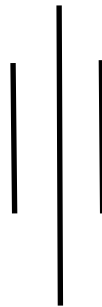


Monitoring Report

A comparison of three reporting periods

July 2008-June 2009, July 2009-June 2010, and July 2010-June 2011



Nepal Family Health Program II

Monitoring and Evaluation Team

October, 2011



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Analysis of Monitoring Data

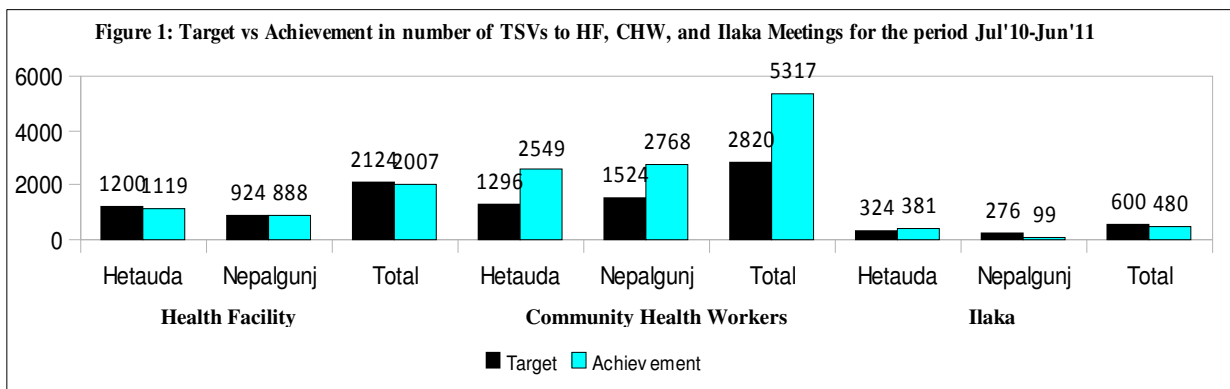
1.0 Background

Nepal Family Health Program (NFHP)-II maintains a strong emphasis on performance monitoring and evaluation. Among the various approaches to performance monitoring, Technical Support Visits (TSVs) have been an important for monitoring program performances at Health Facility (HF) and community level. Through TSVs, NFHP II tracks indicators related to inputs, processes, and outputs on a regular basis for both the overall NFHP II activities and project specific activities. TSV is a process which assesses the knowledge and skills of service providers and monitors commodities availability, service provision and its quality, infection prevention, staff availability, conduct of meetings, and recording and reporting of routine Management Information System.

This report includes trend analysis of integrated TSV data collected on monthly basis from the 20 NFHP-II districts for three periods: July 2008 to June 2009 (first year), July2009 to June 2010 (second year) and July 2010 to June 2011 (third year). Overall this report presents the trend in various indicators over the three years period in NFHP II districts. Furthermore, the trend in achievements is also disaggregated by two NFHP Field Offices, Hetauda and Nepalgunj. In addition to analysis of integrated TSV data, TSV data on the Health Facility Management Strengthening Program (HFMSM) of 13 districts, together with TSV data on Primary Health Care Outreach Clinic (PHC ORC), Immunization Clinics and Mothers Group Meeting (MGM) are also presented in this report.

Moreover, this report also includes analysis of monitoring data (service data) of MNH at Community Level including Chlorhexidine (Kawach), Neonatal Vitamin A Supplementation (NVAS), Community Based Neonatal Care Program (CB-NCP), and Literacy/Life skills (LLS) program.

TSV Target Vs Achievements: Figure 1 presents target vs achievement status of TSVs to HFs, Community Health Workers (CHWs) and Ilaka meetings disaggregated by the two field offices (Nepalgunj and Hetauda) for the period Jul'10-Jun'11 (third year). Overall, in year three, TSVs provided to CHWs has nearly doubled as against the targeted but that to HFs and Ilaka meetings are lower than that targeted. In Nepalgunj, TSVs to HFs and Ilaka meetings are slightly less than the annual target but that to CHWs are much higher than the target whereas in Hetauda, only TSVs to HF is lower than that targeted. TSVs to CHWs are almost double and that to Ilaka Meetings is slightly higher than that targeted in Hetauda.



NFHP focuses on providing quality and supportive TSVs at all levels rather than merely increasing the number of TSVs. Therefore, all the TSVs provided by the NFHP II staff should be of high quality which can help HFs and CHWs in improving their performances. However, reviewing targets and making them achievable should also be focused by NFHP II staff.

The key findings of the integrated TSV data for the three comparison periods are presented in Table 1.

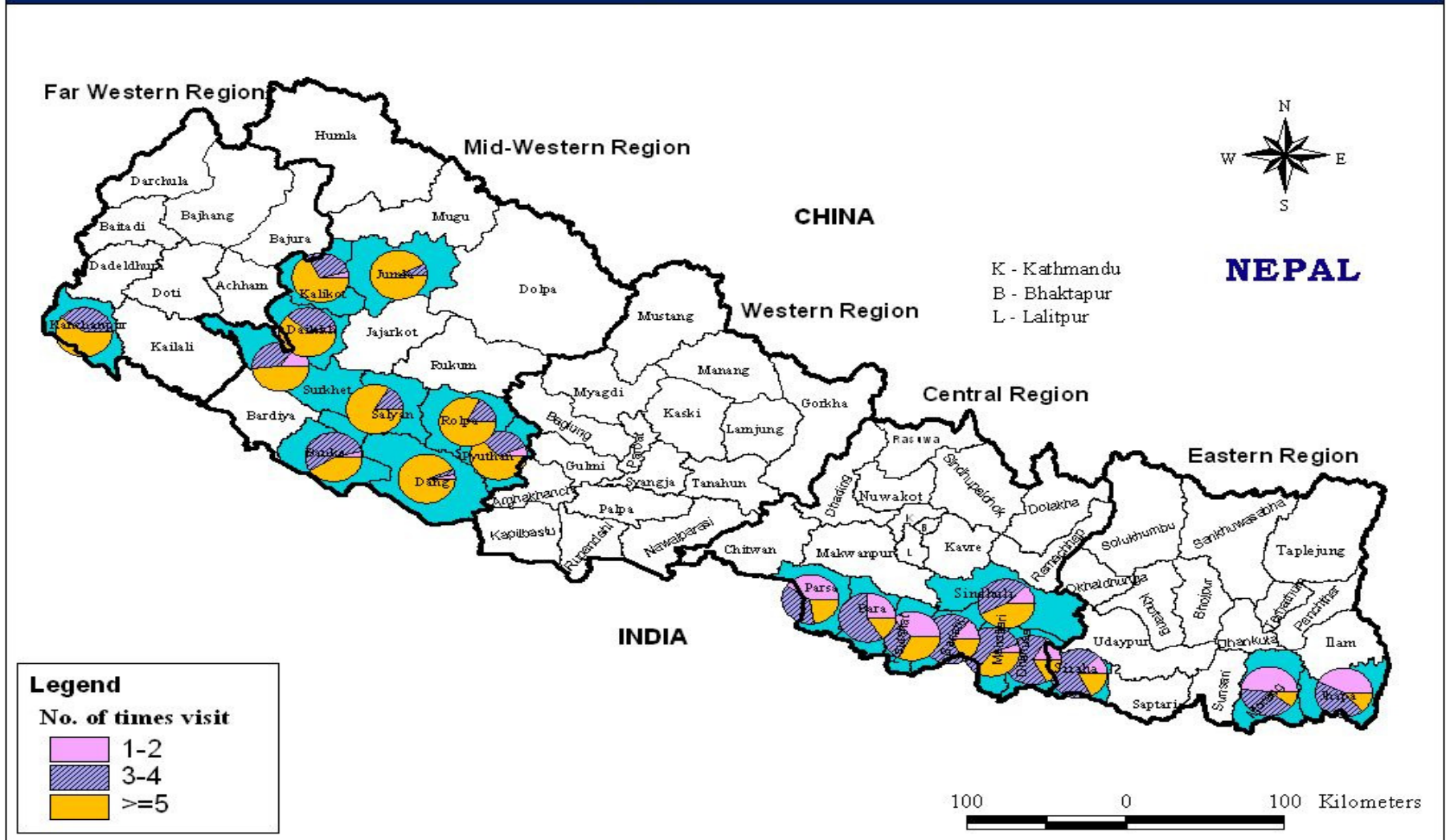
Table 1: Key findings of the integrated TSV data

Key Indicators	Hetauda			Nepalgunj			Total		
	July 2008- June 2009	July 2009- June 2010	July 2010- June 2011	July 2008- June 2009	July 2009- June 2010	July 2010- June 2011	July 2008- June 2009	July 2009- June 2010	July 2010- June 2011
Number of TSVs to HFs	950	847	1119	696	730	888	1,646	1,577	2007
Number of Ilaka Meetings Attended	240	292	381	81	94	99	321	386	480
Number of TSVs to CHWs	1,474	1,712	2549	1,460	1,914	2768	2,934	3,626	5317
Family Planning/Maternal Health									
% of pregnant women with swelling examined among the observed ANC cases	82	93	87	86	90	87	84	92	87
% of pregnant women who received TT during ANC or who were confirmed by health workers that they received it in the past	86	95	97	85	97	98	86	96	97
Pregnant women who were advised for delivery at a HF or by a SBA	47	70	85	63	80	90	55	75	87
% of pregnancy ruled out before giving contraceptives among observed cases	50	80	82	70	50	51	59	66	69
% of new FP clients helped for voluntary decision making	74	92	96	82	85	94	79	88	95
% of FP clients asked about side effects of FP methods being used	62	77	92	62	86	86	62	81	89
% of FCHVs who referred pregnant women to HF for delivery services	52	59	70	57	57	63	55	58	66
% of FCHVs who talked to PP mothers about FP	71	76	82	75	79	76	73	78	79
% of FCHVs who discussed preparedness with pregnant women	85	87	92	70	87	91	77	87	92
Child Health									
% of pneumonia cases treated correctly among the observed OPD case	67	68	73	74	77	77	70	73	75
% of cases marking consistent age dose and 3 rd day follow up	96	97	99	93	94	94	94	96	96
% of FCHVs with knowledge of three or four home rules of diarrhea	73	82	79	62	75	81	67	78	80
FCHVs knowledge of Zinc dose for 6-60 months child	90	91	80	76	93	90	81	92	86
Infection Prevention									
% of HFs with clean environment	51	74	77	60	81	87	55	77	82

Key Indicators	Hetauda			Nepalgunj			Total		
	July 2008- June 2009	July 2009- June 2010	July 2010- June 2011	July 2008- June 2009	July 2009- June 2010	July 2010- June 2011	July 2008- June 2009	July 2009- June 2010	July 2010- June 2011
% of HFs that used sterilized equipments	15	28	39	20	50	58	17	38	47
Logistics/Supplies									
% of HFs with all 3 (pills, injectable, and condom) contraceptives	92	96	97	89	94	95	90	95	96
% of HFs with all 4 (iron, ORS packet, cotrim, vitamin A) commodities	83	89	85	86	88	84	84	89	83
% of HFs with Informed Choice (IC) poster displayed in a visible place	65	96	94	53	96	92	60	96	93
% of FCHVs having functioning timer	84	88	91	85	92	93	84	90	92
% of FCHVs having of 3/4/5 key commodities (ORS, condom, pills, cotrim , iron)	38	57	67	42	58	62	40	57	64
System									
% of HF that held staff meeting in the last month	55	55	68	25	31	35	42	43	54
% of ilaka level meetings that discussed on data quality	90	94	97	91	87	90	90	92	96
% of ilaka level meetings that had updated Monthly Monitoring Worksheet	35	42	50	40	41	45	36	42	49
% of HFs where MMW was reviewed in ilaka level meeting	27	35	46	30	32	40	28	33	45
% of PHC/HP that were supervised by DPHO during last three months	67	76	87	63	64	68	64	70	77
% of FCHVs who used FCHV fund or received cash/kind support from community	79	94	95	56	65	71	66	77	82

Frequency of TSVs to Health Facility

Period: July 2008 - June 2011



Selected data given in Table 1 are analyzed in the following sections.

