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AN EVALUATON OF THE JUMLA HEALTH PROJECT

Submitted to : Nepal Red Cross Society / International Human Assistance Program
Jumla Health Project
Kalimati
Kathmandu

Submitted by : New ERA
Post Box 722
Maharajgunj
Kathmandu

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August, 1983

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	i
LIST OF TABLES	ii
PROJECT STAFF	iii
I. BACKGROUND	1
II. SCOPE OF THE STUDY	2
III. METHODOLOGY	5
A. Evaluation Instruments	5
B. Sampling	5
IV. PROJECT ASSESSMENT	10
A. Overall Achievement and Completion Status	10
B. The Effectiveness of CHLs	16
C. The Effectiveness of Community Health Committees	26
D. Viability and Status of Construction Projects	28
E. Physical Evidence of Effects of the Project in Jumla District	30
F. Attitude Towards the Project and Health Care	31
G. Extent of Local Participation to Effect Change	34
H. Extent of Coordination and Integration in the Health Delivery System by All Existing Agencies	36
I. The Need for the Extension of the Project	38
V. CONCLUSIONS	40
A. Contrast Between the Final Year and First Three Years of the Project	40
B. Change is Evident in the Project Area	40
C. Local Participation is Important	41
D. The Training of CHLs is Effective	41
E. Training for Women CHLs	42
F. The Role of Sudenis	42
G. Community Health Committees Not Yet Effective	43
H. Apparent Over-Involvement in the Construction Programme Without Long-Term Planning	43
I. General Lack of Long Term Planning for the Entire Project	44
J. Need for Continuation	44
K. Programme Objectives Too Broad	45
VI. RECOMMENDATIONS	46
APPENDICES	

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New ERA Study Team

LIST OF TABLES

		Page
Table 1 :	Questionnaire Respondents	6
Table 2 :	Profile of Respondents Selected Randomly from Twelve Panchayats	7
Table 3 :	Training Targets Achieved	10
Table 4 :	Medical Supplies Delivered to Jumla	15
Table 5 :	CHLs Recall of Training Content	17
Table 6 :	CHLs Test Results on Training Content Knowledge	18
Table 7 :	CHLs Knowledge on How to be An Effective Change Agent	19
Table 8 :	Physical Improvements in Jumla Area as a Result of Demonstrations and Training	20
Table 9 :	Villagers' Knowledge About CHLs	21
Table 10 :	Villagers' Opinions on CHLs Training and Performances	21
Table 11 :	Women CHLs Candidates Who have Taken the First and Second Phases of Training	24
Table 12 :	CHC's Participation in the Project	27
Table 13 :	CHC's Performance Vis-a-Vis Their Job Responsibility	27
Table 14 :	Changes from the WRCS/IHAP Project as Perceived by the Local Population	31
Table 15 :	Peoples' Attitude Towards the Programme	32
Table 16 :	Extent of Peoples' Participation	32
Table 17 :	Peoples' Attitude Towards Preventive Health Measures	33
Table 18 :	Role of Various Agencies to Bring Change in the Villages	35
Table 19 :	Reason for Peoples' Participation	35
Table 20 :	Opinion on Extension of Project	38

PROJECT STAFF

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I. BACKGROUND

In line with Nepal's long term health plan (1975-90) and the then current Five Year Plan (1975-80), which placed emphasis on providing minimal health care to the maximum number of people on an equitable regional basis as the country's main health objective the NRCS/IHAP Jumla Project was initiated. Its main aim was to establish a primary health care system (mainly preventive health care) in Jumla district of Karnali Zone, using Volunteer Village Health Workers (VVHW) as the chief agents for change. This project is funded by an Operational Programme Grant (OPG) from USAID, Nepal, to the International Human Assistance Programme, Inc. (IHAP) and was implemented, in coordination with Nepal Red Cross Society, for four years. It was initially implemented from August, 1979, through September 1982, and was later extended for an additional year until August, 1983. His Majesty's Government's Ministry of Health and IHAP, created a joint memorandum of understanding on October 18, 1977, in order to implement this project, in coordination with the Nepal Red Cross Society (NRCS), under the Health Services Coordination Committee of the Social Services National Coordination Committee (SSNCC), at the request of IHAP. The present investigation is an attempt to study and evaluate the achievements and impact that the NRCS/IHAP Jumla Project has made on the Community Health Sector in the Jumla district over the past four years.

II. SCOPE OF THE STUDY

The scope of the study was limited to the objectives stated in the "Terms of Reference for the Evaluation of NRCS/IHAP Jumla Project" submitted to New ERA by the NRCS/IHAP Jumla Project. These are as follows:

1. The extent to which individual objectives[1/] stated in the UJC proposal have been accomplished.

2. With the benefit of hindsight, were these objectives sound and realistic?

3. The education of the CHLs trained--

   --CHLs' knowledge of the training content, and
   --CHLs' knowledge of how to be effective change agents.

1/ The NRCS/IHAP Project was designed with five main objectives. According to the project design they were:

1. To conduct a baseline data health survey of the district.

2. To conduct a community dialogue that would provide a framework for broad-based community participation and feedback into the project.

3. To conduct a training programme for volunteer village health workers (VVHWs), new Community Health Leaders (CHLs).

4. To establish a health care delivery system at the grass-roots level.

5. To establish demonstration activities with community participation.

4. Proof of the effect of the project on the people in the Jumla district.

   --Physical evidence (latrines, kitchen gardens, compost pits, cleanliness of environment, other) as compared to:

      i) People's memories of the situation before the project, and
      ii) Another similar area in Nepal without village health promotion campaigns.

   --Villagers' knowledge of the content of the CHL training;
   --Villagers' attitudes towards preventive health measures.

5. Viability and effect of construction projects with completion status:

   --Training Centre
   --Health Post
   --Water supply systems
   --Latrine programmes
   --Bazar drainage
   --Other environmental sanitation activities

6. Attitudes of a sample of villagers, village officials, district officials and zonal officials towards the project.

7. Extent of cooperation and institutionalization of the project with all other health and welfare programmes in the Jumla district.

8. Knowledge of and attitudes towards the project by appropriate officials in the HMG Health Ministry and SSNCC.

9. Discussion on reasons for determined project successes and failures.

10. Comparison of this project with other CHL projects or similar projects.

11. Projected effect of the project without further inputs.

12. Recommendations on the necessity for and extent of further inputs to improve the health of the people in the Jumla district.

III. METHODOLOGY

A. Evaluation Instruments

The evaluation instruments used were as follows:

1. Formal Interviews based upon a questionnaire which was administered to a sample of CHLs, CHCs and villagers involved in the project from twelve panchayats. (The questionnaire is shown in Appendix A.)

2. Informal Interviews with officers of government and other agencies in any way connected or interacting with the project. As well zonal and district officers at Jumla were interviewed, as were related officers in Kathmandu. Guidelines for these interviews cover questions on attitudes about achievement and impact (see Appendix B).

3. Tests which were administered as part of the questionnaire above to CHLs only to ascertain the extent of their knowledge about basic health care (see Appendix A).

4. Observations by the New ERA Team using guidelines relating to general environmental impact in areas covered by the project.

B. Sampling

The sampling for the study consisted of subjects from five categories.

1. Community Health Leaders (CHLs) formerly known as Voluntary Village Health Workers (VVHWs).

2. Community Health Committee (CHC) members. As the study developed it became clear that CHCs were not functioning.

Instead the Pradhan Panchas were used for interview since they were to have functioned as Chairman of each CHC.

