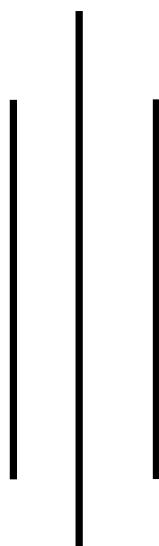


Monitoring Report

(October 2010 – March 2011)



Nepal Family Health Program - II
Monitoring and Evaluation (M&E) Team

May, 2011



Summary of Monitoring Data

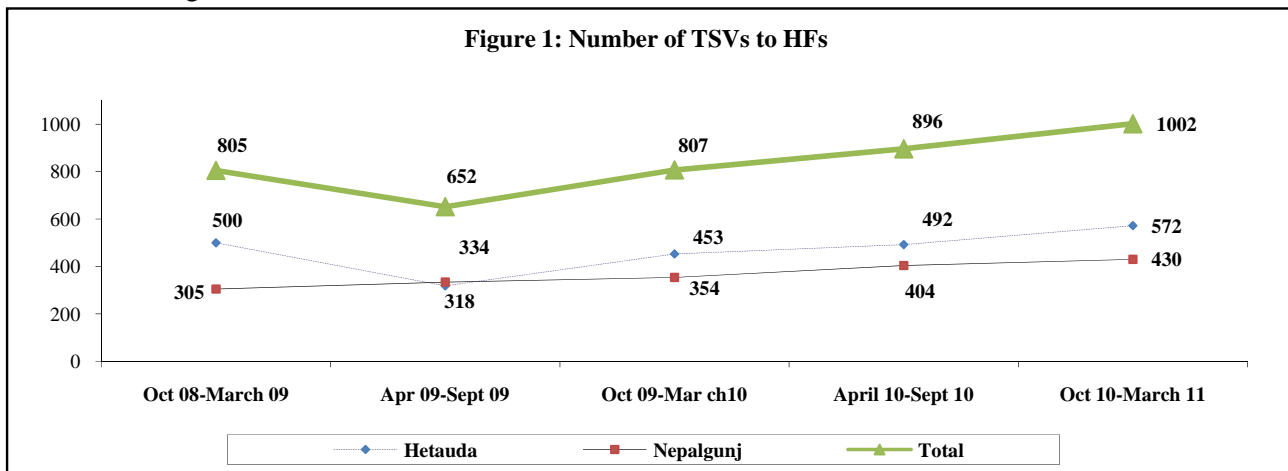
1.0 Background

Building on the success of NFHP-I, NFHP-II has been making continuous efforts to maintain a strong emphasis on performance monitoring and evaluation. NFHP-II tracks indicators at all levels including inputs, processes, outputs, outcomes and impacts. Among several sources, Technical Support Visit (TSV) data is the major source which includes knowledge and skills of service providers, commodities available at health facilities (HFs) and service providers, recording and reporting system, and staff availability in HFs.

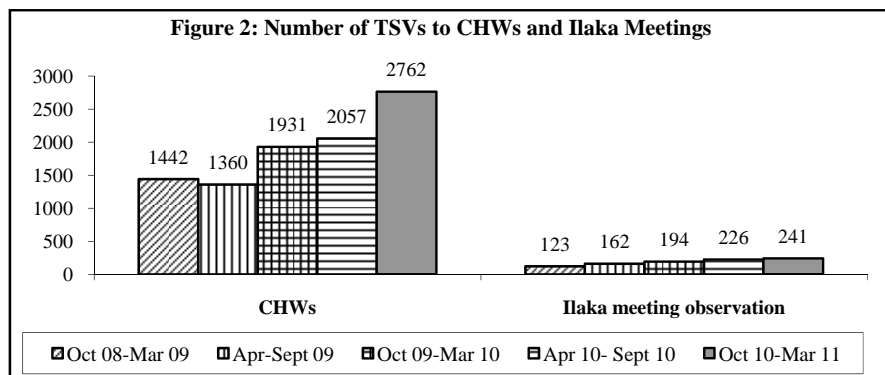
One of the objectives of the NFHP-II is to enhance the performance of community-based volunteers and facility-based government service providers. For this reason, NFHP-II has been using TSV approach since NFHP-I. TSV process includes need-based planning of field visits, gathering information, analyzing the data, identifying the performance gaps, making solutions and monitoring implementation of Plan of Action.

The first part of this monitoring report presents comparison of NFHP-II general TSV data between the five Semi Annual (SA) periods i.e October 2008 to March 2009, April 2009 to September 2009, October 2009 to March 2010, April 2010 to September 2010 and October 2010 to March 2011. The TSV data of HFMSP is also included in this section. The second part includes service and TSV data of the special projects such as MNH activities at community level including Kawach and Newborn Vitamin A Supplementation (NVAS), and Literacy and Life Skills (LLS). Data tables in length are provided only for the current SA period (October 2010 to March 2011), which not only provide detailed monitoring data but also disaggregated by 20 Core Program Districts (CPDs) of NFHP-II. Though Mugu and Bajhang are also CPDs of NFHP II, TSV data from these districts are not reported here.

Overall, during this SA period 1,002 TSVs were provided to health facilities (HFs), which is the highest, reported in the 5-SA periods. More TSVs were conducted in the HFs of the districts under Hetauda Field Office (FO) than that in Nepalgunj FO (572 vs 430) during this SA period. In both FOs, increase in TSVs is noted. See Figure 1.



In the current SA period 2,762 Community Health Workers (CHWs) (2,126 FCHVs, 345 MCHWs and 291 VHWs) were supported through TSVs, which is much higher than that supported in the previous 4 SA periods (Figure 2). Disaggregated data by the FOs shows that Nepalgunj FO provided TSVs to 1,367 CHWs



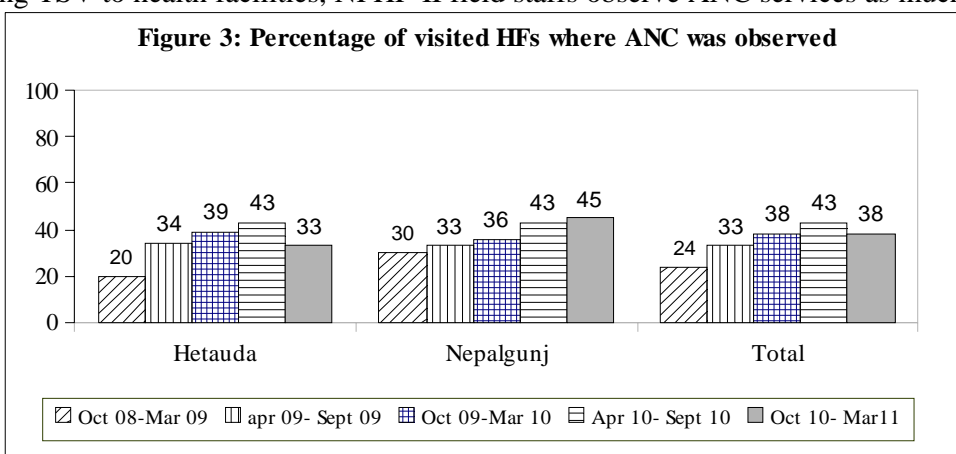
in the current SA period which was only 918 in the previous SA period. Hetauda provided TSVs to 1,395 CHWs, which is also higher than that of the previous SA period (1,013). See Table C-4.