TSVs to HFs, Ilaka meetings and CHWs:

Figures 2, 3, and 4 displays the number of TSVs conducted to HFs, Ilaka meetings and CHWs respectively during the three year periods disaggregated by Hetauda and Nepalgunj Field Offices. Overall, Figure 3 and 4 shows that TSVs to Ilaka meeting and CHWs have increased remarkably every year in the three years period (from July 2008-June 2009 to July 2010-June 2011). Whilst TSVs to HFs declined from 1st year to the 2nd but increased remarkably in the 3rd year (Figure 2). Total TSVs to HF in the 3rd year is 2007 compared to 1,577 in the 2nd year. Similarly, TSVs to Ilaka meeting and that to CHWs are 480 and 5,317 in the 3rd year, which is an increase by 24% and 47% from the 2nd year respectively.

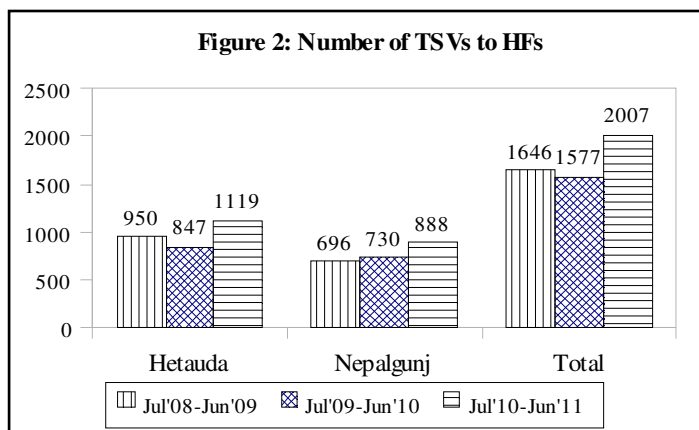
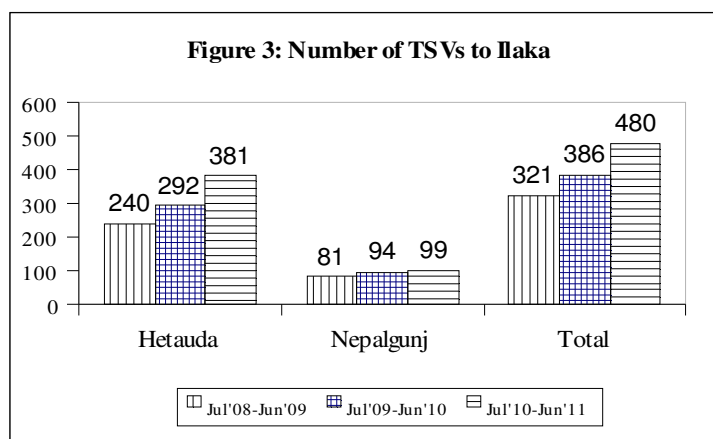
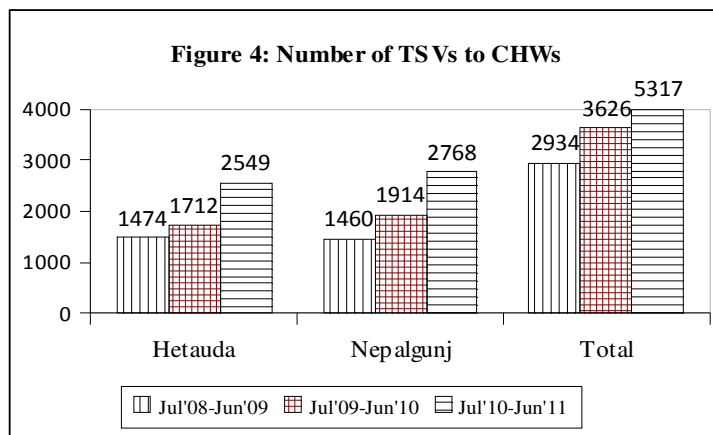


Figure 2 depicts that between the two FOs, a greater number of TSVs were provided to the HFs under the districts of Hetauda (1,119) than in Nepalgunj (888) in the most recent year. Trend in three years TSVs shows that in Hetauda, TSV to HFs declined by 11% in the 2nd year from the first year but increased by 32% in the 3rd year from the 2nd year. In Nepalgunj, a 5% point increase in TSVs to HF was reported from first year to the 2nd which quadrupled to 22% from the 2nd year to the 3rd year.



With respect to the TSVs to ilaka meetings, the achievements are good with increasing trend in both the field offices. Ilaka meeting is a forum where all the Sub Health Post (SHP) In charges under an Ilaka meet every month at their respective Ilaka to discuss on the HMIS reports and submit the same to the Ilaka. Participating in these meetings has been one of the important parts of regular monitoring in NFHP II since NFHP II staffs provide feedback on HMIS and data use to the HFs in group and individual in these meetings.

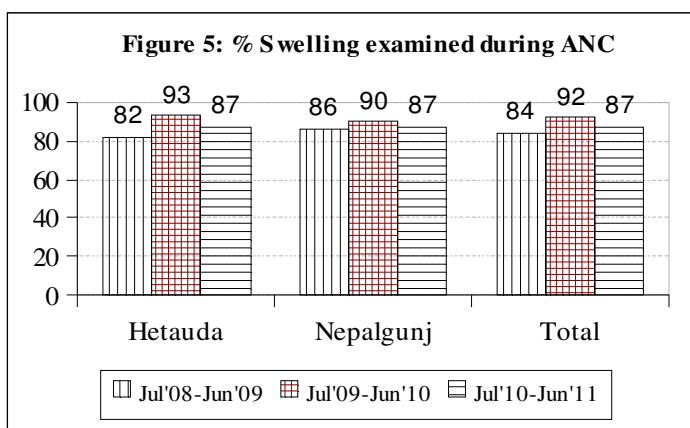


Providing TSVs to CHWs has been one of the major approaches to increase the knowledge and improve the performances of these health workers. In both the FOs, TSV to CHWs has increased remarkably from the 1st year to the 2nd and that to the 3rd year. Both of the FOs witnessed high increase in TSVs to CHWs- in Hetauda, the increase was by 49% point (from 1,712 to 2,549) and in Nepalgunj it increased by 45% point (from 1,914 to 2,768). In addition to increasing TSV numbers, enough attention should also be paid in the quality of TSVs provided to these cadres of CHWs.

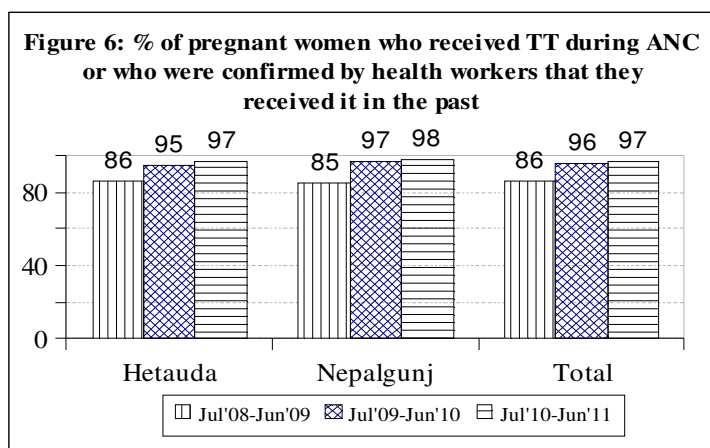
2.0 Programs:

2.1 Maternal Health

Swelling of hands and feet: Swelling of hands and feet during pregnancy is one of the danger signs of pregnancy which needs to be examined by health workers when women visit them for antenatal care (ANC) services. In the 1st year 429 ANC cases were observed while in the 2nd and 3rd year 611 and 813 cases were observed respectively. Monitoring data shows that the proportion of pregnant women who received swelling check-up from a health worker has increased by eight percent points (from 84% to 92%) from the first year to the 2nd but has decreased by five percent points (from 92% to 87%) from the 2nd year to the 3rd. In both the FOs the proportion of pregnant women who were examined for this danger sign in the 3rd year is 87%, which is a decline from the previous year (Figure 5). It is very essential that health workers examine this danger sign along with other signs during antenatal checkups. Therefore, NFHP II needs to make a closer look at this indicator.

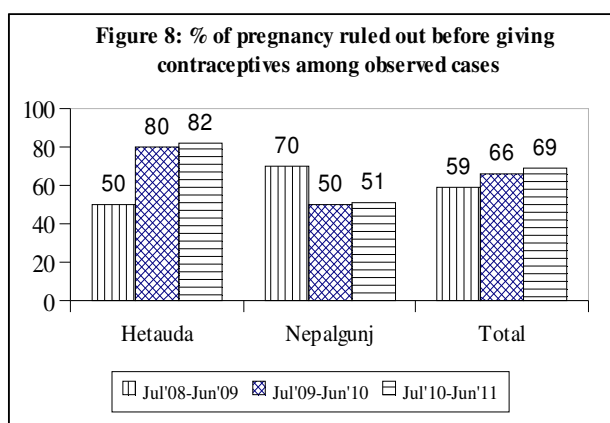
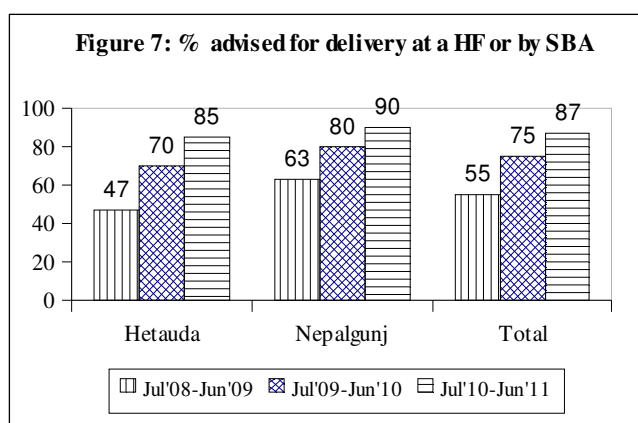


Tetanus Toxoid (TT) provided during ANC: Figure 6 shows that the proportion of pregnant women who received TT vaccine or were confirmed that they had received TT is almost universal (> 95%) in the last two comparative years in both field offices. In the 1st year it was about 85%. The current achievement is very encouraging and this should be maintained in future.



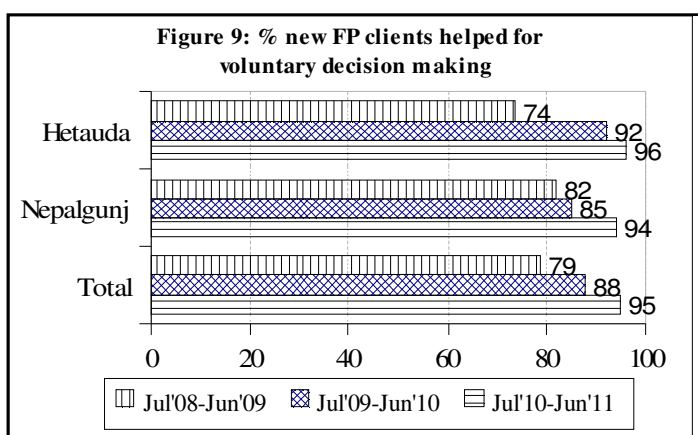
Advised for delivery at a HF or by a SBA: The service provider should advise pregnant women to deliver in a HF or seek assistance of a SBA for delivery. Monitoring data shows that over the past three years there has been a uniform increase in this indicator, which is very encouraging. In the first year, 55% of the women coming for ANC service were advised to deliver in a HF or seek assistance of a SBA which increased to three-quarters in year 2, and further increased to 87% in year 3. The rate of increase from the first to the 3rd year is 58% while that from the 2nd to the 3rd year is 16%.