3. Government officials at the district, zonal and central levels.

4. Other project related personnel in Jumla and Kathmandu.

Twelve Panchayats were chosen for this study from the 30 possible in Jumla district because they were reported by NCRS/IHAP to be those in which follow-up studies had been done. They were as follows:

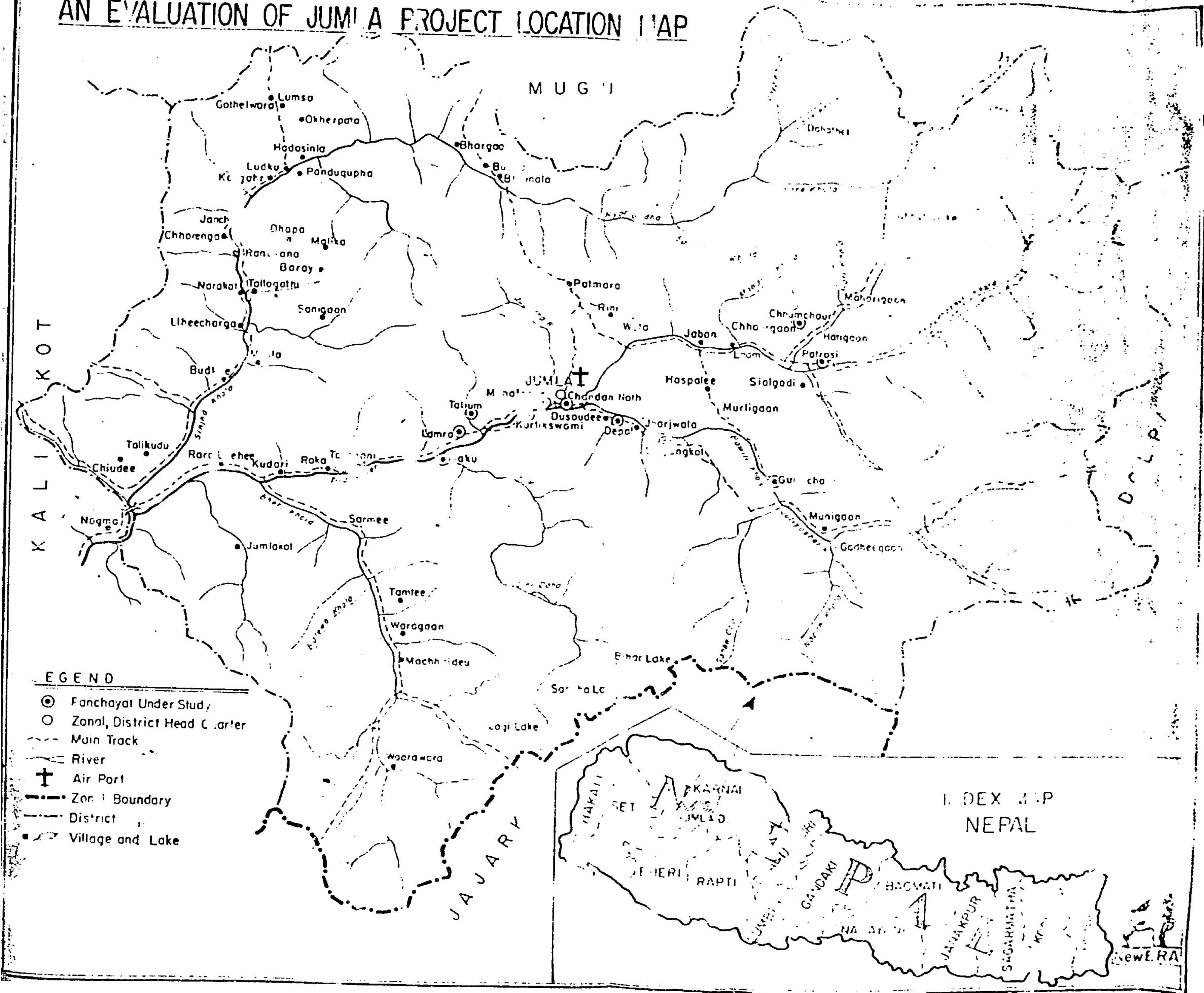
1. Guthichaur
2. Patarasi
3. Chumchaur
4. Garjyankot
5. Dipalgaun
6. Chandan Nath
7. Kartik Swami
8. Mahat Gaun
9. Taliom
10. Lamra
11. Haku
12. Tatopani

The general profile of the sample subjected to formal interviews by questionnaire is shown below in Table 1.

Table 1 : Questionnaire Respondents

Questionnaire Respondents from each Panchayat	Planned from 12 Panchayats	Actual Number
Villagers	60	60
Community Health Leaders (CHLs)	24	22
Community Health Committee (CHC) Members (Pradhan Panchas)	12	12
Total:	96	94 (98%)

The majority of the questionnaire respondents were Chhetris (63%) while the traditionally untouchable castes (Damai, Kami, and Sarki)



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made up some 12 percent. Females represented some 24 percent of this group. Some 33 percent of the total sample were illiterate. A more detailed profile of the questionnaire sample is shown in Table 2 below.

Table 2 : Profile of Respondents Selected Randomly from Twelve Panchayats

Caste	CHL	CHC	Villagers	Total	Percentage
Chhetri	18	7	34	59	63
Brahman	1	4	12	17	18
Damai, Sarki, Kami	1	-	10	11	12
Thakali, Bharti, Newar	2	1	4	7	7
					100
Age Group					
Below 20	-	1	7	8	8
21-30	3	3	21	27	29
31-40	10	3	20	33	35
41-50	4	4	4	12	13
51 and above	5	1	8	14	15
					100
Sex					
Male	12	10	49	71	76
Female	10	2	11	23	24
					100
Education					
Illiterate	11	-	20	31	33
Literate					
Class 1-5	8	6	16	30	32
Class 6-10	3	3	18	24	25
SLC and above	-	3	6	9	10
					100
Total:	22 (23%)	12 (13%)	60 (64%)	94	100

Villagers CHLs, and CHC members were chosen randomly from twelve panchayats of the districts.

In order to get the most valid responses possible the villagers' sample was chosen from randomly selected households of different communities and wards of each of the 12 panchayats. In the case of CHLs, however, the sample was selected from among those who were most readily available to the interviewers.

Informal interviews were conducted with the following people:

1. <u>In Jumla</u>

   Acting Zonal Commissioner
   Acting Superintendent of Police (S.P.)
   Acting Chairman, District Panchayat
   Chief District Officer (C.D.O.)
   Local Development Officer (L.D.O.)
   Acting District Education Officer (Acting D.E.O.)
   Medical Officer, Jumla Hospital
   Principal, Karnali Technical School
   Headmaster, Jumla High School
   Health Post In-charge, Depalgaun
   Personnel at IHAP Jumla

2. <u>In Kathmandu</u>

   C.B. Gurung, Member Secretary, NSSCC
   T.R. Onta, Chief Executive Officer, Nepal Red Cross Society
   G.B.S. Thapa, Account Officer
   Dr. Paul Goff, Director IHAP, Kathmandu.

3. <u>Data Collection</u>

   Data collection for this report was done by two New ERA staff members who flew to Jumla and spent ten days in the field. Working with them were four locally hired interviewers. Between these six people twelve panchayats of the 30 involved in the NRCS/IHAP project were covered.

Interviews were conducted and questionnaires and tests administered in the 12 panchayats named above and in district and zonal offices. Other interviews were conducted later in Kathmandu where the data collected and other material for this report were drawn together.

4. Constraints

It was not possible with the time or resources available for us to compare the NRCS/IHAP project with a similar project elsewhere.

IV. PROJECT ASSESSMENT

A. Overall Achievement and Completion Status

The original time span to achieve the five broad objectives which were contained in the original operational grant submission was from August, 1979 to September, 1982. Due to several constraints these objectives were not achieved within that term and at the request of the SSNCC the project was extended for one more year to be concluded by August, 1983. By that date a great deal more had been achieved by way of meeting specific targets outlined in the first three of the project's stated objectives. An overview of these achievements is shown immediately below. More detailed assessment of all aspects of the project then follow.

1. The Baseline Health Survey was targeted for 12 panchayats which was accomplished.

2. The Community Dialogue was also targeted for 12 panchayats and was accomplished.

3. The Training Component of the project has been accomplished as follows:

Table 3 : Training Targets Achieved

Category	Target Number	Trained	Comments
CHCs	120 Persons (Covering 12 Pan)	N.129 (107.5%)	Trained but never functional.
CHLs	432 Persons (Covering 24 Pan)	N.452 (104.6%)	Training for 189 is ongoing will be finished by August 27.
Female CHLs	216 Persons (50% of total CHLs)	N.146 (32.3%)	
Other Females	No Prior Target		276 Commenced, but left unfinished.
Sudenis	No Prior Target	N. 47	

A follow-up programme has been accomplished with all 12 panchayats having fully trained CHC members and CHLs.

4. The Construction Project Targets were as follows:

--Health Post at Depalgaun

--Drinking water systems at Garjuankot, Dipayal and Kartik Swami

--Renovate the government-owned guest house at Jumla

--Drainage system at Khalanga Bazar

--Latrines at Jumla District schools.