Figure 2 shows that support to Ilaka level HMIS review meeting has also increased in NFHP II CPDs. Overall, 241 Ilaka level HMIS review meetings were observed and supported during the current SA period, which was 226 in the previous SA period (Apr 10- Sept 10). Trend in TSVs to ilaka meetings over the past five SA period shows that the number of TSVs to ilaka meetings are increasing gradually. More efforts should be made to provide TSVs to ilaka meetings. Disaggregated data by FOs shows that TSVs to the ilakas under the districts of Nepalgunj FO is lesser than that in the Ilakas under the districts of Hetauda FO (Table H-15). The number of TSVs to CHWs and Ilaka meetings of 5 SA periods is presented in Fig 2.

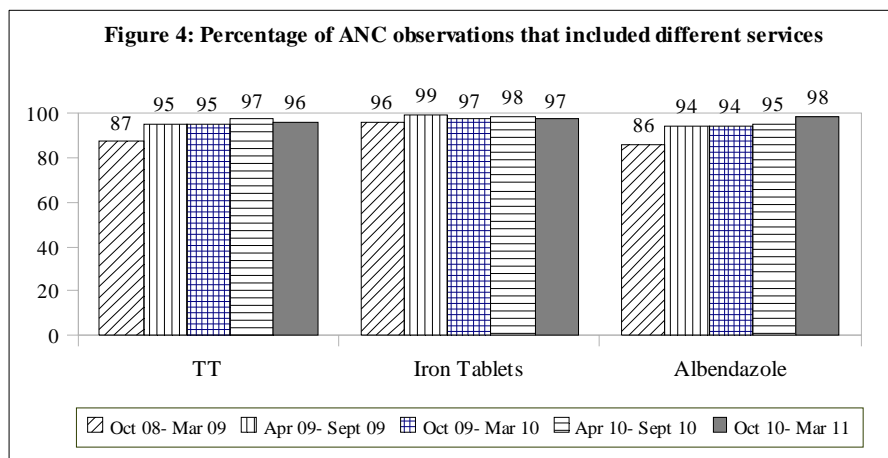
2.0 Programs:

2.1 Maternal health

Observation of ANC: During TSV to health facilities, NFHP-II field staffs observe ANC services as much as possible and record the quality of services provided. Overall, the number of ANC observation has stayed constant in the last two SA periods (April 10 to Sept 10 - 384 and Oct 1 to Mar 11 - 385) but as the total TSVs to HF were higher in this SA period, the proportion of HF level TSVs with observation of ANC cases decreased from 43% to 38%. See Table H-1 and Figure 3. Between the two FOs, the percentage decline in ANC observation was seen only in the CPDs under Hetauda FO (from 43% to 33%) whereas in Nepalgunj it stayed almost constant (43% and 45% respectively).

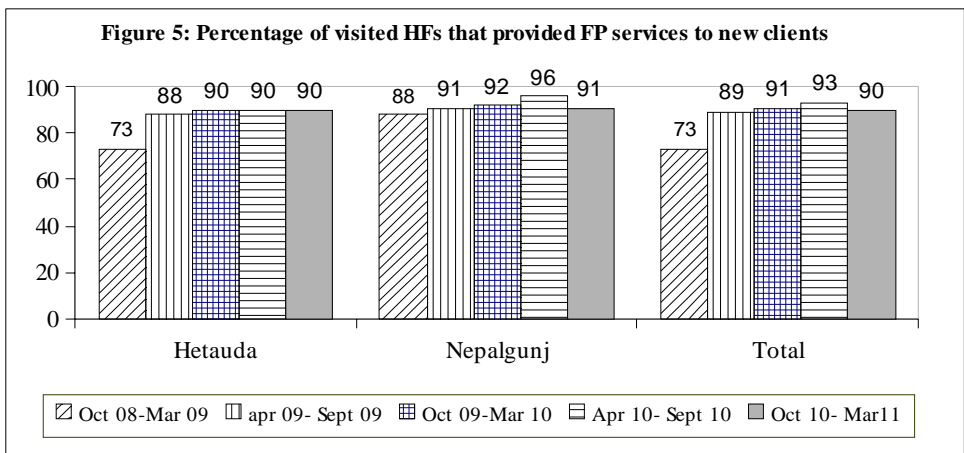


Services provided during ANC: ANC includes providing a wide range of services to a pregnant woman which mainly includes, BP check, abdominal examination, observation of danger signs, giving TT, iron and albendazole, and providing health education and counseling. Of the total observed ANC services in HF of the 20 CPDs, more than 95% HF provided TT, gave iron tablets and also gave albendazole to pregnant women during this SA period which is similar to the previous two periods (Figure 4). Over the last four SA periods these services has remained consistent at around 95%. Year-round availability of TT injection, albendazole and Iron tablets in the HF needs to be ensured to maintain the current level of achievements in the future.



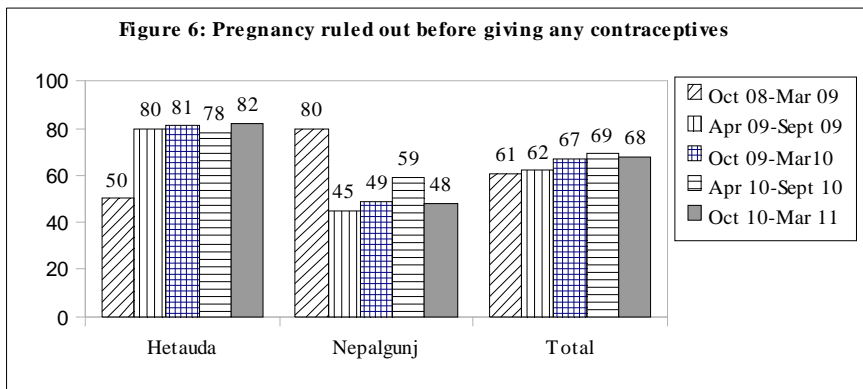
Counseling during ANC: During ANC checkup HF staff should discuss with pregnant women on danger signs during pregnancy, delivery and postpartum period. Of the total ANC cases observed during this period, 88% of the pregnant women were advised to deliver in HF or with the assistance of SBA. Whereas only two-thirds (68%) of the pregnant women were told that labor pain longer than 12 hours is a danger sign and three-quarters were told that heavy bleeding during postpartum period is also a danger sign. All these have improved compared to the previous SA periods, which is encouraging. See Table H-2.