Between the two FOs, the progress is slightly better in the Nepalgunj where nearly two-thirds (63%) of the observed women were advised by a health worker to deliver in HF or seek assistance of a SBA, which increased to four-fifths (80%) in the 2nd year and to 90% in year 3. In Hetauda nearly one-half of the women (47%) were advised for the same in the 1st year which increased to 70% in year 2 and to 85% in year 3. Refer to Figure 7.



Ruling out pregnancy before giving contraceptives: Confirming whether a woman is pregnant or not before giving any contraceptive is essential in family planning. In the most recent year (Jul'10-Jun 2011) more than two-thirds (69%) of the women were found confirmed about the pregnancy status before giving any contraceptives. Though there has been increase in this indicator every year in the three year period, the progress is still not satisfactory because all women before giving a contraceptive have to be confirmed that she is not pregnant. Between the two FOs, a higher proportion of women were ruled out in Hetauda (82%) than in Nepalgunj (51%). This indicator had remained almost constant in the preceding two years therefore need attention. Moreover, it is also a concern that it has declined significantly from the first year in Nepalgunj.

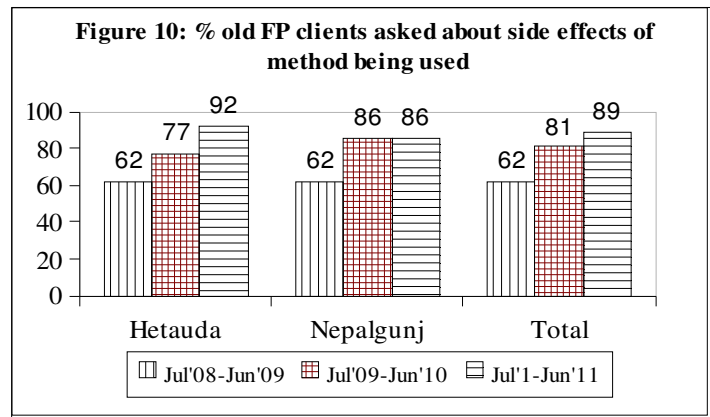
Voluntary decision making in contraceptive use: As a part of quality assurance NFHP II also monitors the quality of counseling services provided to the FP clients. The monitoring data shows (Figure 9) that there has been a remarkable increase in helping clients to make voluntary decision about FP in



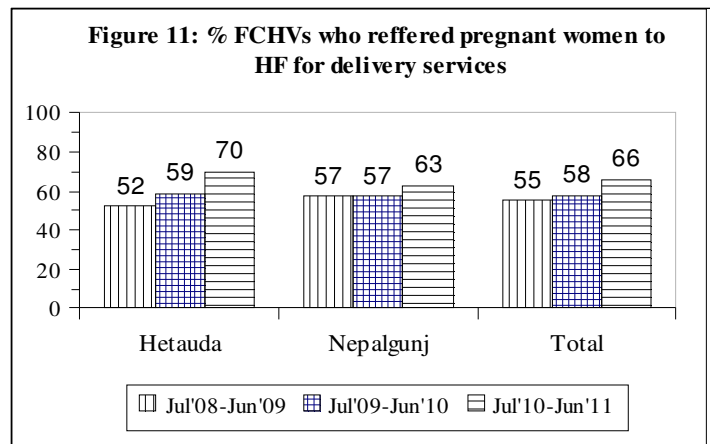
CPDs over the three years period, which is encouraging. Overall, 8 in 9 FP new clients were helped by the health workers in voluntary decision making in the first year which increased to 88% in year 2, and further to 95% in year 3. Increase in this indicator has been noted in both the FOs, and remain at the level of 94%-96%. See Figure 9.

HP clients asked about side effects of FP methods being used: During the TSVs, NFHP II also monitors the quality of counseling services on FP. Progress made in this indicator over the three years period is noteworthy. In the most recent year, 9 in 10 women were asked if they experienced any side effects of the contraceptive that they are using, which was 81% in the previous year and 62% in the year one.

Between the FOs, the rate of increase is greater in the Hetauda, where 62% were asked of the side effects in the first year and in the subsequent years, the achievements were 77% and 92% respectively. In Nepalgunj, though the improvement from the first to the 2nd year is remarkable, it stayed constant in the third year.



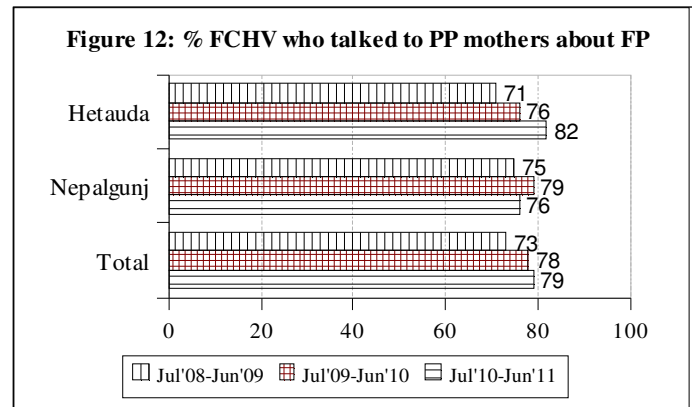
Pregnant women referred to HF for delivery services: At community level, FCHVs are supposed to refer pregnant women to HF for delivery services which NFHP II has been monitoring through TSVs. During the period Jul'1- to Jun'11, two-thirds of the FCHVs that were provided TSVs reported that they referred pregnant women to HF for delivery, which is a 14% increase from that of the period Jul'09-Jun'10, and 5% increase from the period Jul'08-Jun'09.



In the first and 2nd year the achievements in this indicator was almost equal in both the field offices, but in the third year Hetauda made a good progress than Nepalgunj (70 vs 63%). See Figure 11. As institutional deliveries in Nepal is still low (28%), FCHV's referral services can contribute a lot in this aspect therefore needs to be emphasized during TSVs.

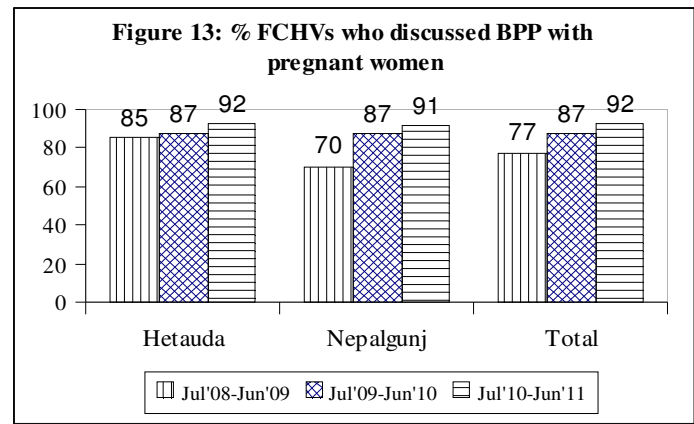
FCHV talked about FP with postpartum (PP) mothers: It is essential that FCHVs discuss about FP with every postpartum women. Figure 12 shows the percentage of FCHVs who talked about FP with postpartum mothers. Overall, this indicator has stayed constant in the last two years (nearly four-fifth).

In Hetauda, the percentage of FCHVs that talked to PP mothers about FP has increased over the years whereas it has slightly declined in Nepalgunj in year 3 from the level of year 2.



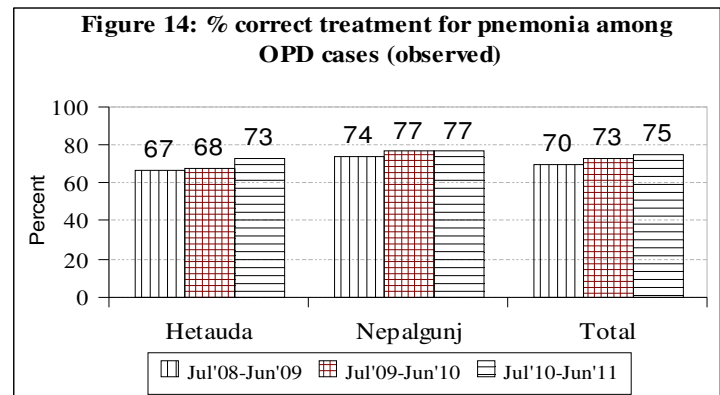
FCHV discussed birth preparedness with pregnant women: Preparing for birth during pregnancy is very important for the healthy delivery of a baby and good health of the mother. Overall, the proportion of FCHVs who discussed BPP with pregnant women has increased over the three year period. In the first year, 77% of the FCHVs discussed about birth preparedness with pregnant women which increased by 10 percent points in the 2nd year to further increased by 5 percent points (92%) in year 3.

Both the FOs has made progress in this indicator but the progress made by Nepalgunj is somewhat greater than that made by Hetauda FO. See Figure 13. The current achievements are overwhelming in both the FOs and needs to be maintained.



2.2 Child Health

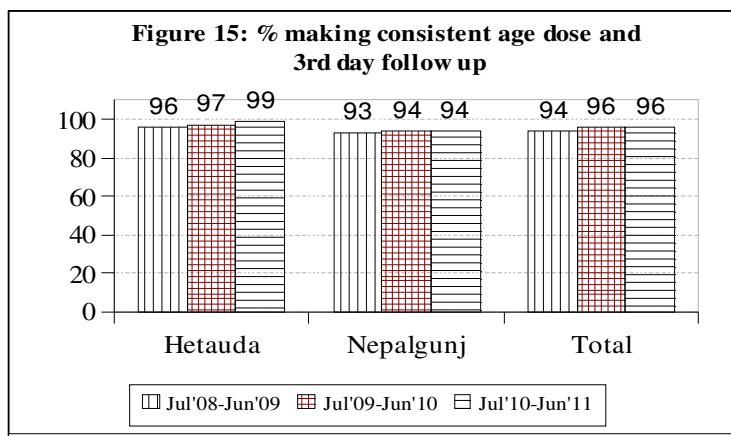
Correct treatment of pneumonia: During TSVs to HF, NFHP II staffs also observe assessment, classification and treatment of one pneumonia case recorded by the service provider in the OPD register (HMIS 16A). In the most recent year, 6,233 OPD cases were reviewed, out of which three-quarters were found correctly classified by the health workers. The correct classification was 70% in year 1 and 73% in year 2 out of 4,376 and 4,609 cases reviewed from OPD registers. These findings show slight improvement in correct classification of pneumonia cases.



Correct classification for the most recent year is higher in Nepalgunj (77%) than in Hetauda (73%) based on the number of observations of 2817 and 3,416 respectively. Data also indicates a 5% increase in Hetauda whereas no increase in Nepalgunj when figures for year 3 is compared with that of year 2.

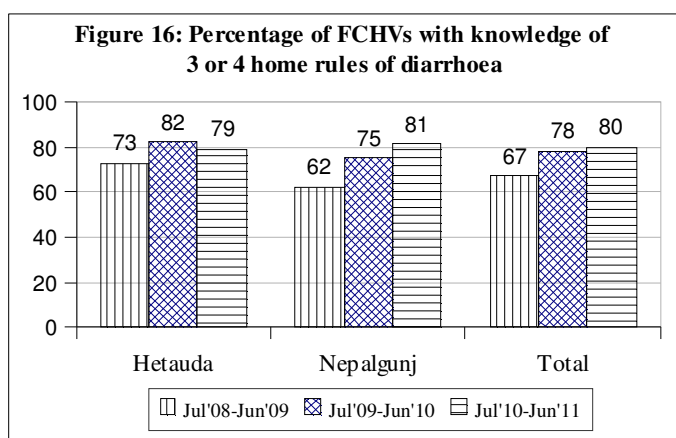
Consistent age dose and 3rd day follow up: During TSV NFHP II also reviews the 10 most recent cases of ARI from the treatment book of every CHW. In year 3 a total of 33,311 cases of 5,317 CHWs were reviewed. Of these cases 96% cases were found marked consistently with age/dose and were followed up on the third day. This figure has remained constant over the three year period.