--Medical supplies to Jumla Hospital

The completion status of these construction projects by August 17, 1983 is given below:

a. Depalgaun Health Post

The building has been erected. Outside plastering is finished. Plastering inside and constructing a drainage system are still on-going. The Health Post In-charge at Depalgaun will no doubt be pleased to move from his dilapidated old health post into the newly completed building in September, 1983 (see General Comment below).

b. Drinking Water Systems

i) Gargyankot Village Panchayat Ward No. 4

This panchayat has two separate systems (729 meters of pipe total) in two different villages i.e., Pyakudi Bara and Ukhadi.

--Pyakudi Bara : Source--Two small springs, each supplying a different part of the village.

Intake Structures : 100 percent completed. Due to limited flow of water these structures are simple.

Pipelines : 32 mm HDP (high density polythene) approximately 500 meters in length. 100 percent completed.

Tapstands : Mud-stone masonry structures with plaster shells. Because of a shortage of available water only two (2) structures have been provided and extension of this system would be inadvisable. Thirty-five percent completed.

--Ukadi : Source--Spring.

Intake Structure : Stone masonry tank. 100 percent completed.

Pipeline : Main line and two branch lines, approximately 430 meters in length. 100 percemt completed.

Tapstands : Mud-stone masonry structures with plaster shells. Total number of tapstands four. One tap is built. Twenty-five percent is completed.

Other Structures : Separation tank to allow for sedimentation before the water enters the main part of the system. Eighty percent completed.

ii) Depal Goan Village Panchayat Ward Nos. 2,3,4 and 5

Source : Spring Intake. 100 percent completed.

Intake Structure : 100 percent completed. Constructed by a contractor to ensure a steady water supply for the Health Post situated in this panchayat.

Reservoir : $3.26m^3$.

Pipeline : 50 mm approx, 1.5 kilometres in length. Most of this line follows the older system built by the Jilla Panchayat. Much pipe has had to be replaced and several sections will require further attention after the rice has been harvested in the fall.

Tapstands : Mud-stone masonry with plaster shells. No. of taps five; completed.

Other Structures: In addition to the five taps being provided to the villages included is a branch line for the HMG Health Post. This will supply a tank at the Health Post to provide necessary water.

iii) Karkit Swami Village Panchayat Ward Nos. 5,6 and 7.

Source : Spring Intake.

Systems Description : This system is the largest of the project systems (1200 meters) at this time.

Intake Structure : Stone masonry spring intake structure. 100 percent completed.

Reservoir : Concrete base laid only.

Pipeline : 32 mm HDP with 20 mm HDP branch lines approximately 350 meters is yet to be laid. Seventy-one percent completed.

Tapstands : Six in number. Stone masonry structures with plaster shells are yet to be made.

Other Structures : None.

c. Renovation of Government Owned Guest House - Jumla

This target has been accomplished and the building is used by the project as the training centre and IHAP Jumla office (see General Comment below).

d. Khalanga Bazar Drainage System

At the time the evaluation team left Jumla on August 17, 1983, the drainage had been dug 100 meters and 70 meters of stones were laid of which 40 meters was cemented (see General Comment below).

e. Latrines at Jumla District Schools

The project had a target for the promotion of proper construction and use of latrines through the Jumla district schools. The project targeted two schools Chandan Nath High School and Ashok Primary School. It supplied materials and technical assistance provided that labour was supplied by the teachers and students. The high school had dug the pit already with the assistance of KTS students. Classes on personal hygiene and environmental sanitation were developed around this latrine construction programme (See general comment below).

f. Medical Supplies Delivered

Following is an inventory of requested medical supplies which have been transported to Jumla from the packaged disaster hospital. In addition approximately 30 stretchers will have been distributed to the panchayats in Jumla district. A volunteer stretcher bearer corps is also being established to facilitate the transport of sick and injured people to the Jumla Hospital.

Table 4 : Medical Supplies Delivered to Jumla

Item	Amount Delivered
Operating Table	2
Compress and Bandage Gauze	1 Box (12)
Gauze Spages	5 Pkgs
Autoglave	1
Suction and Drainage	1 System
Surgical Dressing Jar	2
1st Aid Kit	2
Kwell Shampoo	2 Boxes (24)
Splint	1 Box
Cotton Tipped Applicators	5 Boxes
Suture	12 Boxes
Vaseline Gauze Dressing	6 Boxes
Tongue Blades	2 Boxes
Triangular Bandages	1 Box + 3
Airway	6 Child and 5 Adult
Gauze Bandage Roller	3 Boxes
Hypodermic	1 Box
Hypodermic Needles	1 Box
Dressings	1 Box
Medicine Droppers	1 Box.
Syringe	3 Boxes
Safty Pins	6 Pkgs
Scissors - Bandage lister	6 and 7
Needle, Spinal - 1 Suture - 7	8 Boxes
Suture Clip	1
Tourniquests	4
Blades	1 Pkg
Forceps - Dressing - 2, Curved - 2	4
Operati g Knife Handle	1
Adhesive Plaster	1 Pkg
Needle Holder	3 Nos
Life Saving Tube	3
Scissors (Dissecting)	2

B. The Effectiveness of CHLs

1. Training and Follow-up Programme for CHLs

As proposed in the Operational Project Grant submission Volunteer Village Health Workers, later known as CHLs, who are also volunteers, were to be the main agents through which the project would facilitate the targeted change in the villages of Jumla district. A great deal of effort has been put into this aspect by the project. A 24 day training session was provided to CHLs (32% of which are females) of 26 village panchayats in Jumla district. They were equipped with the skills required for their identified jobs. According to project staff and CHLs themselves the CHLs were very enthusiastic in their work in the village after they went back from the training but lacked support from the CHCs and technical know-how about how to start work. Realizing this, the project staff conducted a follow-up survey in 12 panchayats to assess their progress and to assist where necessary.

2. CHL Recall and Knowledge about Training Course Content

In order to ascertain the level of general recall by CHLs about their training they were invited to volunteer to interviewers what they felt they had learned during their course. Table 5 below shows that apart from kitchen gardens directly health related issues seem to have had more impact than others. Their own level of understanding about those subjects they mentioned is also shown in this table.

Table 5 : CHLs Recall of Training Content

Subject Mentioned	Under-stood	Not Under-stood	Total
1. Community Health Programmes the CHL's Role	3	4	7
2. Health Education	14	1	15
3. Maternity Child Health and Nutrition	17	-	17
4. Personal Hygiene and Environmental Sanitation	16	-	16
5. Communicable Disease and Control	16	-	16
6. Family Planning	11	1	12
7. Traditional Home Remedies	9	1	10
8. Kitchen Garden	19	-	19
9. Smokeless Stove	2	5	7
10. Animal Diseases	4	3	7
11. Plant Diseases	6	2	8
12. Horticulture	9	2	11

In order to assess the knowledge by CHLs of their training content a series of questions on course context were designed. The test results show that in some areas knowledge of basic health concepts is very good. Table 6 below shows the results of the test administered as part of the questionnaire to 22 CHLs. Particularly reassuring is that relating to latrines (Question 7) where only one response was unsatisfactory. With regard to questions 8 and 9 about sileage and compost it will be necessary for the project to ensure coverage of these areas again.

Table 6 CHLs Test Results on Training Content Knowledge

Training Content	No Response	Good	Fair	Unsatisfactory
1. Way to make Sarbottam Pitho	-	12	9	1
2. Easiest method of temporary family planning	5	8	7	2
3. Way to make rehydration solution	6	13	1	2
4. Immunization and its reasons	4	8	8	2
5. Transmission of infectious diseases	1	6	13	2
6. Methods to control infectious diseases	3	9	7	3
7. Benefits of latrines	-	16	5	1
8. Differences between new and traditional compost pits	1	9	5	7
9. How to make silage	11	2	5	4
10. Advantages of kitchen gardens	2	9	10	1

3. <u>CHLs' Understanding of How to Be An Effective Change Agent</u>

When asked about this the CHLs responded with more than one answer. The highest response is related to the knowledge of their subject matter. As Table 7 below shows 64 percent said that one should be well equipped with the relevant subject matter. The second highest response (59%) was related to the CHLs' own motivation to work with people. Fifty percent said that one should be a hard worker. Leadership qualities were mentioned by only 18 percent. This quality, however, was mentioned most frequently by higher educated CHLs.