FP Services to new clients: In order to monitor flow of new family planning clients in HFs, FP Register (HMIS 13) is observed during TSVs. In the current SA period 90% of the HFs provided FP services to new clients. The trend in FP services provided to new clients by the HFs suggests that it has been around 90% and fairly consistent over the last four SA periods, which was only 73% in the first SA period. When these data are



disaggregated by NFHP II FOs, as shown in Figure 5, Nepalgunj observed 5% point decline in the proportion of new clients in this SA period whereas Hetauda was able to stay constant at 90%. Nevertheless, the achievements are around 90% in last 4 periods in both the FOs.

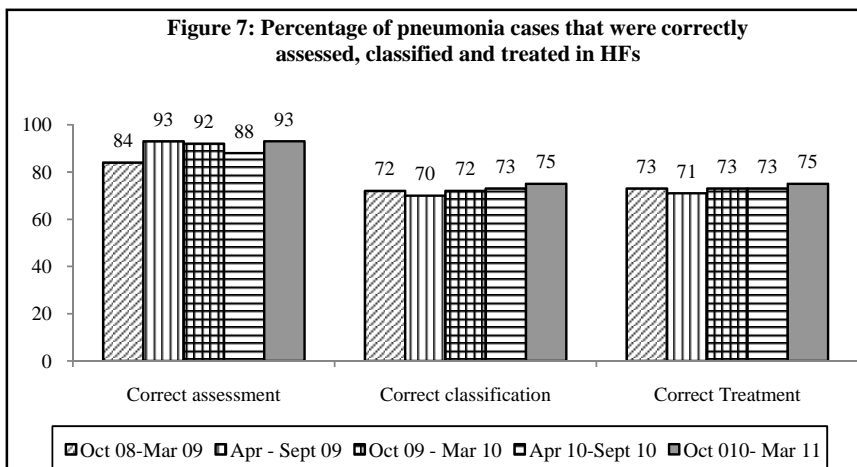
Ruled out pregnancy before giving any contraceptive: In NFHP II CPDs, more than two-thirds of the HFs (68%) ruled out pregnancy before giving any contraceptives in this SA period and this has been almost constant during the last three SA periods (Oct 09-Mar 10 to Oct 10-Mar 11). Between the two FOs, Hetauda has been able to rule out pregnancy before giving contraceptives in around 80% of the HFs visited over the past four SA periods whereas Nepalgunj saw fluctuations in achieving it and in the current SA, it dropped from 59% to 48% (Figure 6). Ruling out pregnancy before giving FP contraceptives to a woman is very important, therefore, Nepalgunj FO should try to improve this indicator while Hetauda need to make continuous effort to maintain the current achievements.



2.2 Child Health

Correct classification of pneumonia cases in HFs:

During TSVs to HFs, NFHP-II staff review 3 most recent cases (2 cases from 2-60 months age group and one case from under 2 months age group) from HMIS 16A and observe assessment, classification and treatment of one pneumonia case, if possible. Figure 7 shows that 93% of the HFs correctly assessed the cases while 3/4th classified and treated CB-IMCI cases correctly in this SA period. These figures are almost stagnant during the five SA periods but it should be noted that correct classification and correct treatment has stayed around three-quarters of the total cases observed, which is much lower than correct assessment of the cases. Therefore, coaching during TSVs should focus on correct classification and treatment of the cases.

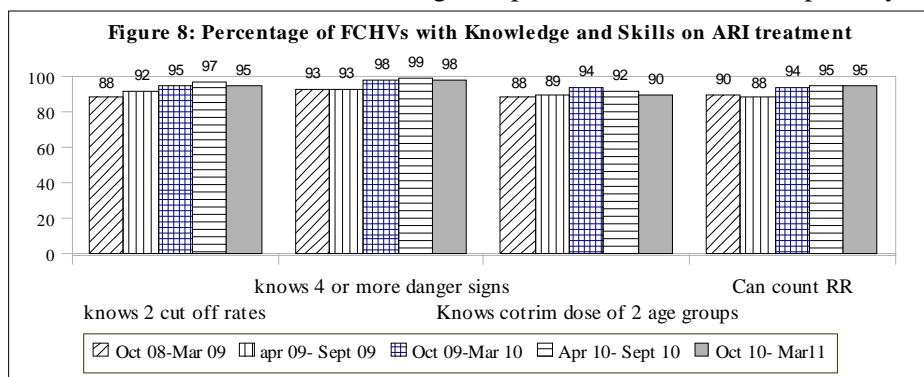


Correct classification of pneumonia cases by CHWs: In this reporting period TSVs were provided to 2,762 CHWs. During the TSVs a maximum of 10 most recent cases were reviewed from each CHW's treatment book and recorded in TSV tool which comes to a total of 16,703 pneumonia cases during the reference period. Of the total cases reviewed during this period, 98% of the cases were correctly classified which is higher than the cases correctly classified (75%) by health facility staff (Figure 7). Similarly, among reviewed cases, about 96% of the pneumonia cases were marked both with consistent age and dose, and 3rd day follow up in this SA period. As these classification and treatment are at maximum level in last three SA periods, no differences is expected in their trend. See Table C-4.

Similarly, correct classification and 3rd day follow up of 5 recently referred cases by CHWs were also reviewed during the TSVs. Overall, among referred cases, 94% were marked with 3rd day follow up (an increase by 14 percent points) and 98% of the cases were correctly classified, both being slightly higher than that reported in the previous SA period. See Table C-5.

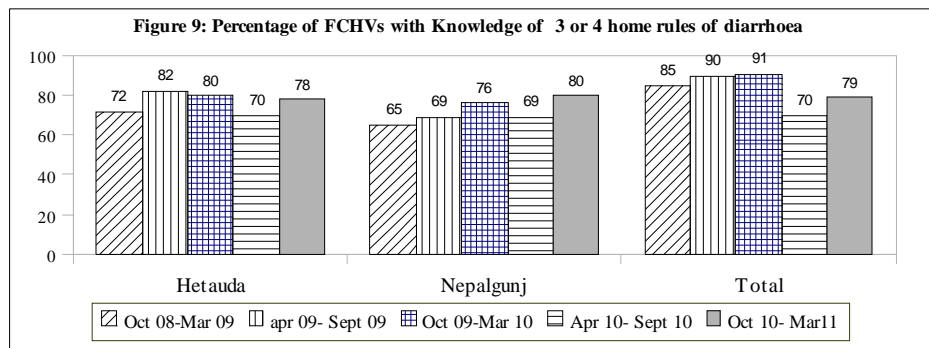
FCHVs' knowledge of ARI: Out of 2,126 FCHVs visited during this period, 95% knew 2 respiratory cut

off rates for two age groups (< 2 months and 2 to 60 months), 98% knew four or more danger signs of ARI, and 90% knew correct cotrim doses for 2 age groups (2 to 12 months and 12 to 60 months). Ninety-five percent of the FCHVs also were able to count respiratory rates correctly using a Timer (Figure 8).