In Hetauda, in the third year almost all of the cases observed (99%) were correctly marked with age/dose and were followed up on the third day and in Nepalgunj this figure was 94%. Data shows that the proportion of reviewed ARI cases which is marked consistently with age-dose and third day follow up has stayed almost constant and above 90% over the two year period in both the field offices. This level should be maintained in future too. See Figure 15.



In Figure 14, it is seen that 75% of the pneumonia cases were correctly treated at HF's by the health workers whereas Figure 15 depicts that 96% of the cases are correctly marked, dosed and followed up by CHWs. These data shows that more CHWs are treating pneumonia cases as depicted in protocol than the health workers.

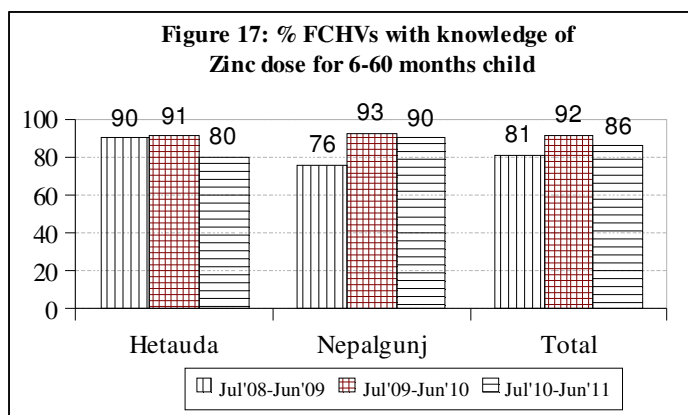
FCHVs knowledge of three or four home rules of diarrhea: Diarrhea is one of the common problems among fewer than five year children. FCHVs contribution to prevent diarrhea is noteworthy. FCHVs should have knowledge of the following home rules for treating diarrhea: continue feeding, giving plenty of liquids, giving Zinc tablets, and signs for referral (frequent diarrhea, frequent vomiting, and, too thirsty, uninterested to eat, fever and blood in stool). In the most recent year, a total of 4,102 FCHVs were provided TSVs of whom 4 in 5 had knowledge of 3 or 4 home rules of diarrhea. The indicator value for the first and the 2nd year are 67% and 78% respectively. See Figure 16.



The disaggregated data by FOs shows that in Nepalgunj, there has been progress in this indicator from first to the third year and in the most recent year the figure is 81% whereas in Hetauda, there is increase from 1st to the 2nd year (73% to 82%) but a slight decline from the 2nd to the 3rd year (82% to 79%).

FCHVs knowledge of Zinc dose for 6-60 months child: In Figure 17 knowledge of Zinc dose for 6-60 months child among the FCHVs who were provided TSVs is presented. In aggregate 86% of the FCHVs had knowledge of Zinc dose for 6-60 months child in the most recent year (Jul'10-Jun'11), which is a decline by six percent points from year 2 (Jul'09-Jun'10).

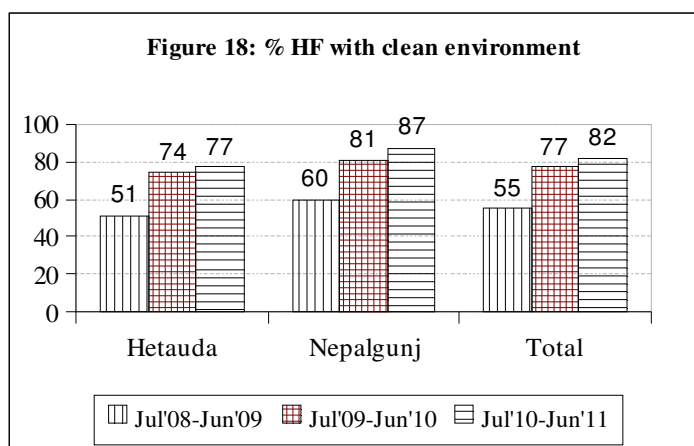
There is a difference of 10 percent points in the percentage of FCHVs having knowledge of Zinc dose for 6-60 months in Hetauda and Nepalgunj FO in the most recent year (80% vs 90%). In both the FOs, trend data shows that there has been increase in this indicator from first to the 2nd year but a decline from 2nd to the 3rd year. The decline is more pronounced in Hetauda than in Nepalgunj.



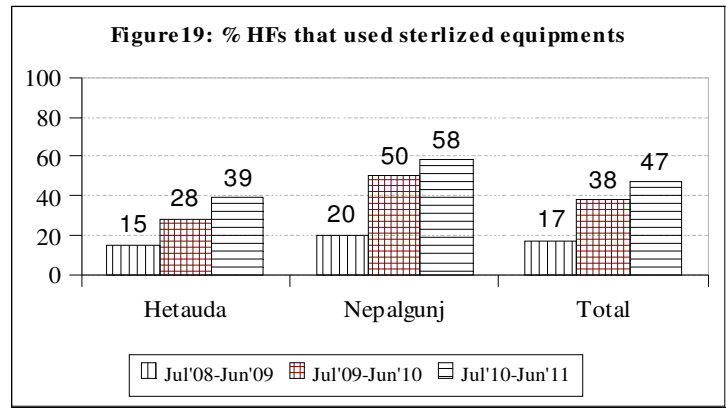
3.0 Infection Prevention:

HFs with clean environment: NFHP II monitors infection prevention (IP) activities at HFs by observing the cleanliness inside the HF and its premises during the TSVs. The three year trend in keeping HFs clean depicts that the progress is noteworthy. In the first year 55% of the HFs maintained their environment clean, which increased to more than three-quarters in year 2, and further to 82% in year 3 (Figure 18).

Between the two FOs, the achievements made by the Nepalgunj in all the years are higher than that made by Hetauda FO.



HFs that used sterilized equipments: Another area which NFHP II monitors for IP is the use of sterilized instruments in the HFs. Data for the most recent year shows that nearly one-half (47%) of the visited HFs were using sterilized equipments. Though this indicator has improved much over three years period (from 17% to 47%), the achievements are not satisfactory. This indicator being consistently low amongst other indicators draws attention towards the poor IP practices prevailing in many of the HFs of NFHP II CPDs. Therefore, it is important that NFHP II pay greater attention in improving this indicator through TSVs.



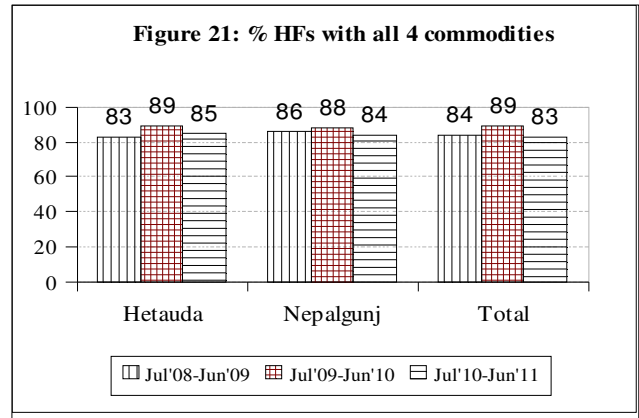
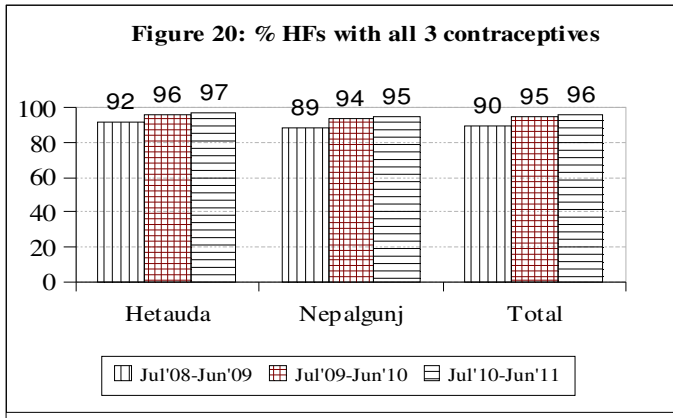
As in the case of cleaned environment, comparatively Nepalgunj FO has been performing better with regards to this indicator. In the 3rd year, the proportion of HF that used sterilized equipments reached 58% in Nepalgunj, which is much better than that reported in Hetauda (39%). In both the FOs, there has been consistent increase in the indicator over the three year period.

4.0 Supplies/Logistics:

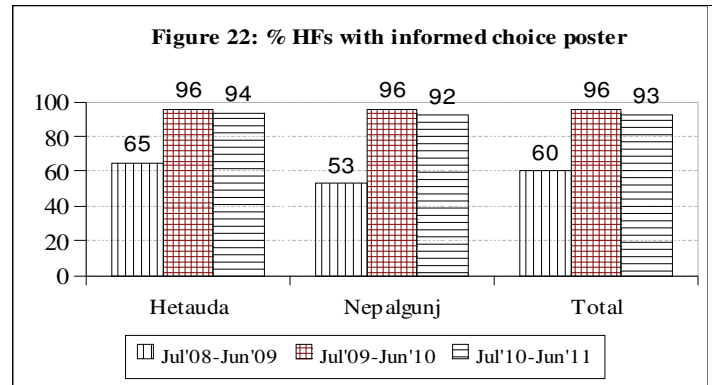
Key commodities at HF: It is important that all the health facilities have stock of three contraceptives: oral pills, injectable and condom and four other commodities: iron, vitamin A, cotrim and ORS throughout the year. This is a reporting indicator to USAID reported through LMIS data. NFHP II also monitors this indicator in a cross section of time during HF TSVs, which is presented in Figures 20 and 21.

The achievements in maintaining the availability of all 3 contraceptives has been consistently high (>90%) in 20 CPDs in all three years, with increase in achievements every year. In the most recent year the proportion of HFs that had all 3 commodities on the day of visit was 96%. It is also seen that there is no major difference in the proportion of HFs that maintained 3 contraceptives in year 2 and 3 in both the FOs, whilst in the first year; this figure was lower (Figure 20).

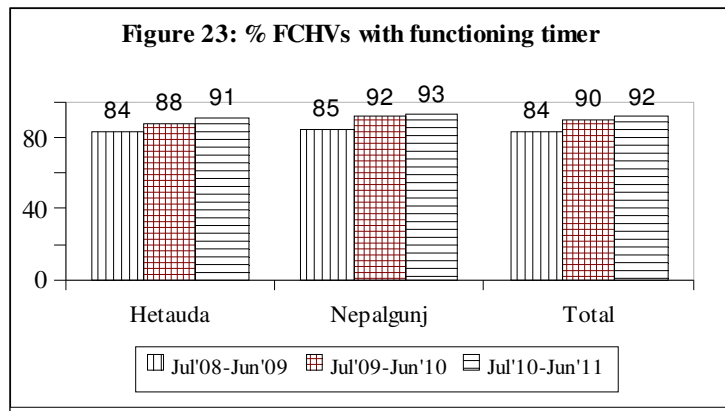
Comparison of Figures 20 and 21 reveals that the availability of all four commodities: ORS, Vitamin A, Iron Tablets and Cotrim are less likely to be available than the availability of all 3 contraceptives (Figure 21). In NFHP II districts, the availability of all four commodities was 84% in the first year which increased to 89% in the 2nd year but declined to 83% in the 3rd year. It is also seen that there is not much difference in this indicator between the two field offices over the years. It is essential that all the HFs maintain adequate stock of these commodities throughout the year.