Table 7 : CHLs Knowledge on How to be An Effective Change Agent

Responses	N= 22	(% of N)
Knowledge of subject	14	64
Willingness	13	59
Hard work	11	50
Honesty	1	5
Leadership	4	18
Education	4	18
Don't know	1	5

4. The Demonstration Projects by CHLs

This consisted of activities like kitchen gardening, making compost pits, and pit latrines. These activities were to be introduced and promoted by the CHLs after they got back to the village from the training. Table 8 shows some immediate effects of the programme on the first 12 panchayats (which are also the studied panchayats) for which the CHLs training programmes were completed. This data is obtained from the follow-up surveys conducted for the most part immediately after the completion of the training. This data shows only the immediate effect of the programme.

Table 8 : Physical Improvements in Jumla Area as a Result of Demonstrations and Training

Panchayat with date CHLs finished training	Latest follow-up date	Properly constructed and employed latrines		Kitchen gardens	Compost pits	Comments
		Public	Private			
Depalgaon 8 Oct. 1982	Sept.'82	0	9	8	17	Follow-up conducted between Phase II and III of training
Gajankot 8 Oct. 1982	Sept.'82	0	12	2	12	
Gothichour 16 Oct. 1982	May '83	0	14	11	8	
Patarasi 24 Dec. 1982	May '83	3	60	37	9	
Chandanath 3 Feb. 1983	Mar.'83	0	73	19	10	Only 8 of 9 wards surveyed
Kartic Swami 3 Feb. 1983	Mar.'83	3	81	10	10	Only 7 of 9 wards surveyed
Mahatgaon 3 Feb. 1983	Mar.'83	0	3	1	0	
Tailum 3 Feb. 1983	Mar.'83	0	3	1	0	
Chhumchour 18 Mar.1983	May '83	1	16	10	0	
Totapani 18 Mar.1983	Mar.'83	0	21	12	0	
Lamra 18 Mar.1983	Mar.'83	0	23	8	0	
Haku 18 March'83	Mar.'83	0	36	0	0	

Note : Follow-up surveys are reported ward by ward. Each survey was signed by the Pradhan Pancha, Ward Chairman and CHLs in the ward follow-up team.

Source: Progress Report, NaCS/IHAP Jumla, 11 July, 1983.

5. Villagers' Views on the Performance of CHLs

As we see from Table 9 below CHLs are well known to the villagers. Only 13 percent of the respondents did not know of the CHLs' presence in the village. Those who knew of the presence of the CHLs knew who their CHLs were.

Table 9 : Villagers' Knowledge About CHLs

Questions	Yes		No	
	N	%	N	%
Is there CHL in your village?	52	87	8	13
Do you know him/her?	52	86	-	-

Villagers were asked about what they knew about the content of the CHLs training. Varieties of answers were recorded. The responses are given in Table 10. They were also asked whether CHLs were using their knowledge in working on the project and whether they were satisfactory. It is noteworthy that the highest response was on personal hygiene, and environmental sanitation (57%). Similarly health education which was mentioned by 43 percent of the sample, came on the third positio

Table 10 : Villagers' Opinions on CHLs Training and Performances

Subject Mentioned	Responses		Satis-factory	Good	Unsatis-factory
	N	%			
1. Role of CHLs and CHCs	6	10	3	3	-
2. Health Education	26	43	15	11	-
3. MCH and Nutrition	22	37	12	10	-
4. Personal hygiene and Environmental Sanitation	34	57	13	18	3
5. Diseases and their control	8	13	3	5	-
6. Family Planning	2	3	1	1	-
7. First-Aid	3	5	1	2	-
8. Horticulture	3	5	2	1	-
9. Kitchen Gardening	29	48	14	15	-

Sudeni (mid-wife) trainees are greatly appreciated by the people. All of the respondents commented that Sudeni CHLs are very effective. In view of the poor level of health delivery system in rural areas Sudeni are seen as offering great hope. One woman said emotionally, "Sudenis are like goddesses for village women, for they give life to us".

6. CHL Selection

This was left to Pradhan Panchas who were requested to send candidates with specific qualities, fifty percent of whom were to be women. Pradhan Panchas did not seem to take their responsibilities for sending qualified candidates very seriously. Many people reported that they often sent their own relatives or supporters. It was observed that some of the candidates at the Khalanga Bazar for training were hardly seventeen. Some others were too old for the CHL job. There was also an imbalance of numbers from the various panchayats. Some wards sent more than the specified two from each location and some sent none at all. There was a general feeling that project personnel did not spend enough time with Pradhan Panchas or others at the village level discussing this matter.

7. Applicants for CHL Positions

The overwhelming number of CHL applicants for the training programme was another proof of the popularity of the project and its effect on local people. There was great competition to be selected as a CHL candidate in the villages. Old people, women and even children approched the Pradhan Pancha hoping to be selected. Some district officers and a number of people in the villages suggested that the overwhelming number of people applying for training 95 CHLs was because of the incentive provided as Per Diem during the training period. Some people reported that people bribed the Pradhan

Pancha to be selected. However, the CHLs undertaking training in the Khalanga Bazar reported that they wanted to be equipped with health education information which is very important to them as individuals as well as to their community. Ten candidates, including women of all castes and age groups, were interviewed and each of them stressed that they did not come for the money. According to them, people who were not selected and who were really after the money were creating rumors that the overwhelming number and competition was due to the cash incentive.

Whether the overwhelming response was due to cash incentives or due to real motivation for acquiring health related education it was found that the training was well accepted by the people and was very popular. It is reported by the villagers that people who took the 24-day training were greatly changed afterwards. If not always practising the improved way, still they were now aware of health problems and possible preventive measures.

8. <u>The Issue of Women CHLs Training</u>

A lot of women were found in the area having had only 12 or 6 days of training. These women were expecting a call to complete their training. On studying the project files at the IHAP Jumla office it became clear that the project had started training programmes for women CHLs but the idea was dropped before the completion of the training. The records which were not very clear and not uptodate show that there are 276 such women out of which 108 from Haku and Lamra panchayats finished two phases of training (i.e., 18 days training) and the rest 168 women from Garjyankot, Depalgaun, Chandan Nath, Kartic Swami, and Tatopani who finished only the first phase of 12-day training. The number of representatives from the villages is also haphazard and uneven. According to the monthly report of March 1883, there was no

such specific plan and budget allocation for this training. The report says that the IHAP Director simply wanted more women trainees and promised cash incentives for the panchayats which could send the maximum number of women trainees. This promise caused an overwhelming response which could not realistically be dealt with.

Table 11 : Women CHLs Candidates Who have Taken the First and Second Phases of Training

Panchayat	Number	Phase Completed
Haku	42	1st & 2nd Phase
Lamra	66	
Garjyankot	34	
Dipalgaun	23	
Chandan Nath	32	
Kartic Swami	52	
Tatopani	27	

The March report says that the IHAP Director later wanted to stop the training which was impossible for some obvious reasons. The reasons were not given clearly, however, and the training is not yet completed. The women are still waiting to be called.

The IHAP Director's explanation is that the Jumla Coordinator's March report was very different from any understanding that he had. The Director says he wanted more women CHLs because they seemed to be more effective in the villages but certainly not more than 18 from each village, which the OPG clearly allows. The cash incentives for the panchayats was planned for only four panchayats--Chandan Nath, Kartic Swami, Mahatgaun and Tailum (because of its larger population, district leadership and central location) and only for public latrine construction. The other women shown in table were not included in the original plan.

He added that the difference of opinion and understanding caused Red Cross, Kathmandu, to call in the Jumla Coordinator to modify his understanding. With all this indecision the project could not provide the training programme for the rest of the targeted panchayats in time and in phases as originally planned.

Nine panchayats finished their training in July or August 1983. Five of those panchayats, in three different training classes, started their training in June or July, 1983. Their training was approximately one month between phases. There was a 24-day consecutive training held for four panchayats due to time constraints in the last month (August 1983) of the project. Due to the time constraint the training programme was conducted in one stretch for 24 days. This involved too much time for the trainees who could not stay away so long from their domestic and agricultural obligations and who were illiterate and had no such intensive training experience before. The shortage of time also did not provide enough time for careful selection of the CHLs. Had there been more time the target would have been met effectively plus there could have been follow-up work done in their panchayats.