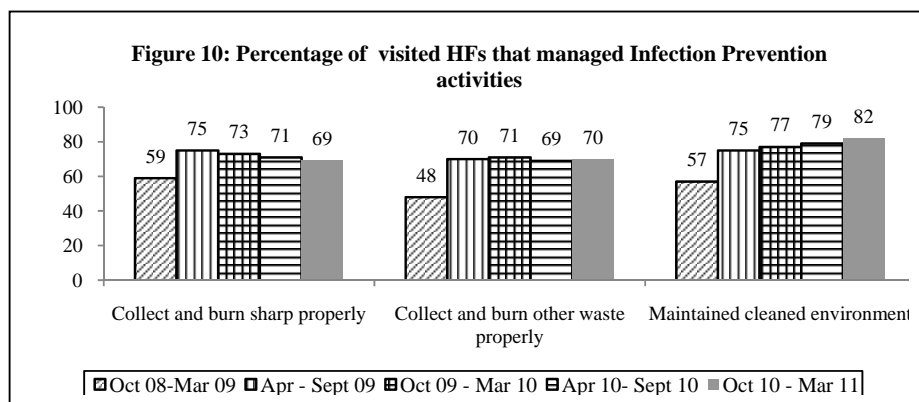
The achievements reported in this SA period for these indicators is slightly less than that reported in the previous period. As most of the indicators are above 95%, increase in these indicators is not much anticipated.

FCHVs' knowledge on home rules on diarrheal disease: The diarrheal disease home rules include giving increased fluid, continued feeding, giving zinc for 10 days (only in Zinc districts) and knowledge of at least two referral signs (Table C-8). Overall, 79% of the FCHVs had knowledge of 3 or 4 home rules of diarrheal diseases in this SA period, which is higher than that of the previous period (70%). Figure 9 shows that in the last two SA periods, there has been some decline in the proportion of FCHVs who know the 3 or 4 diarrhoeal home rules compared to the first three SA periods. In the first three SA periods, nearly 90% of the FCHVs had knowledge of 3 or 4 home rules. Therefore more effort is needed to increase the achievements and make it consistent in the future.



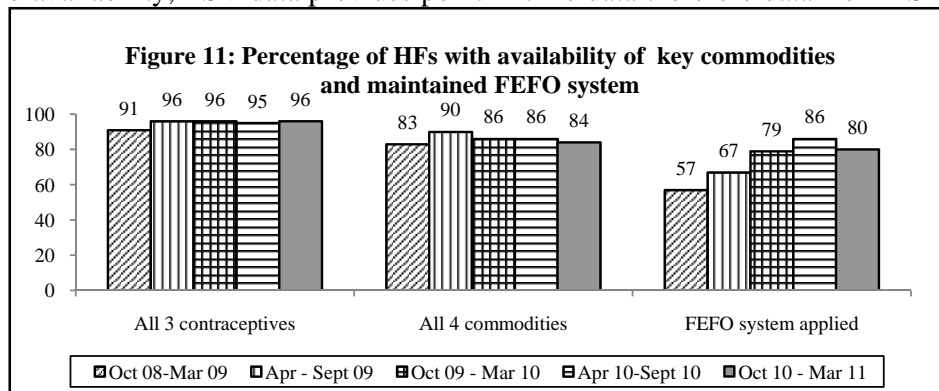
3.0 Infection prevention:

NFHP II monitors the management of wastes in HFs to ensure the prevention of infection. In this SA period, collecting and burning sharp properly, collecting and burning other wastes properly and maintaining clean environment were accomplished in 69%, 70% and 82% of the visited HFs (Figure 10). These achievements are almost constant since the past four SA periods. In future, more efforts should be in place to ensure infection prevention activities in all HFs.



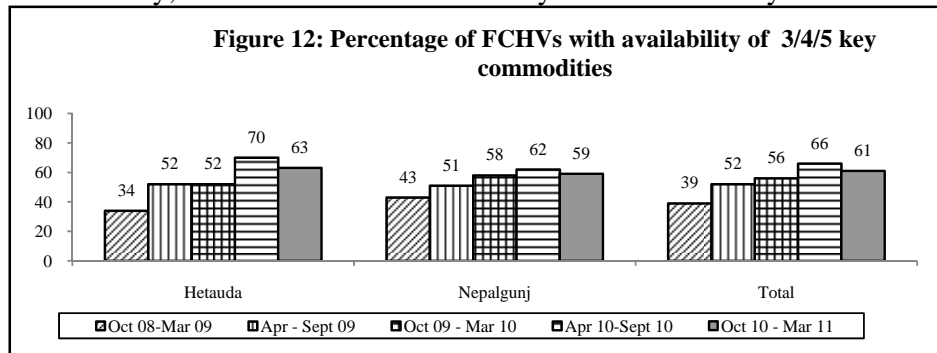
4.0 Supplies/logistics:

Key commodities with HFs: Year round availability of all 3 contraceptives (oral pills, condom and injectable), and all tracer drugs (ORS packets, Iron tablets, Cotrimoxazole (Ped) tablets and Vitamin A capsules) in the HFs are reporting indicators of NFHP-II. Although these indicators are reported from LMIS, being a reporting indicator their availability is also regularly monitored during routine TSVs. Unlike LMIS data which is year round availability, TSV data provides point in time data therefore data from TSV should be interpreted with caution. In the current SA period all 3 contraceptives was available in 96% of the HFs while all 4 commodities was available in 84% of the HFs. Trend in the availability of key commodities for the five SA periods is presented in Fig. 11, which shows that the availability of these commodities have stayed almost stagnant. All three contraceptives is nearly 95% and all tracer drugs is around 85%. See Figure 11.



FEFO System: Storing commodities in FEFO order is very essential in HFs to minimize expiry of commodities. In the current SA, 80% of the HFs stored commodities in FEFO order whereas it was higher by six percent point in the previous SA period (Figure 11). Continuous effort should be made to store commodities in FEFO system in all HFs of the CPDs.