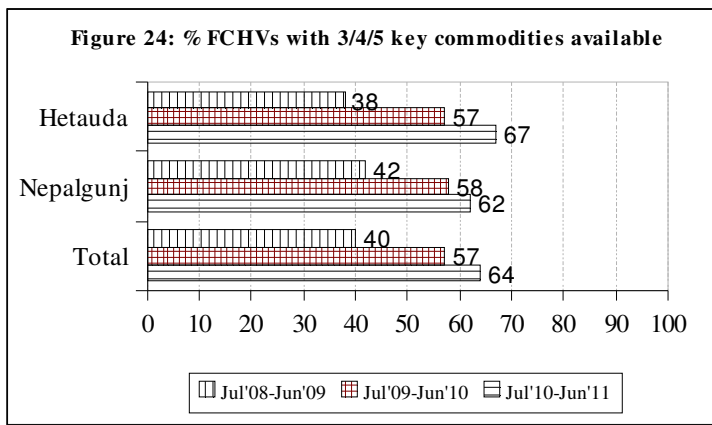
Availability of Informed Choice Poster: NFHP-II has been monitoring display of Informed Choice (IC) poster in a visible place at health facilities, which is also in compliance with the Tiaht Amendment. Trend analysis of the display of IC poster in a visible place in HF depicts that there has been an overwhelming increase from three-fifths in the first year to 96% in the 2nd year in NFHP II districts. However, in the third year it declined by three percent points (from 96% to 93%). The progress made by Hetauda and Nepalgunj FOs in this indicator is similar in the last two years. See Figure 22. NFHP II during TSVs should ensure that the ICP are displayed in all the HF's in a visible place.



Availability of a functioning timer with FCHV: Fig. 23 shows trend in availability of ARI timer with FCHVs in CPDs, which is also disaggregated by the FOs. Overall, 84% of the FCHVs who were provided TSVs in the first year had ARI Timer with them on the day of visit which increased to 90% and 92% in the 2nd and the 3rd year respectively. In the last two years the achievement in this indicator has stayed almost constant in both the field offices. Refer to Figure 23. These achievements though high, should be monitored regularly by NFHP II because without a functioning ARI Timer, FCHVs cannot provide quality ARI services.



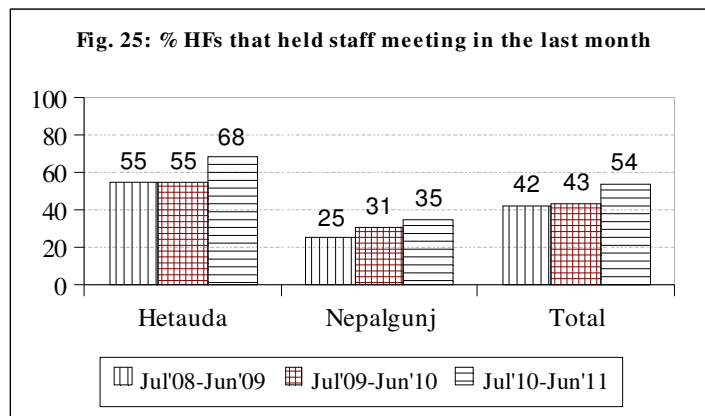
Availability of 3/4/5 key commodities with FCHVs: NFHP II also monitors the availability of 3/4/5 commodities (ORS, oral pills, vitamin A, cotrim, and iron) with FCHVs during TSVs, which is one of the reporting indicators to USAID. Three years trend in the availability of 3/4/5 key commodities with FCHVs in all the 20 CPDs show that there has been increase in this indicator over the years and in the most recent year the achievement is nearly two-thirds (64%). Comparatively, Hetaud FO made a better progress in improving this indicator than by Nepalgunj. See Figure 24.



5.0 Systems

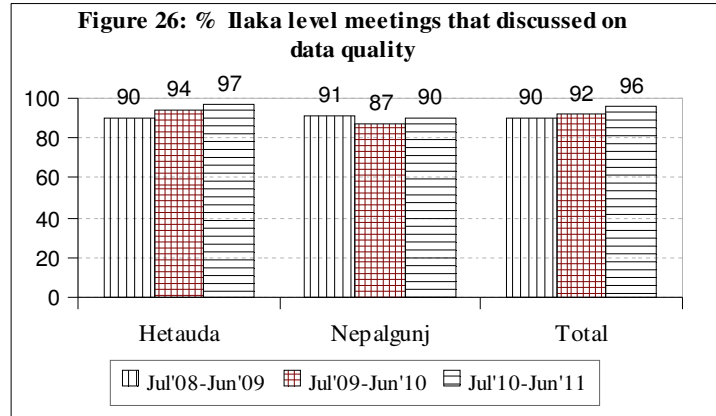
Health Facility staff meeting: HF staffs should meet every month to discuss on various aspects of HF management, service provision and recording/reporting. Regular staff meeting in a HF reflects a strengthened system. Figure 25 displays that overall, the proportion of HFs that held staff meeting in the last month has increased from the first year (42%) to the third (54%). But greater effort is still needed as nearly in half of the HFs monthly staff meetings are not held.

Relatively, the HFs under Hetauda FO has been holding staff meeting more regularly than the HFs under Nepalgunj FO. In the most recent year 68% of the HFs visited under Hetauda FO had staff meeting in the previous month as against of 35% under Nepalgunj FO. While both the FO needs to focus on improving this indicator, Nepalgunj have to make it an utmost priority.

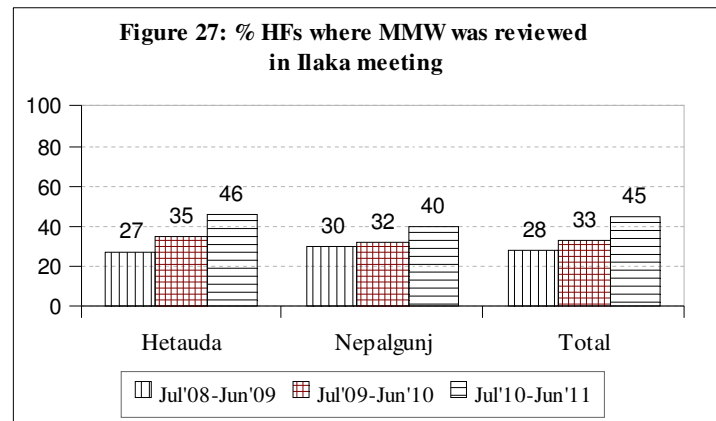


Discussed on data quality during ilaka level meeting: NFHP II supports ilaka level meeting by participation in the meeting. During the meeting they encourage district supervisors to have their active participation. NFHP II has also provided Data Display Flex Charts to review progress in HFs, which is discussed during Ilaka meetings. Every month all the SHP in charges of an ilaka meet in their ilaka to discuss on and submit the monthly report. Overall, more than 90% of the HFs visited in all three years mentioned that data quality was discussed in the ilaka meeting which is very encouraging. In the most recent year (Jul'10-Jun'11) 96% of the HFs reported of discussing HMIS data quality in the meeting which is the highest percentage reported in the three year period. Between the two field offices, Hetauda has made consistent progress in the three year period whereas in Nepalgunj it has remained almost

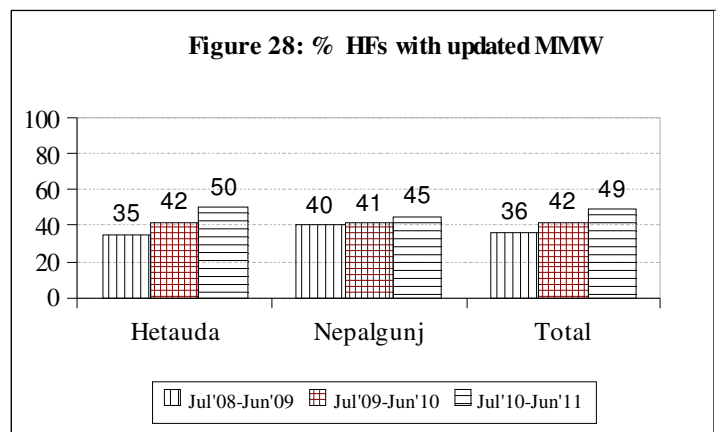
constant. In the most recent year the achievements for Hetauda and Nepalgunj are 97% and 90% respectively. Refer to Figure 26. Improving Data Quality has already become a focus of NFHP II, therefore, though the achievements are high, it is essential that NFHP II staff continuously monitor this indicator for maintenance and further improvements.



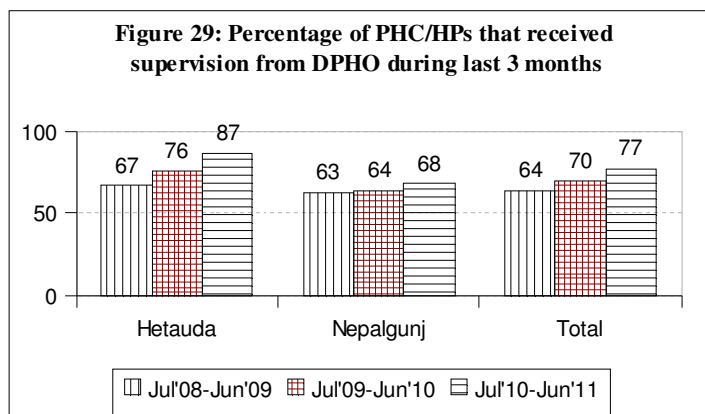
Review of MMW in ilaka level meeting: In the ilaka level meeting it is equally important that the participating HFs review the Monthly Monitoring Worksheet (MMW). While the above Figure (26) shows that data quality are discussed by most (>90%) of the HFs in ilaka meeting, but less than one-half of the HFs reviewed the MMW (Figure 27). Though monitoring data of three consecutive years show that the proportion of HFs that reviewed MMW has increased from first year to the third, the current level is still a challenge. In Hetauda 46% of the HFs reviewed it in the most recent year whereas the figure is 40% in Nepalgunj (See Figure 27). NFHP II should ensure that MMW are reviewed during monthly ilaka meetings in the CPDs.



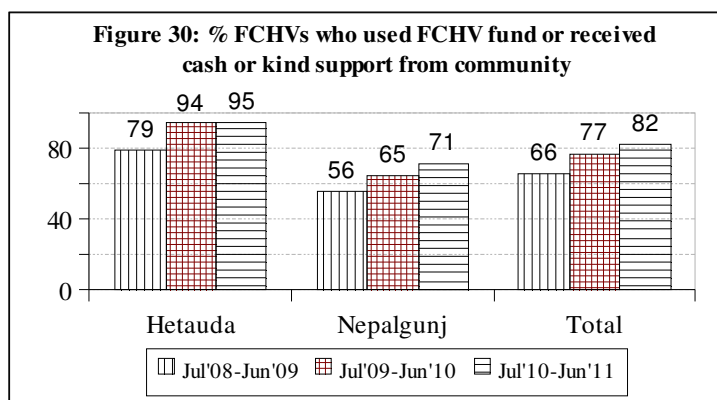
Updated Monthly MMW: Updating MMW was also as low as reviewing MMW in the HFs of NFHP II CPDs. In Figure 27, 45% of the HFs reviewed MMW in the most recent year (Jul'10-Jun'11) whereas 49% updated MMW in the same year. Similar pattern is observed for the two preceding years, where updating MMW is slightly higher than reviewing MMW. The disaggregation in data shows that the improvement made by Hetauda FO is somewhat greater than that made by Nepalgunj FO.



Supervision of PHC/HPs by DPHO: Figure 29 displays the status of supervision from district to the ilakas during last 3 months. An improvement has been noted for this indicator as it went up to 70% in the 2nd year from the previous level of 64%. Supervision from district to ilaka level is greater in Hetauda field office than in Nepalgunj in both the years. In Hetauda, supervision to PHC/HPs increased from 67% to 76% and that in Nepalgunj it remained almost constant (63% to 64%). These result shows that NFHP II staff, particularly in Nepalgunj need to encourage district supervisors to make visits to the ilaka health facilities.



Support to FCHVs from Community: Figure 30 displays that more number of FCHVs are receiving support from community. Overall, in year one only two-thirds of the FCHVs reported that they used FCHV Fund or received cash/in-kind support from community which increased to above three-quarters (77%) in the year two and above four-fifths (82%) in the year three, which is a noteworthy improvement.



Between the two field offices, support to FCHVs is remarkably high in Hetauda than in Nepalgunj in all three years. In the year three, 95% of the FCHVs who received TSVs from NFHP II used FCHV Fund or received other support from community and this was true with 71% of the FCHVs in Nepalgunj.

