	# of 10 most recent cases	#/% cases of marking third day followup	# of 10 most recent cases	#/% of cases marking consistent age and dose
1252	4752	3958 (83%)	344	238 (69%)	5096	4196 (82%)	4752	4423 (93%)

* 10 most recent cases