Key commodities with FCHVs: Similarly, NFHP-II monitors availability of 3 or 4 or 5 key commodities (condom, oral pills, ORS with all FCHVs; Iron - only in program districts, and cotrimoxazole – only with treatment FCHVs) with FCHVs. This is also a reporting indicator to USAID. TSV data indicate that commodities availability with the FCHVs increased during the first

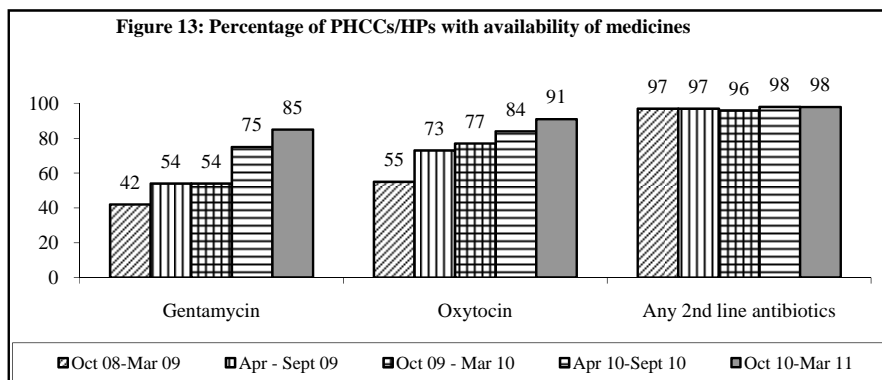


four SA periods but decreased slightly from 66% to 61% in the current SA period. Disaggregated data by the FOs reveal that in the current SA period, Hetauda observed 7 percent point decline in the availability of the commodities with FCHVs whereas Nepalgunj observed 3 percent point decline in the same.

Figure 11 shows that the availability of 3 contraceptives and 4 commodities in store room is maintained by nearly 96% and 84% of the visited HFs but figure 12 shows that relatively fewer FCHVs are keeping 3/4/5 key commodities with them. Henceforth, through TSV, NFHP II staffs need to ensure that the FCHVs get commodities resupply in time on a regular basis.

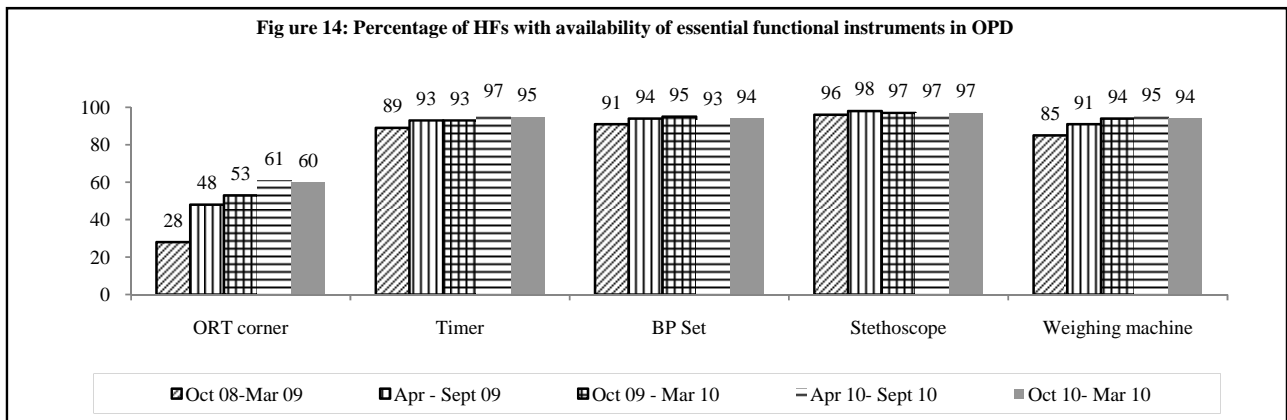
Other medicines with HFs:

The availability of other commodities such as Gentamycin, Oxytocin and any 2nd line antibiotics were also monitored in the PHCCs and HPs. Overall, availability of Gentamycin has increased to 85% in the current SA from 75% in the previous SA period. Similarly, the availability of

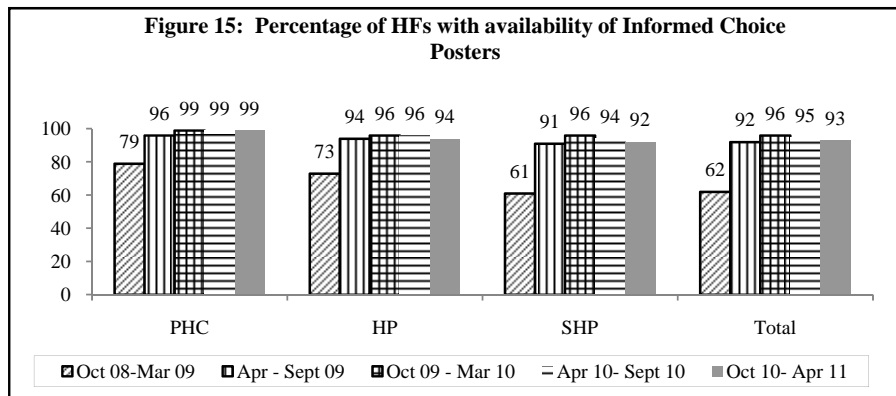


Oxytocin has increased to 91% in the present SA from 84% in the last SA period. Nevertheless, the availability of 2nd line antibiotics stayed constant at 98% in both the SA periods. In the future, efforts should be made to make Gentamicin and Oxytocin available in each and every PHCC and HPs whereas the availability of 2nd line antibiotics in all HFs (Figure 13 and Table H-9) should be maintained.

Functional Instruments: NFHP-II monitors the availability of essential functioning instruments in OPD of HFs which includes ORT Corner set, Timer, BP set, Stethoscope and Weighing Machine. Availability of functional ORT corner which is essential to manage diarrheal disease cases has increased over the five SA periods and in the current SA period it is reported as 60%. The availability of other instruments: Timer, BP set, Stethoscope and Weighing Machine has been consistent and high in all the SA periods. In the current SA period Timer, BP set, Stethoscope and Weighing Machine were available in more than 90% of the visited HFs. Figure 14.



Display of RH/FP Posters: NFHP-II monitors display of the informed choice (IC) poster in a visible place of HF where clients can see it. This is a compliance monitoring with Tiaht amendment. In this SA, 93% of the visited HF's displayed IC poster in a visible place. Comparatively, the proportion of SHP's and HP's that displayed IC poster in a visible place were less than the PHC's. Trend in display of IC poster in visible place in HF's has been above 90% over the past four SA periods (Figure 15). Similarly, the display of FP poster, and any poster on pregnancy, delivery or postnatal in the clients' waiting room/area of HF's were observed in 95% and 92% of the visited HF's (Table H-11).