9. The Issue of Incentive Payments for Latrine Construction

A complaint among the CHLs was that the project did not pay the promised incentives for the latrines constructed. The project's March report makes clear that the project advisor promised to pay Rs. 600/- for each public latrine constructed and Rs. 100/- for each private latrine constructed by the CHLs. The CHLs in Chandan Nath, Kartic Swami, Mahatgaun, Lamra, and Haku made their latrines and came to collect the incentive promised. Only the CHLs of Kartic Swami got the promised amount. The rest are very unhappy. The IHAP Director's explanation is that the Rs. 600/- incentive was

offered to pay for construction costs for public latrines. As incentive for the CHLs to organize all the work that went into public latrine construction (i.e., land acquisition, materials collection and labour), Rs. 100/- was offered to them to pay for costs of their own private latrines. Both incentives were to be paid after completion of latrines to project staff's satisfaction. So, the only CHLs who were offered Rs. 100/- for latrine construction were those from the above four panchayats who were able to successfully complete proper construction of a public latrine in their ward and completed a proper latrine of their own. Upon reading the Jumla Coordinator's March report he was called to Kathmandu. He accepted the rectifications and the project has since been run along the above guidelines.

3. <u>The Effectiveness of Community Health Committees</u> (CHCs)

CHCs were created in Jumla district as part of the basic infrastructure necessary to establish a village health care delivery system. The committees were formed in 12 panchayats with about 10 members under the chairmanship of the Village Panchayat's Pradhan Pancha. As part of the basic infrastructure for village health delivery systems it was planned that CHCs should play a vital role in the project. As Table 12 shows CHCs are not functioning at present. Although those interviewed were, as Pradhan Panchas or Acting Pradhan Panchas, supposed to be chairman of their Community Health Committee, few of them were aware of this. One man said that he did not know anything about a Community Health Committee. Two respondents remembered only that the CHC had a meeting once in the beginning and resolutions were passed regarding environmental sanitation.

Table 12 : CHC's Participation in the Project

Questions	Yes		No		Don't Know	
	N	%	N	%	N	%
1. Is there a CHC in this village?	4	33	7	58	1	8
2. Are you a CHC member?	4	33	7	58	1	8
3. Did you have any health training from the project?	3	25	9	75	-	-
4. Have you attended any CHC meetings?	2	17	10	83	-	-

The reported performance assessment of CHCs vis-a-vis their planned responsibilities is given in Table 13. The description of these responsibilities was extracted from the Jumla project paper submitted by the training coordinator Miss Ribeca Rugain on July 26, 1983. All respondents were asked their opinions on CHC performance.

Table 13 : CHC's Performance Vis-a-Vis Their Job Responsibility

Responsibilities	Performed Job
1. Assist in CHLs programme and help with selecting CHLs for 24 days training	Only Pradhan Pancha did it
2. Cooperate with the CHLs in their health activities	None as reported by CHLs
3. Monitor the work of CHLs	None as reported by CHLs
4. Inform CHLs about the health problems identified among the people in the village	As reported by CHLs only personal requests were made for personal and family problems of their own
5. Motivate people for specified health activities as needed i.e., family planning, immunization building pits, latrines, etc.	Only 7 percent of villagers reported that they were involved in this job effectively (Table 19)
6. Facilitate in maintaining promotion of health and the health care of the people	No specific or planned activities by the CHCs

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7. Organise people's participation in the activities of the project	6 percent of the total respondents reported that CHC contributed to greater local participation. Ten percent of the total respondents gave credit to their Panchayats for this (Table 19).

Through informal discussions with the Pradhan Panchas as the supposed Chairmen of the CHCs it was understood that newly elected Pradhan Panchas knew nothing about CHCs' existence and their own expected role in them. The above mentioned four respondents who gave the positive responses were either re-elected Pradhan Panchas or re-elected ward members of the panchayat. From the very beginning of the CHCs' formation these committees have not been very effectively involved in the project. The statistics show that out of 60 villagers only 4, and of community health leaders only 2, reported that participation from the people's side was due to the efforts of CHCs. No CHLs at all gave any credit to the CHCs (Table 19). No follow-up trials were made in order to activate these CHCs. Pradhan Panchas were contacted, however, regarding the selection of CHLs and planning of local participation, especially in drinking water projects. The idea of using the CHC as the basic infrastructure for village health delivery system in the district has been a total failure to this point in time. The Project Director is aware of this, but has felt constrained by time and resources to concentrate on CHLs as delivery agents.

). Viability and Status of Construction Projects

nder construction projects the project targeted renovating the overnment Guest House, at Khalanga Bazar, building a health ost at Depalgaun, building water systems at Depal, Garjuankot, and Kartic Swami Bazar as well as drainage and latrine programmes.

Progress to date on these projects has been reported in detail below. With so many of these construction projects not yet completed it was difficult to assess the impact of the construction projects.

The only fully completed project is the renovation of the Government Guest House which is presently used by the NRCS/IHAP project itself as its office-cum-training centre. This has certainly benefitted the project by providing facilities for conducting the training programmes, store-room and an office.

No water supply project was yet supplying water to the communities. However, people are very pleased to have water projects from NRCS/IHAP project. Most people believe that these water projects are much more viable, being concrete and better quality, than any other water projects in the district. Some technicians in the district also said that because of close and direct supervision the construction projects of NRCS/IHAP project are much more effective. Maintenance training has also been given in those villages with NRCS/IHAP water projects.

The Health Post building at Depal Gaun also was not yet providing services. However, it is considered the best building in the whole of Jumla district. People of Depal Gaun are proud of it and people from the Cuthichaur and Lamra and Tatopani side wanted the same kind of Health Post building which would stand for a hundred years in their area too. District officers also liked the building but they expressed the view that it is not the building that people need so much as the services for health care. They hoped that any extension of the IHAP/NRCS project would consider this. Villagers too thought that since the building is of such good quality the medicine and services would surely also be available.

Bazar drainage was only in the beginning phase of its constructio
However some people expressed concern that the construction

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contractor was not doing his job properly. It was observed that the contractor and the project officials were in a hurry to complete the system as quickly as possible within the limited time before the project is terminated. This haste has caused defects in the quality of work.

The community latrine programmes were initiated in some villages and in two schools of Chandannath. Other school latrines have not been built yet. The community latrines were sometimes found not to be in use because people still go on the trail. People are not used to using latrines and they do not like the smell. There is a real need for educating the people in this matter, of which the Project Director is aware.

5. Physical Evidence of Effects of the Project in Jumla District

As compared to memories of the situation before the project, people (94%) expressed the feeling that there has been a great change after the project launched its programme in the district. The changes respondents mentioned were as follows in Table 14. It seems that people have been particularly influenced by the changes through demonstration, such as latrine construction (89%), and kitchen gardening (59%). It is encouraging that 46 percent of the people observed changes in environmental sanitation in their areas. The change in environmental sanitation was also observed by one of the evaluation team members who had visited Jumla for work on another project two years before. According to him some of the villages had considerably improved in this respect.

Similarly the follow up survey (Table 8) relating to the physical improvements as a result of demonstrations and training also shows the changes which occurred immediately after the CHLs got back to the villages.

Table 14 : Changes from the NRCS/IHAP Project as Perceived by the Local Population

Mention of Changes Seen Since the Project	Percentage of Respondents Commenting				Before the Project
	Villagers N=60	CHLs N=22	CHC N=12	Total N=94	
No change at all	3	9	8	5	
Don't know	3	9	-	2	
Latrines constructed	88	91	92	89	Only educated and rich families had latrines which were very few.
Kitchen gardens	40	86	75	55	People used to maintain gardens before. The number has greatly increased.
Improved environmental sanitation	45	50	42	46	It was dirtier before.
People's knowledge of personal hygiene	22	-	75	18	People were completely ignorant.
Others*/	7	-	33	6	

*/ "Others" consists of drinking water supply systems, presence of trained Sudenis, and consciousness among the people. Responses on water supply were found in the area where they have such projects.

F. Attitude Towards the Project and Health Care

1. Villagers' Attitude Towards the Project

All categories of respondents (villagers, CHLs, and CHCs) were asked whether the villagers liked the project and to what extent. Table 15 shows that 74 percent said that the programme is well liked and 24 percent saying fairly liked. There were no negative responses.