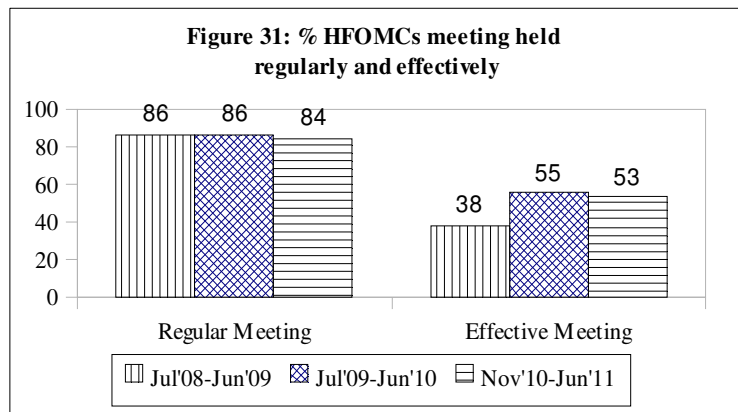
6.0 Health Facility Management Strengthening Program (HFMSp)

In 2010, the Health Facility Management Strengthening Program (HFMSp) was scaled up covering 612 HFOMCs (VDCs) of 13 districts which was confined to only 55 VDCs of four districts (Banke, Dang, Surkhet and Kanchanpur) previously. As the program was expanded to 557 new HFOMCs during 2010, the M&E system was also revised. Here, TSV data of the 55 VDCs for two years: July'08-June'09 and July'09-June'10 and that of the 612 VDCs for **eight months** has been presented. However, the data presented here should be interpreted cautiously for comparison because of the vast difference in the number of HFOMC before and after 2010.

HFOMC meeting: There are two USAID reporting indicators in HFMSp that is reported from HFOMC meetings, the first being the HFOMCs that conducted meeting with meeting minutes every month (defined as current month/last month), and the second, HFOMC that conducted effective meeting in the last month (defined as meeting with i) \geq 51% participation including at least a dalit and a woman member; ii) developed action plan, and iii) shared responsibilities among the members).

Data presented for 1st and 2nd year in Figure 31 represents of 55 VDCs whereas last year data is for all the 612 VDCs. In the 55 VDCs of the four

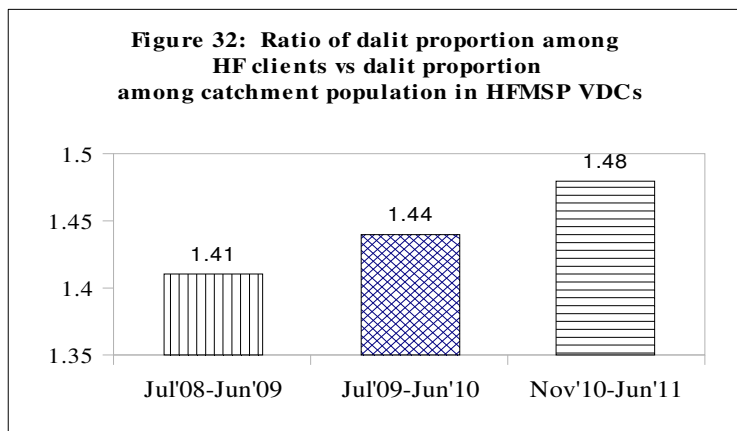
districts, the percentage of HFOMCs that met regularly has stayed constant and high at 86% in both the years (Jul'08-Jun'09 and Jul'09-Jun'10). Nevertheless, the proportion of HFOMC that conducted effective meetings is comparatively low, 38% in the first year and 55% in the second year. It is also seen that from the first year to the second there has been increase in effective meetings by 17 percent points, which is noteworthy.



The data presented for the period November 2010 to June 2011 is from the 13 HFMSp districts i.e. after the program expansion. During this period, 84% of the visited HFOMCs held regular meetings out of which 53% held the meetings effectively. Though regular meetings are being held in most of the HFOMCs, these are effective in only about one-half of the HFOMCs. As criteria for effective meeting is a harsh one, HFMSp staff should focus more on the quality of the HFOMC meeting and its minutes in the future.

Service utilization by Dalits: NFHP II also monitors the service utilization by Dalits in the HFOMC VDCs which is also one of the reporting indicators to USAID.. During the first two years, when the program was implemented in only 55 VDCs of 4 districts, the ratio of dalit proportion among HF clients vs dalit proportion among catchment population was 1.41 in year one which increased to 1.44 in the year two.

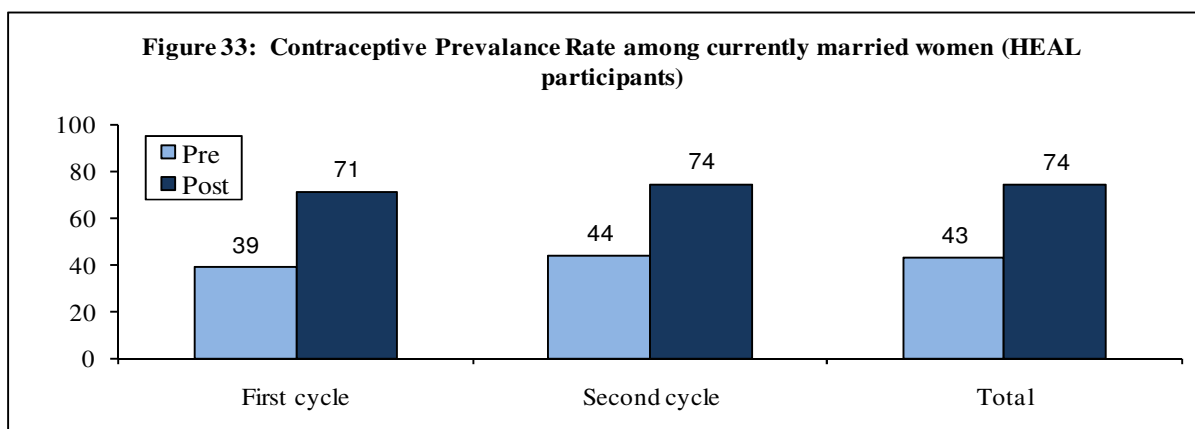
After the scaling up of the program, the **eight months** data depicts that the ratio has increased to 1.48. NFHP-II aims to increase service utilization by dalit clients, especially in the HFMSp districts.



7.0 Literacy and Life Skills Program (LLS)

LLS Program has been implemented in eight districts which includes three components: Health Education and Adult Literacy (HEAL), Girls' Access to Education (GATE), and learning circles (LC). Among these components, HEAL and GATE have intensive monitoring system.

HEAL: Pretest and posttest were conducted among HEAL participants of which the overall contraceptive prevalence rate (CPR) for any methods among MWRA of HEAL participants was calculated to monitor change in CPR from pretest to that in posttest. First and second cycle of HEAL classes have been completed till date and data are analyzed. Combined pre-



test results (total) showed that the overall CPR for any methods among the 1st and 2nd cycle of HEAL participants is 43% which is estimated 74% in the pos-test, an increase by 31% points.

GATE: The program is being implemented in three districts (Sarlahi, Rolpa, Dang, Surkhet and Salyan) in 2nd cycle and five districts (Sarlahi, Mahottari, Dang, Banke and Surkhet) in 3rd cycle. The number of GATE students increased significantly over the years mainly due to addition of new districts. Combined data of three cycles show that 4,393 students joined GATE classes of whom 7% dropped the classes, resulting in continuation of classes by 4,104 students.

When drop out students from the GATE classes are excluded from the analysis, the percentage who joined a formal school is 76.

One-fourth of the students enrolled in grade three and one-fifth in grade 4.

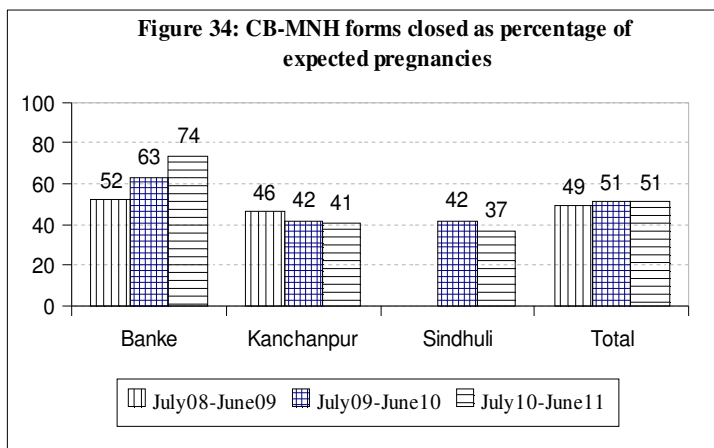
Table 2: Formal school enrollment by GATE students				
	First	Second	Third	Total
Total GATE students	679	2276	1438	4393
% of GATE Drop outs	13	4	8	7
Total eligible students for formal school (excludes drop outs)	589	2195	1320	4104
% of class enrolled				
< 3	11	13	9	11
3	32	22	28	26
4	13	19	27	21
5	4	13	20	14
5+	2	5	4	4
Did not join formal school	38	28	12	24

8.0 Community Based-Maternal and Neonatal Health Interventions

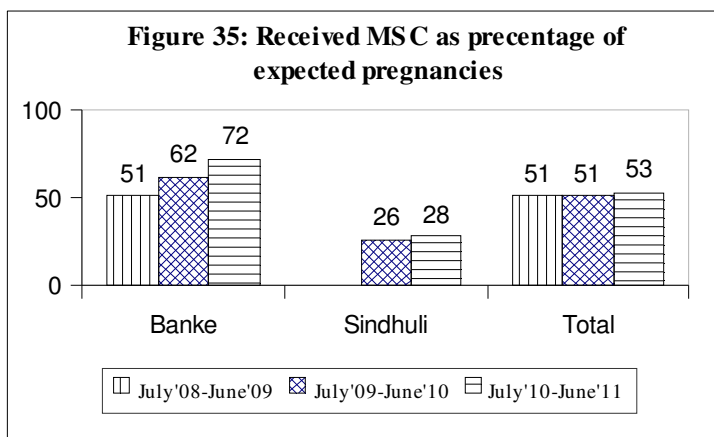
Service data of MNH at CL including Kawach, *Matri Surakshya Chhaki* and Newborn Vitamin A Supplementation and CB-NCP has been included in this section.

Maternal and newborn health at community level: The CB-MNH intervention is in place in four districts: Banke, Jhapa and Kanchanpur and Sindhuli at different times. However, in Jhapa NFHP II support is provided only for maintenance, therefore, the current analysis does not include data from this district. In addition, in the current analysis data for three years (July'08-June'09, July'09-June'10 and July'10-June'11) is compared for Banke and Kanchanpur districts whereas for Sindhuli data for only the latter two year period has been analyzed as the intervention began late.

Pregnant women enrolled by FCHVs: The proportion of forms closed, i.e. the proportion of pregnant women who were registered by FCHVs among the total expected pregnancies (EP) has remained consistently one-half of the expected pregnancies in all three years of comparison. Both in Kanchanpur and Sindhuli there has been a slow decline in the proportion of women registered by FCHVs. However, in Banke the results are encouraging with increase in coverage by 11 percent points every year. In the most recent year the coverage was around three-quarters (74%). See Figure 34. Program should emphasize that all pregnant women are contacted by the FCHVs in both Kanchanpur and Sindhuli where it is low.



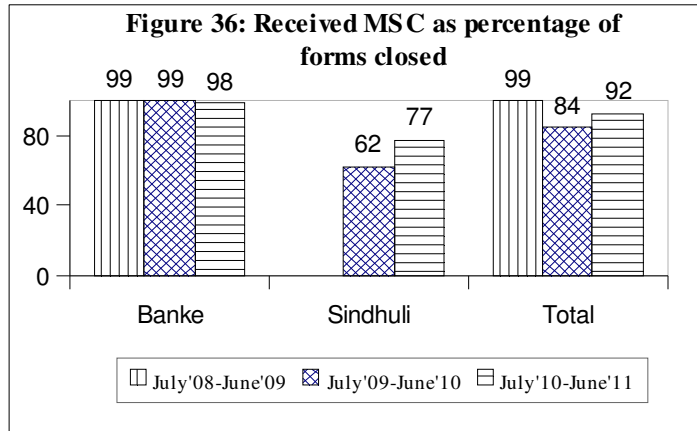
Received MSC: Misoprostol known as *Matri Surkshya Chakki* (MSC) helps in the management of postpartum hemorrhage (PPH) which helps to reduce maternal mortality. Therefore, MSC is being distributed at the community level to the pregnant women in Banke since 2005 and in Sindhuli since 2008, and since 2010 in Kalikot, Dailekh and Rolpa.