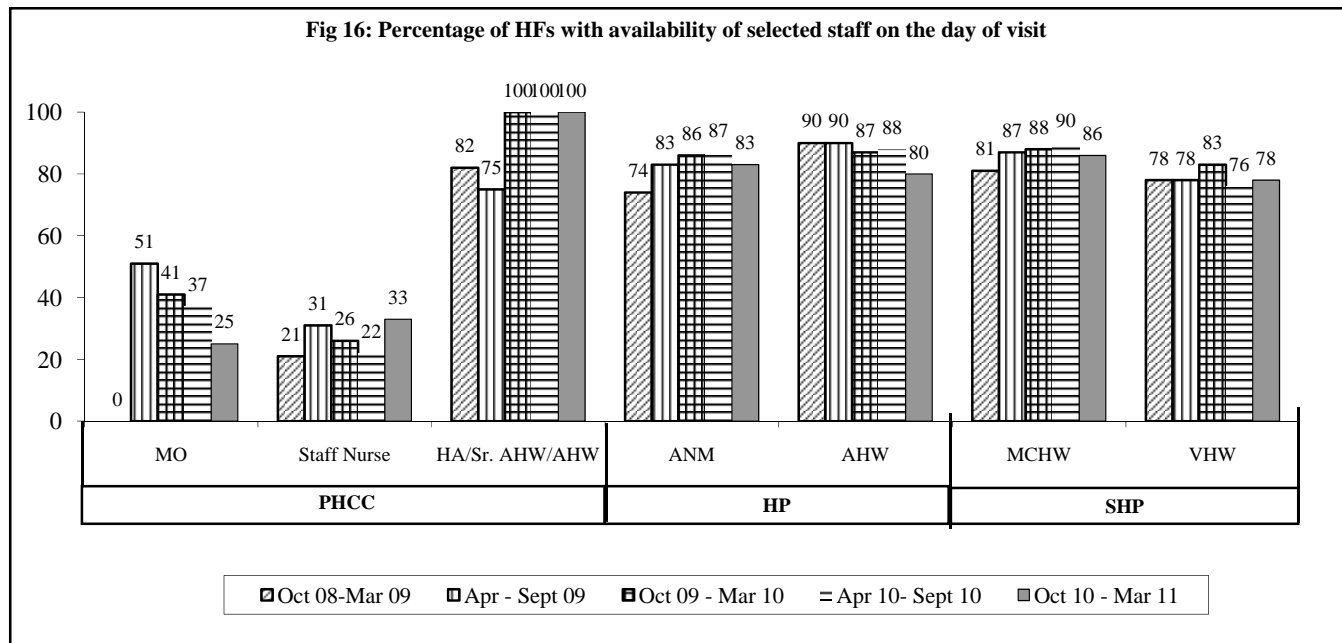


Availability of protocols with HF's: NFHP-II also monitors the availability of various protocols in the examination room of the HF's. During this SA period the percent of HF's with availability of IMCI Classification card, Zinc card (in Zinc implemented districts), IMCI chart booklet and FP flip chart in HF's was above 90%, all of which were higher than that reported in the previous SA. The availability of Vitamin A protocol was in three-quarters of the HF's (Table H-12).

5.0 Systems:

HF staff availability: NFHP II also monitors the availability of the technical staffs on the day of TSV or who had not been absent (either on leave or on deputation) for more than 7 days preceding the day of TSV. During this SA period, the availability of Medical Officer which is a sanctioned position at PHCC has decreased to a quarter from 37% reported in the previous SA period. However, the presence of staff nurse in PHCC has increased to one-third from 22% reported in the previous SA period. HA/Sr. AHW/AHW were available in all PHCC's in all the last 3 SA periods.

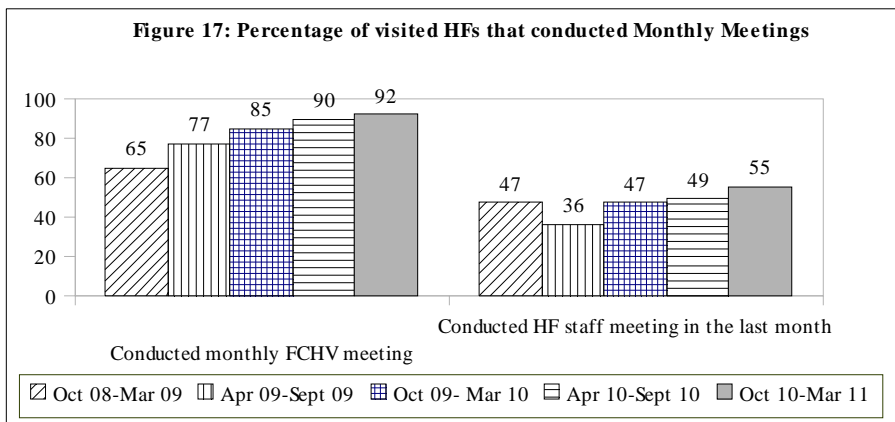
In 8 of the 10 HPs, ANM and AHW were present in this SA period whereas in the previous SA, they were present in 9 out of 10 HPs. The technical staff in SHPs includes, VHW and MCHWs in addition to Sr. AHW/AHW. NFHP II monitored the availability of MCHWs and VHWs, and in the current SA, MCHWs



were present in 86% of the SHPs and VHWs in 78% of the SHPs. Figure 16 shows the trend in availability of the above staffs in respective HF for the five SA periods.

FCHV and Health Facility staff meetings:

Meetings are important forum for program performance improvements as they are part of improved systems. Through TSVs, NFHP-II has been monitoring health facility staff meeting and FCHVs meeting held in the last month. In the current SA period, a remarkable 92% of the HF held monthly meeting of FCHVs but monthly meeting of HF was held in only 55% of the HF (Figure 17).



The trend in FCHVs monthly meeting in the HF in the last month shows that it increased gradually from 65% in the first SA period to 85% in the third SA period and eventually to 92% in the current SA period, which is a very encouraging result that needs to be maintained in the future. The trend in HF staff meetings however is not uniform. In the current SA it stands at 55%, an increase by 12% from the previous SA period. See Table H-14 detail results on monthly meetings.

Ilaka level meetings: NFHP-II supports Ilaka level meeting by direct participation in the meeting. A total of 241 Ilaka meetings were observed in this period as against 226 during the preceding SA period. In all the SA period, observation of Ilaka meetings as part of TSVs has been greater in the CPDs under Hetauda FO than that in Nepalgunj FO (199 vs 42). See Table H-15.