Table 15 : Peoples' Attitude Towards the Programme

Rating	Villagers N=60		CHLs N=22		CHCs N=12		Total N=94
Very much liked	43	72%	17	77%	9	75%	74%
Fairly liked	15	25%	5	23%	3	25%	24%
Not liked	–		–		–		–
Don't know	2	3%	–		–		2%

Based on the hypothesis that if people liked the programme it should be reflected in their actual participation a question was asked on the extent of people's participation. According to Table 16 below it was felt by 92 percent that the local people have participated in the programme to a good or fair degree.

Table 16 : Extent of Peoples' Participation

Rating	Villagers N=60		CHLs N=22		CHCs N=12		Total N=94	
Good	26	43%	9	41%	5	42%	40	43%
Fair	30	50%	10	45%	6	50%	46	49%
Bad	2	3%	3	14%	1	8%	6	6%
Don't know	2	3%	–		–		2	2%

2. Villagers' Attitudes Towards Preventive Health Measures

As mentioned in the Operational Programme Grant (OPG) the project's main thrust was to be given in preventive health care and thus the prime objective was to develop positive attitudes towards health care. Table 17 shows the degree to which this has been achieved. Asked about preventive health measures 54 percent of the respondents said that preventive

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health measures are possible and very necessary. Only 16 percent did not know about preventive measures and whether they are possible or not.

Table 17 : Peoples' Attitude Towards Preventive Health Measures

Opinion	Villagers	CHLs	CHCs	Total N	%
Possible and necessary	48	20	11	79	84
Don't believe in such measures	-	-	-	-	-
Don't know	12	2	1	15	16

3. <u>Attitude of Other Officials</u>

Village level officials, district officials and zonal officials were contacted and asked what they thought about the project.

The only village officials are Pradhan Panchas whose attitudes is reflected in Table 17 above. Most of the CHC members consulted at that time were Pradhan Panchas or Acting Pradhan Panchas.

The district officers almost all thought that the project had shown a great deal of progress in the quality of work within the last 8 or 9 months. They thought that this was a result of the new IHAP Director's effort and dedication.

District Officers, however, together with the district and zonal administration, expressed the opinion that the project is not effectively in touch their own administrations. The local development sector of the district panchayats and the district and zonal administrations do not know enough about the project goals, policies and achievements.

There is no doubt that the project has brought changes in attitude for the good. The physical evidence of the effect on people may not yet be impressive but as observed by the people themselves, the district and zonal officials and IHAP district officials, awareness of and positive attitudes towards preventive health measures have improved. It was felt that follow-up and support should be continued because the changes are still recent and still not a way of life. There was concern that the campaign might fizzle out like other initiatives. The building of latrines particularly needed follow-up if people were not to forget about it very soon.

7. Extent of Local Participation to Effect Change

It is clear from Table 18 below that local people did not give themselves much credit initially for the changes they have seen. But after several discussions what emerged was that although people felt obliged to the project for initiating change it was clear that they had observed local people participating well in the project and realised that without the participation of local people the changes would not have occurred. The negative responses in Table 17 above about local participation are very low indeed compared with those who felt that people had participated to a good or fair degree. It is interesting to see in Table 18 that a very definite acknowledgement is made of the NRCS/IHAP role in bringing change to the Jumla region villages. By giving credit to the project itself people meant that the incentives, facilities and outside resources came through the project and that it should be given credit for this. The participation of local people, particularly CHLs, had been important too, but in a different way.

Table 18 : Role of Various Agencies to Bring Change in the Villages

	Villager N=60	CHLs N=22	CHCs N=12	Total N=94	%
Pradhan Pancha	2	1	1	4	4
Health Committee	-	-	-	-	-
Health Leaders	12	5	4	21	22
Peoples' Participation	1	-	-	1	1
NRCS/IHAF Project it self	50	21	9	80	85
Don't know	1	-	-	1	1

Percentages add up to more than 100 percent because some respondents made more than one response.

Respondents were also asked about what they thought were peoples' reasons for participation in the project. From Table 19 below it is clear that most people give credit to the incentives offered by the project and to the new facilities provided by it. Secondly they rated the efforts of the CHLs as important. It is interesting that CHLs felt that their own efforts were of prime importance and this is no doubt because of the hard work they knew they had done. Little credit is given to the CHCs or Panchayat leadership for effecting change.

Table 19 : Reason for Peoples' Participation

	Villager N=60	%	CHLs N=22	%	CHCs N=12	%	Total N=94	%
CHLs effort	26	43	15	68	5	42	46	49
CHCs effort	4	7	-		2	17	6	6
Panchayat effort	5	8	2	9	2	17	9	10
Villagers' own	4	7	-		-		4	4
Incentives and facilities	27	45	5	23	-		32	34
All other agencies	-		-		1	8	1	1
Redcross project	6	10	2	9	4	33	12	13
Don't know	1	2	-		-		1	1

H. Extent of Coordination and Integration in the Health Delivery System by All Existing Agencies

Many of the officers in various line agencies and district officers, i.e. the L.D.O., the Jumla Hospital Doctor, and the person in-charge of the Dipal Gaun Health Post were recently transferred to the district so they could not really talk about past relationships with the NRCS/IHAP project. The information on working relationships has been given by the officers in-charge and the IHAP Jumla Project Officer. The government offices involved in the project are the District Administration Office, the Jumla Panchayat, the District Education Office, the Family Planning and Maternal Child Health Care Office, the Jumla Hospital, the Dipal Gaun Health Post, and all panchayats.

1. District Panchayat

The NRCS/IHAP Jumla Office wrote to the District Panchayat asking them to allocate 12 panchayats in which to develop drinking water systems. Later the District Panchayat nominated 12 panchayats and the Jumla Project started work in them. The recently appointed L.D.O. thinks the NRCS/IHAP should not concentrate their efforts on water systems because he thinks water is not the real need of the villages in the district. He added that the district panchayat itself provides drinking water projects. It has a bulk supply of pipes which are not yet distributed. He feels that the NRCS/IHAP should rather concentrate on improving other aspects of the health delivery system in remote areas.

2. Karnali Technical School (KTS)

The Project coordinates well with the Karnali Technical School. The health students from KTS have been closely involved in the training of the CHLs and in providing health

education to the schools where NRCS/IHAP have been building toilets. The KTS construction students have been contracted by NRCS/IHAP for surveys and the building of water systems. The KTS staff has been involved in drawing and designing the bazar drainage system and high school toilets.

3. District Education Section and Local Schools

The intervention programme was designed to be implemented by NRCS/IHAP the District Education Section and local schools jointly. The programme will build school latrines and provide some courses to the school children on health and sanitation. NRCS/IHAP planned to provide construction materials and skilled labour for construction and for classes with assistance from the Karnali Technical School. The District Education Section is going to build a water tank and the school will provide volunteer labour for construction.

4. Other District Offices

The NRCS/IHAP projects used people from various district offices as resource personnel in its CHLs training programme. The offices providing manpower for the training were the Agriculture Section, the Veterinary Hospital, the Jumla Hospital, the Leprosy Centre, the Karnali Technical School, and the Family Planning Office.

The NRCS/IHAP Jumla Project has a very good relationship with some of the district offices and gets its training resource personnel from these offices. At present the relationship seems to be one sided because these offices provide personnel for IHAP but the project is not doing anything for them as yet. Except for the donations it has made to the hospital and schools it has not been involved in health service delivery at this level at all.

Nor has it been linked directly to the health delivery system of HMG. Various district officials reported that NRCS/IHAP started its programme without reference to those involved in the existing system. No effort seems to have been made to integrate with other services. Because of the time factor involved the project seems to have focussed only on fulfilling its immediate targets which in the past year have been mainly construction projects.

I. The Need for the Extension of the Project

Though the programmes run for four years the effects have been seen only in the last few months. People are just realizing what the NRCS/IHAP project is and what it does. It is a pity that it is already time for the project's termination. It is very depressing for the people. Nearly all of the respondents are seriously concerned about the extension of the project and think it should be extended as Table 20 shows.

Table 20 : Opinion on Extension of Project

	Villagers N=60	CHLs N=22	CHCS N=12	Total N=89	
Should extend	55	22	12	89	95%
Don't care	1	–	–	1	1%
Don't know	4	–	–	4	4%

The responses of the respondents were emotional regarding extension. A group meeting summarised their feelings as follows. People, especially women, have just understood what the purpose of the project is and it is already time to finish. The efforts made will not mean anything if it is discontinued. Moreover, it will leave a bad impression which would frustrate people from participating in any kind of future project. It could result in people not trusting other projects. Other existing projects in the district are likely to suffer from this.