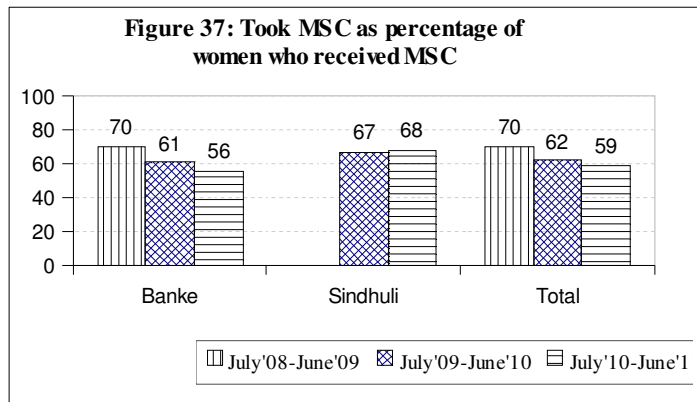
Overall in the two districts about one-half (53%) of the pregnant women received MSC among the total expectants and this proportion has stayed constant in all three years. However, between the two districts there is a large difference in the coverage. In Banke, one-half of the EP women received MSC in the first year which increased to 62% in the 2nd year and to 72% in year 3.

Two years trend in Sindhuli shows that the coverage in Sindhuli has stayed consistently low i.e. below 30%.

Figure 36 depicts that in the most recent year 92% of the women whose forms were closed received MSC which is an increase by eight percent points from the previous year. Banke has been able to keep this indicator consistently at around 100%. Sindhuli, on the other hand, increased this indicator from 62% to 77% over the two years period (from July'09-June'10 to July'10-June'11).



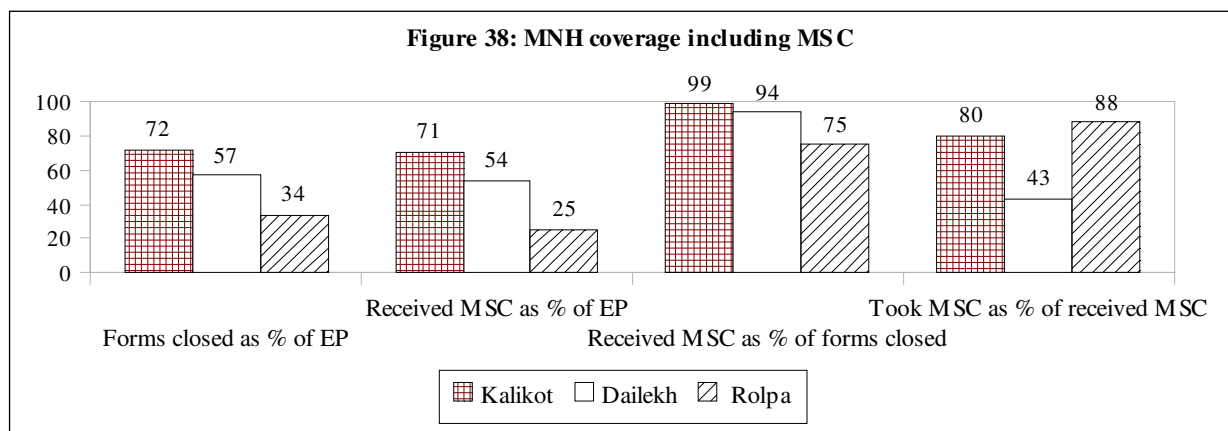
Use of MSC: The proportion of women who took MSC among those who received has decreased over the comparison period. In the first year seven in ten women took MSC which declined to less than two-thirds (62%) women in the 2nd year and further to 59% in the 3rd year. Sindhuli has maintained this indicator at around 70% in both the years while Banke observed decline in this indicator every year. In the most recent year, the proportion of women who took MSC is 56%. If a woman has institutional delivery she will receive other uterotonic drugs instead of MSC even if she has received it, therefore, it is essential to see the proportion of institutional deliveries when interpreting the findings.



Coverage of forms closed and MSC in new districts: In Kalikot, Dailekh and Rolpa, the MNH at CL was introduced in latter 2010. Therefore, for these districts data is available for only one year, hence it has been presented separately hereunder.

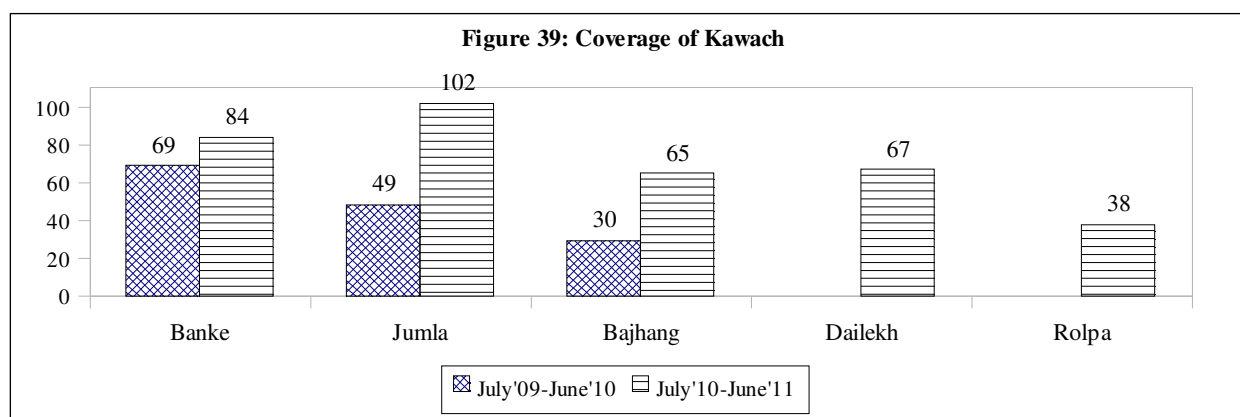
The data collected from Dec 2010/January 2011 to June 2011 reveals that forms closed as percentage of expected pregnancy is just less than three-quarters (72%) in Kalikot, around three-fifths (57%) in Dailekh and one-third (34%) in Rolpa. Almost all those who were enrolled by the FCHVs received MSC in Kalikot and Dailekh but relatively fewer women received MSC in Rolpa.

Among the women whose forms were closed almost all in Kalikot, 94% in Dailekh and 3/4 in Rolpa received MSC. Of those who received MSC, more than 80% in Kalikot and Rolpa took it whereas use of MSC is less than half (43%) among the women of Dailekh. The proportion of women taking MSC in Dailekh is very low; therefore, there is a need to study the proportion of institutional delivery as women delivering in a health facility/birthing center get other uterotonic drug instead of MSC.



Coverage of Kawach: Kawach has been in place in five districts: Banke, Jumla, Bajhang, Dailekh and Rolpa at different times as a component of MNH at CL. Due to difference in intervention time data presented here varies by districts. Banke, Jumla and Bajhang are relatively mature for Kawach intervention while Dailekh and Rolpa are new.

In Banke, Jumla and Bajhang there has been a remarkable increase in coverage of Kawach measured as the percentage of expected live births, however, the variation in the coverage across the districts is very large. The coverage in the most recent year is greatest in Jumla followed by Banke and least in Bajhang. In Banke, it increased by 15 percent points (from 69% to 84%) whereas in Jumla and Bajhang it doubled from 49% to 100% and from 30% to 65% respectively.

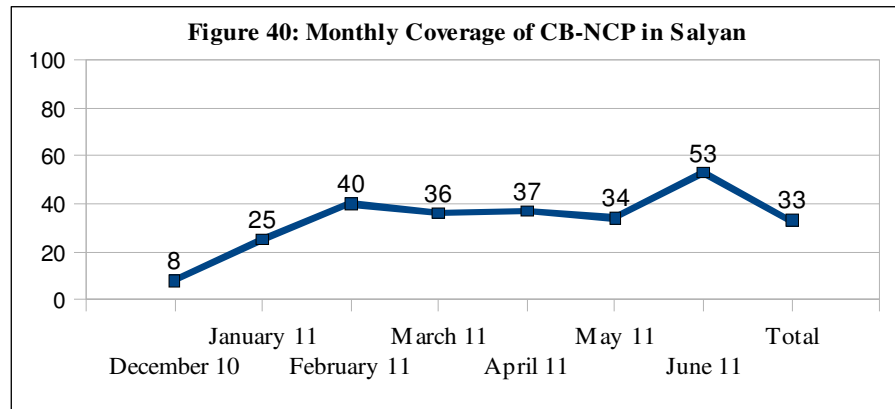


The data presented here are for six months for Dailekh (January 2011-June 2011) and for Rolpa it is for seven months (December 2010-June 2011). Remarkably greater proportion of neonates in Dailekh received Kawach application compared to that of Rolpa (67% vs 38%). See Figure 39.

Community Based-Neonatal Care Program (CB-NCP): This program with support from NFHP II has been implemented in Salyan and Mahottari districts since 2010 and recently it has been introduced in Jumla and Dailekh. The community level training for the CHWs in Salyan was completed in November 2010; therefore, data from December 2010 to July 2011 has been presented in this report.

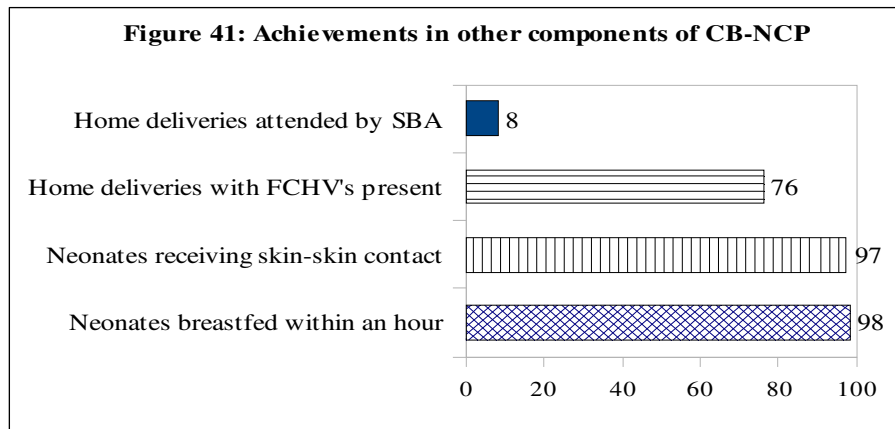
Coverage of CB-NCP:

The coverage of CB-NCP in Salyan is displayed in Figure 40. Overall coverage for seven months is 33%. The CB-NCP coverage is calculated as the percentage of neonates form closed among all the expected live births.