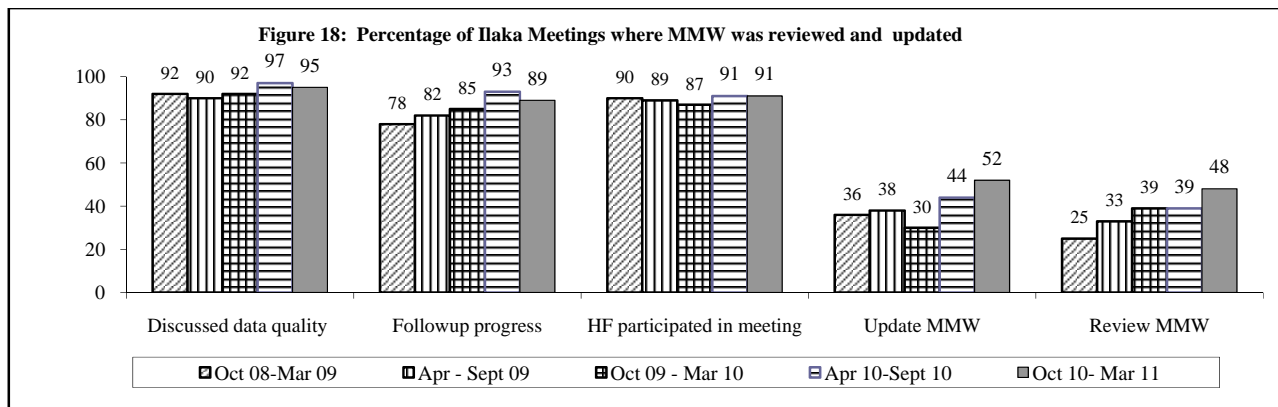
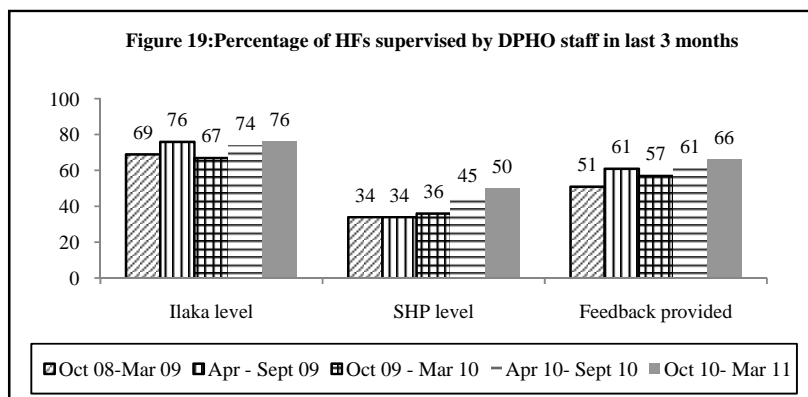


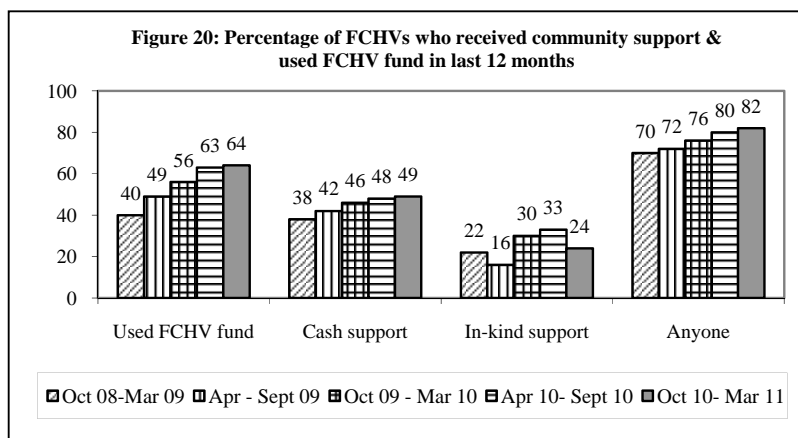
Figure 18 reveals that percentage of HF that discussed data quality and followed up progress has decreased slightly in the current SA than the preceding SA period. The proportion of HF that participated in ilaka meeting has stayed constant at 91% in the last two SA periods. The proportion of HF that updated MMW and reviewed MMW, however increased from 44% to 52% and from 39% to 48% respectively from April-Sept 10 to Oct 10- Mar 11. It is important that all the HF update and review the MMW on monthly basis, therefore, NFHP efforts are needed to improve the quality of these meetings.

HF supervision by district: Supervision from D(P)HO staff to HF is essential to improve both the quality of services and recording/reporting. In this reporting period, three-quarters (76%) of the ilaka HF and one-half (50%) of the SHPs were supervised by D/PHO staffs in the last 3 months. Trend analysis of supervision from D/PHO in Figure 19 indicates that there has been some increase in supervision from D/PHO to peripheral HF.



In the current SA period, among all the health facilities (PHCCs, HPs and SHP) supervised by D(P)HO staff in last 3 months, two-thirds also received written feedback, which is greater by five percent points reported in the previous SA period.

Community support to FCHVs: FCHVs who received either cash or in-kind support, or used FCHV Fund in the last 12 months, is a reporting indicator to USAID. Overall, 82% of the FCHVs had either used fund or received cash/kind support in this SA period. Figure 20. Trend in this indicator over the 5 SAs show that it is gradually increasing. However, when the data is disaggregated, it can be seen that only about one-quarter (24%) received in-kind support, nearly one-half received cash support (49%) and two-thirds used FCHV fund (64%).

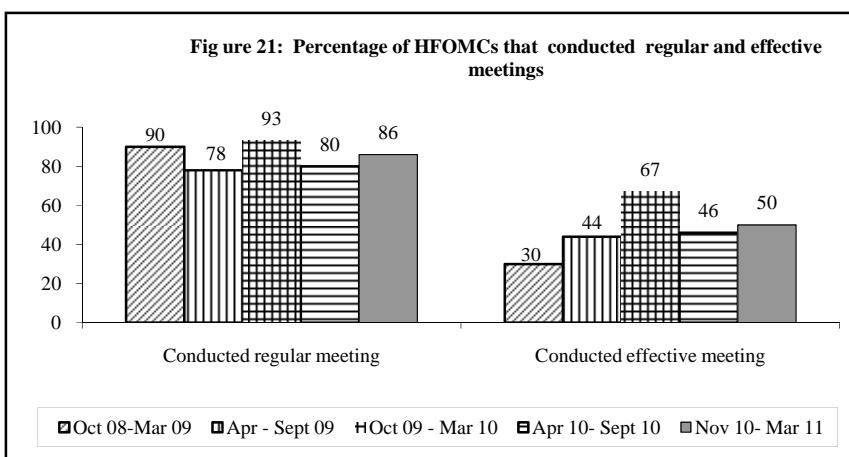


6.0 Health Facility Management Strengthening Program

Until the last SA period (Apr 10-Sept 10) the Health Facility Management Strengthening Program (HFMSp) was limited to only 55 VDCs of four districts (Banke, Kanchanpur, Dang and Surkhet) but now it has been scaled up in 9 more districts covering a total of 612 HFOMCs. Some aspects of HFOMC are also monitored through general TSVs in all the CPDs while focused TSVs to the 612 HFOMCs are also being provided in 13 districts. During the current SA period 632 TSVs were provided to HFOMCs and 955 HFOMC members. As the program was expanded to 557 new HFOMCs during this SA period, the M&E system was also revised. Because a revised TSV tools and software were developed to manage TSV data, data collected in the transition period (October 2010) was not clean enough; therefore, data presented here reflects 5 months data, from November 2010 to March 2010.