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. CONCLUSIONS

. Contrast between the Final Year and First Three Years of the Project

major weakness of the Operation Programme Grant proposal was that no clear schedule was outlined for achieving various objectives. Consequently for the first three years nothing seemed to be happening. It is true that during this time the Health Survey and the Community Dialogue were going on. Although the OPG submission stressed that the ground work for these should be done thoroughly, as far as the local people were concerned little else seemed to have been accomplished apart from consultation and discussion.

The extension year needed up to August 31, 1983, resulted in much more positive action and so it seemed a marked contrast to the previous three years. Credit for the recent effectiveness of the project is given to current staff directing the project.

Administration problems in the early years--delay in the arrival of the technician, recruitment of project staff, transfer of funds, transport and communication difficulties were also factors in the very slow start to the project.

The protracted nature of the community dialogues which were in sense counter-productive should have been accompanied by more demonstration activities which could perhaps have reinforced support achieved during the dialogue.

Change is Evident in the Project Area

t is clear that the project has had an impact on the area. An overwhelming majority of the villagers involved gave credit for this to the project and the initiatives it had undertaken.

Participation by the community, Pradhan Panchas and even the Community Health Leaders was not considered great in comparison with the input of the project administration itself.

C. Local Participation is Important

Villagers acknowledged the importance of their own contribution, however, and particularly that of Community Health Leaders who were overwhelmingly considered major catalysts for change, Sudenis, particularly, who are traditionally birth care attendants, when trained as CHLs with modern health care know-how, were considered to be vital. Incentives for local participation are significant. These, along with improved facilities for participating villages, were among the most important factors in encouraging local participation. Although involved in practical implementation, there was, however, no local input at planning level and in decision making.

Most villagers were receptive to CHL advice. The CHLs have increased local awareness of health problems and possible preventive measures. There are, however, still obstacles to progress; lack of facilities, traditional and conservative attitudes and the real need for a formal infrastructure with responsibility for decisions on grass root health care.

D. The Training of CHLs is effective

The training component of the project which was supposed to include Sudenis, CHLs and CHCs so that a health delivery infrastructure could be created was effective only with Sudenis and CHLs. Nothing lasting was achieved with CHC members and these community committees have not been functioning. For CHLs much more was achieved as is clear from their test results and from the respect they have achieved within their communities The three phase nature of the training was particularly effective, giving trainees (often illiterate and unused to

schooling) the chance to assimilate their new knowledge before returning to build on it again.

The training programme was simple and appropriate in content and methodology. The use of local people who spoke the same language as training personnel was particularly helpful for villagers and women. These trainers from the Jumla Hospital, the Family Planning Office, the Veterinary Hospital, the District Agriculture Section, Karnali Technical School and the Leprosy Hospital deserve particular commendation.

E. Training for Women CHLs

This was not quite so satisfactory. The reason for not completing the training of many of the women initially selected has not been made clear by the project administration to the women trainees and Panchayats. Many women in the project completed only 12 days training, and others only 18 (12 in the first phase and six in the second) compared with the anticipated 24. Since the project guidelines envisaged equal numbers of male and female CHLs this is clearly a short-coming in the training programme. As is the misunderstanding of the field coordinator about the number of women required for training. Misunderstandings such as this, have inpaired the effectiveness of the project.

F. The Role of Sudenis

These women, formerly the only care available to villagers in childbirth and related matters, have proved to be particularly effective as CHLs. The combination of the traditional and culturally acceptable form of care with modern know-how has proved outstandingly successful. Almost all the trained Sudenis have returned to their villages as effective deliverers of health care and advice. Villagers are comfortable with the health care advice of these women to whom they have always turned in ne

G. Community Health Committees Not Yet Effective

The complete lack of follow-up for CHC members meant that these committees which were to have provided an infrastructure for future development of health care projects by local initiatives never functioned at all. Nor was any attempt made to activate them before the project end. CHLs too, though more effective after their training, felt that once back in their villages they were on their own and often at a loss about how to go about effecting change without the support of a CHC or of project direction. There was a clear need for the project administration to continue to monitor and follow through once training was complete and while building projects directly related to this training was going on. A more thorough planning structure at the Operations Grant submission level could perhaps have avoided this failure of CHCs to become functional.

H. Apparent Over-Involvement in the Construction Programme Without Long-Term Planning

The constraints which caused an apparent over-involvement in construction projects in the last year of the project were another feature of the lack of long term careful planning by the project initiators. This left the administrators of the project in its final year with little choice but to develop their own physical and short-term objectives. There is no doubt, from the degree of local participation, that these projects were popular and a great deal was achieved. Now, however, there is the problem of on-going maintenance which has not yet been negotiated either with appropriate government or other officials or with local panchayats. Since CHCs are as yet non-functional it is important that this issue of maintenance responsibility be resolved if all of the physical achievements of the past year are not to be lost through neglect and disrepair.

The misunderstandings with local people about incentive payments for public and private latrine construction is another example of a lack of clear planning directives to advisors and administrators of the project.

1. General Lack of Long Term Planning for the Entire Project

There is nowhere any clear blueprint for the establishment of the community health delivery system which is the project's main goal. Much of its success has "happened" in response to real local need as CHLs became trained and as project initiatives were commenced.

There is no evidence of planned interaction with other health delivering agencies which could result incontinuing cooperation at a formal level. Other agencies, hospitals and so on, have given their services for training. Since then the project itself, it seems, because of lack of time, has not interacted with these bodies in a reciprocal way. If Community Health Committees had proved functional they could have fulfilled the much needed role of formal leadership linked with other existing services, using the CHLs as their delivery agents. As it is no "System" which links existing grass root services has developed. There is no official body with clear responsibility for developing further health policies at village level. The project OPO does not outline clearly how this was to have been achieved.

J. Need for Continuation

There is no doubt that this project fulfils a real need. That it should be continued is the general feeling of both Jumla and Kathmandu officials as well as the local people themselves. Its shortcomings are obvious to all and are certainly not the fault of any lack of effort by project officers. Much has happened. The project has had great impact. With much more

detailed planning and the benefit of hindsight it should be possible to build upon the achievements noted and to set about developing those features of the programme not yet realized. In this way it may be possible to extend the project beyond the current focus out to more remote areas.

8. Programme Objectives Too Broad

With hindsight, it could be said that the programme objectives were far too broad and in themselves created problems for the project staff. It is now clear that a much more detailed operational grant submission would have assisted greatly. In its recommendations for further inputs to improve the health care system for the people of Jumla this report makes suggestions which could provide some basis for more clearly stated objectives for this very worth while project.

VI. RECOMMENDATIONS

The extended programme of the NRCS/IHAP Project may like to consider the following recommendations.

1. First of all a grass root level committee like the intended CHC is greatly needed for the establishment of the targeted health delivery system at the village level. The IHAP Project Director recommends that a Ward Health Committee (WHC) would be much more effective, since it can include the representatives of all rival political groups of a panchayat. However, a consistent follow-up system and continuing assistance should be guaranteed. The WHC should be comprised of all formal panchayat ward members, CHLs, women representatives and representatives of various castes and ethnic minorities. A workshop should be organised to orient the members of the WHC about the project and their role in it. They should be involved in all levels of decision-making, need identification, project planning, implementation, monitoring, and evaluation of the project activities.

   The NRCS/IHAP team should play the role of catalyst in assisting the WHC. The team should try to help the committee understand that it is "their" project and therefore is greatly dependent upon them for success. This realisation would help build more self-reliance in the community. Hopefully it might continue and even expand activities in the future when the NRCS/IHAP project inputs are phased out.

   It is important for the project that the project team feel that they are there to work with local people and not for them. With this in mind effective villager participation in planning and decision making must be achieved.

2. As most health services are administered by the various district offices, the NRCS/IHAP project should consider

organising a district body above village level. In other words, it should have a district coordination committee (DCC) which will be responsible for planning integrated and coordinated activities at the village level which would also ensure that village level participation was effective. This will make for better understanding among officials at the district level as well ensure their active participation in the project. The committee should be comprised of representatives from all of the service related district offices, such as the district education section, the agriculture section, Jumla Hospital, Veterinary Hospital, zonal and district administration and other agencies having health related activities.

3. The NRCS/IHAP project in coordination with the DCC should plan an infrastructure for a unified and coordinated health delivery system, in which the various health related agencies are involved with their defined roles and jobs. All of these agencies should be consulted on the form such a coordinating body will take.