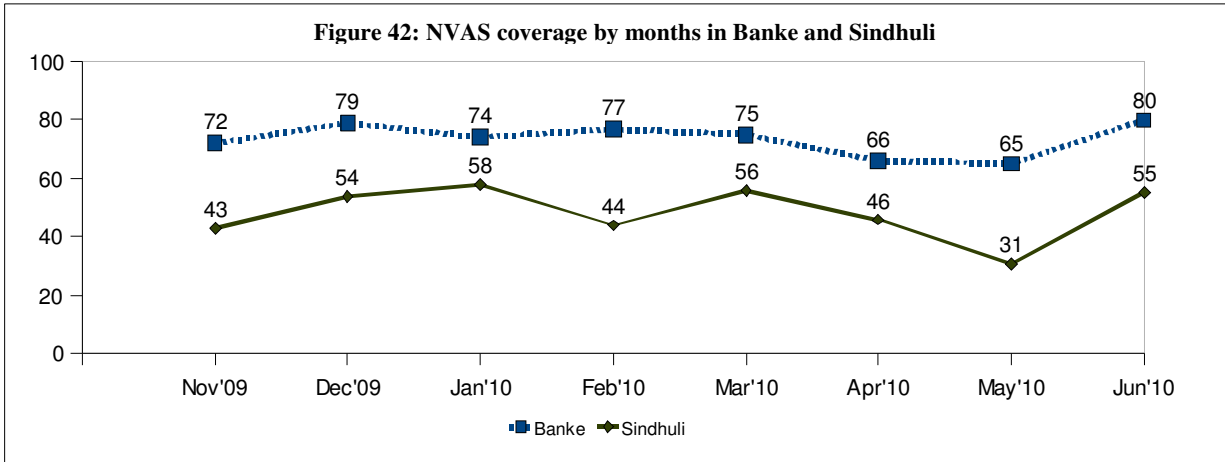


Monthly trend data shows that with the gradual maturity of the program the coverage also increased and reached at 53% in June 2011 from the level of 8% at the beginning of the program. There is an immense need for strong program monitoring, particularly in the first year of the implementation so that FCHVs enroll all the neonates.

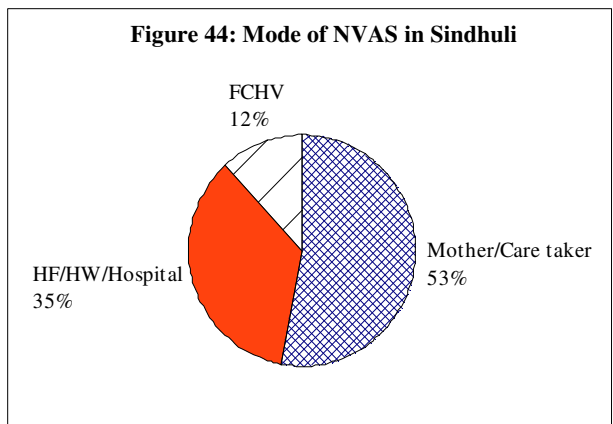
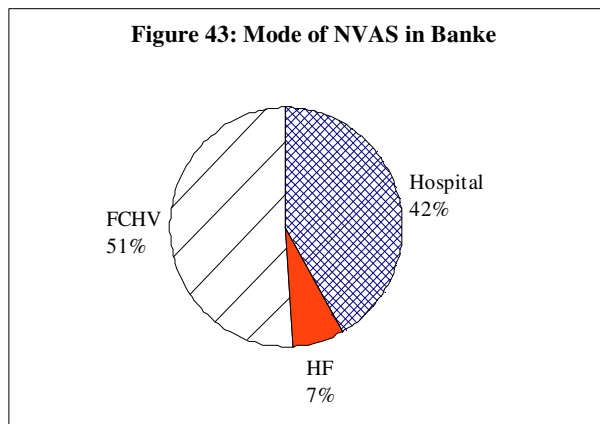
Figure 41 depicts that 8% of the home deliveries in Salyan were attended by SBA. FCHVs present during deliveries are three-quarters. Almost all neonates received skin-to-skin contact after birth and were also breastfed within an hour of birth in Salyan.



Neonatal Vitamin A Supplementation: Neonatal Vitamin A Supplementation Program (NVAS) is a new initiative implemented in Banke and Sindhuli districts since the FY 2066/67. Different program models have been in effect in the two districts. In Banke, FCHVs supplement neonatal Vitamin A to the newborns whereas in Sindhuli mother or caretakers supplements it to them. This report includes monitoring data for eight months, starting from November 2009 to June 2010. The trend in coverage of NVAS presented in Figure 42 shows that there is higher fluctuation in coverage of NVAS in Sindhuli than in Banke. In Banke, the coverage was about three-quarters up to March'10 but declined to two-thirds during April and May, 2010. However, in June'10, the coverage increased to 80% which is quite encouraging and needs to be maintained.



Monthly trend data show that the current coverage stands at the level of 2nd month of the program initiation, reflecting that improvements in coverage has not been in place as the program got more maturity. Moreover, in both of the districts the coverage declined after the month of April. The fluctuating monthly trend in NVAS coverage in both Sindhuli and Banke districts show that more intensive monitoring mechanism should be in place to increase and sustain the achievement in future.



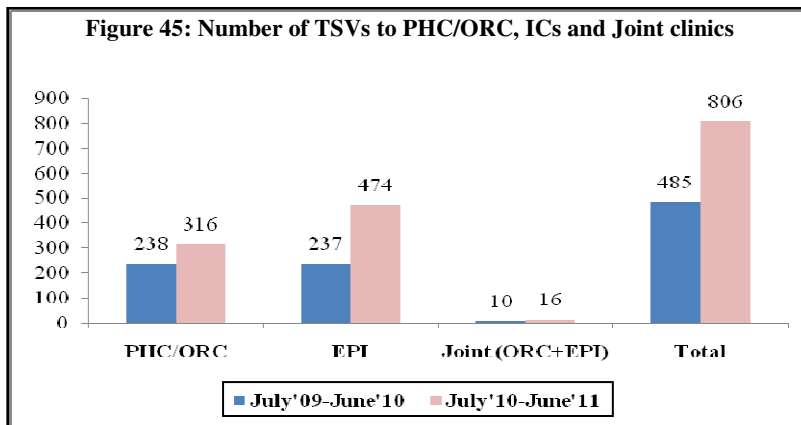
The performance of both the mother/care taker and FCHV model is fairly similar as out of all the neonates supplemented with neonatal vitamin A in Sindhuli, 53% were contributed by mother/care takers, and in Banke 51% were contributed by FCHVs. (Figures 43 and 44). Moreover, as institutional deliveries are increasing, more neonates have been supplemented with vitamin A from the hospitals. However, it should be noted that coverage in Banke is much higher than that in Sindhuli.

9.0 PHC ORC and Immunization Clinics, and Mothers' Group Meeting

Here, findings on TSVs carried out to PHC/ORC and Immunization clinics (ICs) have been compared for two years (July'09-June'10 and July'10-June'11).

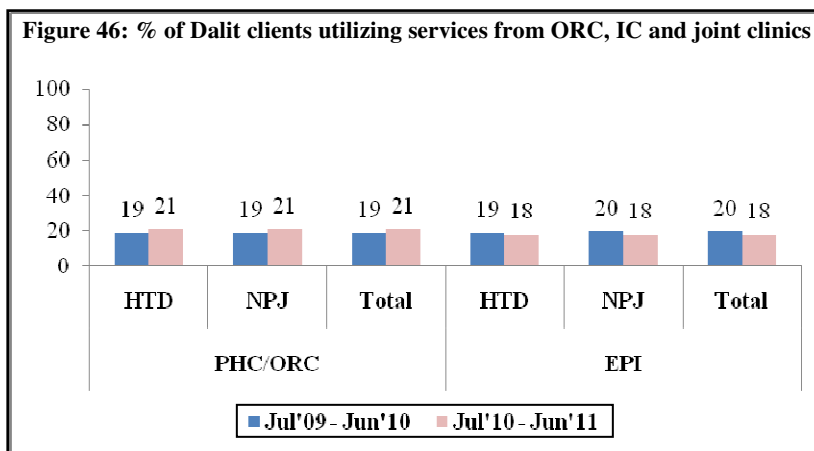
TSVs to PHC-ORC, IC and Joint Clinics:

As seen in Figure 45, there have been improvements in the number of TSVs provided to PHC/ORC and ICs. During July'09-June'10 a total of 485 visits were made to these clinics which increased to 806 in July'10-June'11. In the first year TSVs to 10 joint clinics were done which increased to 16 in the 2nd year. Between the ORC and the EPI clinics, it is noted that in the latter year TSVs to EPI clinics doubled to 474 from 237 in the initial year which is greater than that observed for PHC/ORC.



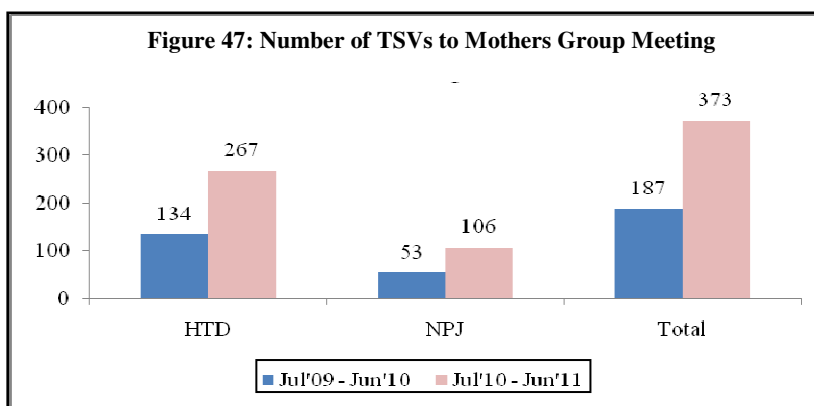
Service utilization by Dalits:

During July'09-June'10, a total of 4,515 clients in ORC (3,361 in Hetauda and 1,154 in Nepalgunj) and 5,041 clients in EPI clinics (3,605 in Hetauda and 1,436 in Nepalgunj) utilized services which increased to 5,810 clients in ORCs (3,955 in Hetauda and 1,855 in Nepalgunj) and 11,205 clients in EPI clinics (8,000 in Hetauda and 3,205 in Nepalgunj) in July'10-June'11. Figure 46 reveals that in all of those clinics, the proportion of Dalit clients is consistently about one-fifth in both the field offices in both the years.



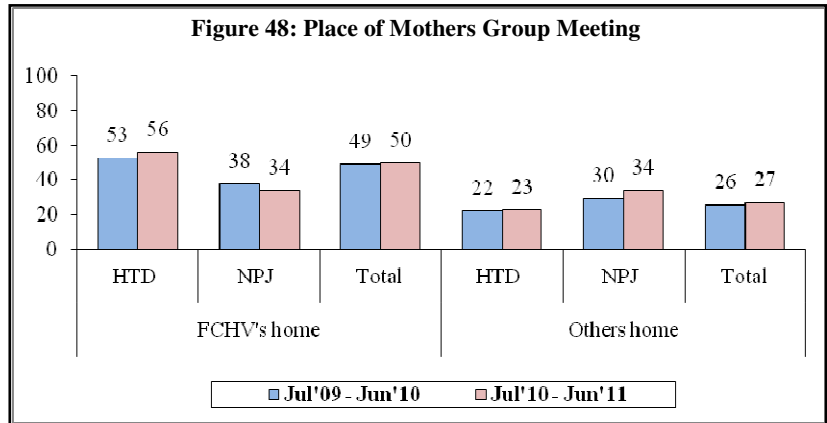
Mothers Group Meeting (MGM):

Figure 47 shows that over the two years period in the NFHP II CPDs number of TSVs provided to mother's group doubled, from 187 to 373. This increase is noted both the field offices. MGM is a very important forum where pregnant women and



new mothers in particular get health information related to safe motherhood, family planning, newborn and child health from FCHVs. Therefore, NFHP II has been monitoring that these meetings are being held effectively and regularly.

Place of MG meeting: With respect to place of MG meeting held, out of all the MG meetings observed, one-half were held at FCHV's house and about a quarter in other people's house. The remaining MGMs were held in schools, *chautara*, and local clubs (Figure 48). MGMs if held in accessible places such as FCHVs own house or other people's house might ensure women's greater participation.



Schedule and FCHV's facilitation in MGM: In the CPDs, there has been decline in the proportion of both the MG meetings that were held on schedule (71% to 56%) and facilitated by FCHVs (97% to 89%). Such a decline is higher in Nepalgunj than in Hetauda. Facilitation of the MG meetings by FCHV is constant in Nepalgunj but declined by 12% points in Hetauda (Figure 49).