4. There is no difficulty in obtaining the trust of people and their participation in direct and immediately benefitting programmes. Activities like the community dialogue with abstract goals such as raising consciousness among the people should be paralleled with demonstration projects like water systems etc. which benefit village people in an immediately tangible way.

5. The project might be unsuccessful if it is rushed. The framework of over-ambitious objectives could create undue pessimism in the community if it fails. The project should therefore pay careful attention to timing and scale while planning activities.

6. The project should develop a monitoring mechanism and ensure the employment of trained and capable staff.

7. The project should extend to more remote areas with more definite plans with the one currently under discussion which includes the CWS projects and four health posts building in the area of Sinja Dara, Panchsaya Dara, Asi Dara, and Chaudabisa Dara.

8. The NRCS/IHAP should formulate a plan for the integration of its WFCs, CHLs, and Sudenis into a larger system as suggested above so that these persons at the bottom level of the village health system will have others at higher levels to turn to for advice on specific public health problems for referal cases beyond their competency and for supply of basic needs and family planning materials. This should ensure more effective communication.

9. Community water supply projects should be continued as clean water is inseparable from health. The construction of other sanitation facilities could be linked more to water so that construction teams could aid in building of these facilities also. This link would increase the desire of the villagers to utilize the units provided. In addition there would be the beneficial result of a heightened awareness of the relationship between clean water and sanitation.

10. For construction projects like community water supplies plans should be formulated earlier so that a target village can be adequately prepared to perform their part within the bounds of a voluntary labour scheme. More emphasis should be placed on the requirements of materials for the project to assure advance material acquisition and to take full advantage of periods of relative inactivity by villagers in the agriculture cycle. By planning well in advance of implementation time can be taken to smooth out those

inevitable political disputes that make the motivation of voluntary labour so difficult. It would also provide for the performance of task by unpaid labour within a reasonable time.

11. The present training staff, training content and methodology should be retained with some improvements. The project should run in-house seminars for training staff in order to improve the course content and methodology from time to time. To improve the training staff's skill in teaching the project should arrange for materials, library access and refresher courses for the trainers. First aid training qualifications could be rewarded by the provision of a simple first aid kit for minor emergencies.

12. Criteria for selecting the CHLs for future programmes should be developed so as to get really motivated and capable candidates for training. The proposed WHCs should be responsible for selecting the two candidates from their area.

13. The project should complete the targets already set for the project, giving them priority over new initiatives.

14. The newly trained CHLs should be followed up immediately and former CHLs should be given a refresher course which will emphasize the skills needed to be an effective change agent and review and reinforce earlier course content.

15. The project should attempt to contact and motivate the few CHLs who are not yet functional.

16. An effort should be made to promote coordinated educational initiatives between CHLs, KTS personnel and public schools particularly in the area of sanitation and use of public latrines.

17. Poor communication, or possibly poor orientation of field staff has resulted in misunderstandings about project policy between field officers and administration in Kathmandu. Some mechanism should be developed to avoid future recurrence of such events.

18. Continuity of administrative staff is important. Frequent staff turn over results in disjointed efforts.

APPENDIX A

NRCS/IHAP/New ERA

An Evaluation of the NRCS/IHAP Jumla Project

Panchayat: ______________ Interview: ______________

Ward No. : ______ Date : ______________

Village : ______________ Respondent:

/_/ CHL
/_/ CHC
/_/ Villagers

1. Name and Caste: ______________ 2. Sex : ______________

3. Age : ______ 4. Education: ______________

5. Are there any construction activities going on in this village under the NRCS/IHAP Project?

/_/ yes
/_/ no
/_/ don't know

Go to Q. No. 7

6. What are they? ______________________________

7. How much the villagers have benefitted or will have benefitt from these projects?

/_/ extremely benefitted
/_/ benefitted
/_/ not benefitted
/_/ don't know

How much have people liked it?

/_/ extremely liked
/_/ liked
/_/ not liked
/_/ don't know

How far have people participated in it? and what is the reason for their participation?

Rating of Participation Level	Reason for Participation
/_/ extremely	______________
/_/ satisfactorily	______________
/_/ no participation	______________
/_/ don't know	______________

10. What do the people think about preventive measures for health care?

- -

11. Have you seen any changes in the project area since the project was launched? What was it like before?

- -

    11.1 Any other comments? - - - - - - - - - - - - - - - - - -

12. Who played the most vital role in bringing this change about?

    /_/ Pradhan Pancha
    /_/ CHC
    /_/ CHL
    /_/ People's participation
    /_/ MOHS/HMG
    /_/ Others (Specify) ____________
    /_/ Don't know

13. Should the programme be extended?

    /_/ yes
    /_/ no
    /_/ don't care
    /_/ don't know
    → Go to Q. No. 13.2

    13.1 Why? ________________________

    13.2 Any other suggestions? - - - - - - - - - - - - - - -

<u>Questions to CHLs Only</u>

1. When did you have the training course?

    1.1 Where? ________________________

    1.2 How long? ____________

2. What were the training contents and were they simple enough to you to understand?

- -

3. What are the qualities of a good CHL as an change agent?

- -

Best Available Document

4. To what extent did you get help from the following?

	No Help	A Lot	Satis-factory	Unsatis-factory
4.1 Panchayat	___	___	___	___
4.2 People	___	___	___	___
4.3 NRCS/IHAP Project	___	___	___	___
4.4 Other line agencies	___	___	___	___
4.5 Others (Specify) ___	___	___	___	___

5. Test questions to CHCs

	No Response	Good	Fair	Unsatis-factory
5.1 Way to make Sarbotom Pitho	___	___	___	___
5.2 Easiest method of temporary family planning	___	___	___	___
5.3 Way to make rehydration solution	___	___	___	___
5.4 Immunisation and the reasons for it	___	___	___	___
5.5 Transmission of infectious diseases	___	___	___	___
5.6 Methods to control infectious diseases	___	___	___	___
5.7 Benefits of latrine	___	___	___	___
5.8 Differences between new & traditional compost pits	___	___	___	___
5.9 Way to make silage	___	___	___	___
5.10 Advantages of kitchen gardens	___	___	___	___

<u>Questions to CHC Members</u>

1. Is there any Community Health Committee in this village?

/_/ yes
/_/ no
/_/ don't know

→ <u>Close the Interview</u>

2. Are you a CHC member?

/_/ yes
/_/ no

→ <u>Close the Interview</u>

3. Did you have any Health Care Training from the Project?

/_/ yes
/_/ no

4. What does the CHC do in your village?

- -

5. Have you attended any CHC meetings?

/_/ yes
/_/ no

→ Close the Interview

6. How many times did you attend and why?

- -

- -

Questions to Villagers

1. Is there a Community Health Committee in this village?

/_/ yes
/_/ no
/_/ don't know

→ Go to Q. No. 3

2. What does it do?

- -

3. Is there a Community Health Leader in this village?

/_/ yes
/_/ no
/_/ don't know

→ Go to Q. No. 7

4. Do you know him or her?

/_/ yes
/_/ no

5. Are they trained as CHLs?

/_/ yes
/_/ no
/_/ don't know

→ [illegible] Q. No. 7

6. What was the training content and how have they performed in this respect?

Training Content	Rating of Performance		
	Good	Satisfactory	Unsatisfactory

7. Is there a trained Sudeni in your village?

/_/ yes
/_/ no
/_/ don't know

→ Close the Interview

Do you know her?

/_/ yes
/_/ no

9. How far are they beneficial to the village?

/_/ extremely
/_/ yes
/_/ no
/_/ don't know

* * *

APPENDIX B

An Evaluation of the NRCS/IHAP Jumla Project

INTERVIEW GUIDELINE

(Informal Interviews with Officers of Government and Other Agencies)

1. How far is the project coordinated/integrated with other projects and line agencies in Jumla?

   ----

2. How far has the project has met its objectives and the promises it had made?

   ----

3. What are the main activities of the project? What stages are they at now? Could you please describe achievements to date?

   ----

4. What are the strong points of the project?

   ----

5. What are the weak points or areas which should be improved?

   ----

6. What are the problems that the project is facing and what could be possible remedies?

   ----

7. Do you think the project should be extended or not?

   7.1 If yes, why? ------------------------------

   7.2 If no, why not? ------------------------------

8. Any further comments?

   ----

* * *