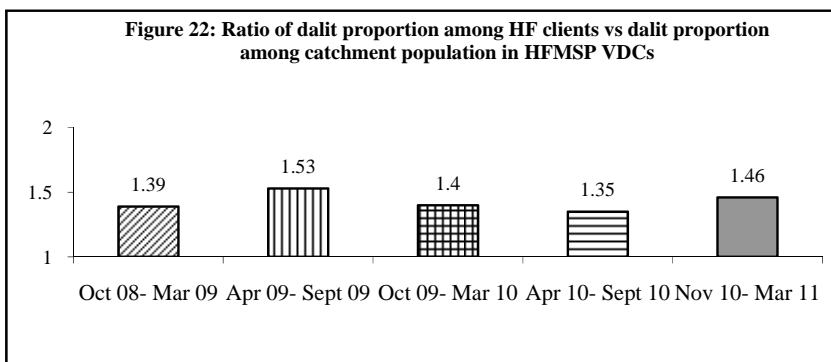
HFOMC Meeting: There are two USAID reporting indicators in HFMSp that is reported from HFOMC meetings, the first being the HFOMCs that conducted meeting with meeting minutes every month (defined as current month/last month) in program VDCs, and the second, HFOMC that conducted effective meeting in the 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).

During this period though 632 HFOMCs were visited only 614 HFOMC meetings were observed or minutes reviewed. In 9 HFOMC visits, neither meeting could be observed nor were minutes available for review. Out of the 614 HFOMCs, monthly meeting was conducted in 86% of the HFOMCs, which is slightly greater than that of the previous SA period (80%). Trend of past 5 SA periods show that regular monthly meeting was highest (93%) during Oct 09-Mar 2010 (Figure 21).



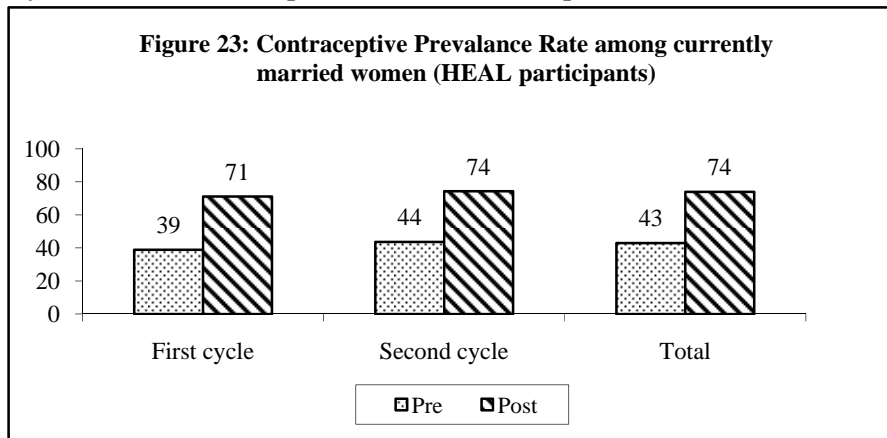
With respect to effective meeting, only one-half of the HFOMCs were able to conduct effective meeting in the current SA period. Though this is higher than that reported in the previous SA period, there is a need to improve the effectiveness of HFOMC meetings. HFOMC meetings when held should be conducted effectively to identify issues of the community make action plans and transform it into actions. Therefore, program efforts should now focus on improving the quality of meeting.

NFHP-II is also monitoring ratio of dalit proportion among HF clients vs dalit proportion among catchment population in HFMSp VDCs of 12 districts which is also a USAID reporting indicator. Data of Kalikot could not be included as we lacked population and caste/ethnicity data of VDCs. The ratio in the current SA period is 1.46 which is greater than that of the previous SA period (1.35). Trend of the past 5 SA periods show that the ratio was highest in the 2nd SA period (1.53) and has been meeting the expectation as it has exceeded 0.75 in all the SA periods. See Figure 22. NFHP-II aims to increase service utilization by dalit clients, especially in the HFMSp VDCs.



7.0 Literacy and Life Skills Program

Health Education and Adult Literacy (HEAL): During this SA period, the post test of 2nd cycle was completed. The CPR among currently married women in pretest was 44%. The post test result shows that 30% point change in CPR among HEAL participants in 2nd cycle which was 32 percentage point in first cycle. Furthermore, health behavior among HEAL participants have improved significantly from pretest to post test. After completion of 2nd cycles of HEAL, currently the 3rd and 4th cycles of HEAL classes are running in eight districts. 239 HEAL classes of 3rd cycle are running which will be completed in June 2011. Similarly, remaining 115 fourth cycle HEAL classes are also ongoing which began in February 2011 in eight districts.

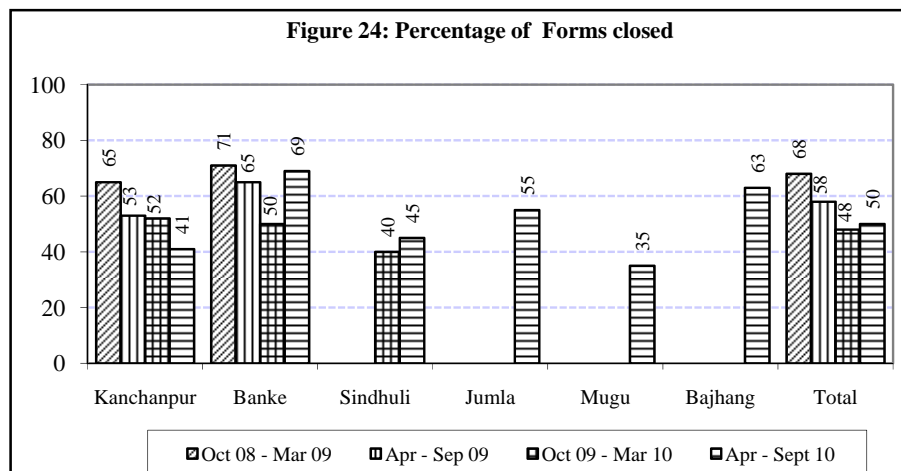


Girls' Access to Education (GATE): The 3rd cycle of GATE classes have just completed. A total of 1,438 adolescent girls aged 10 to 14 enrolled in 65 GATE classes and participated in the nine-month literacy course in five districts (Surkhet, Banke, Dang, Sarlahi and Mahottari). The GATE graduates are enrolling in the formal school now and we are waiting for its final report till date. There will be no new GATE classes in the remainder period of NFHP II.

Learning Circle (LC): A total of 543 Mother's Groups conducted their meetings using the Learning Circle (LC) approach in all eight LLS districts. There was a total number of 11,736 women participants between the ages of 15-49 in the 3rd cycle of LC. The FCHVs who conduct these meetings go through three-day training, concentrating primarily on effective communication. Altogether 576 mother's group conducted their meeting using LC approach in the 2nd cycle of LC

8.0 MNH Program at community level

The MNH program was first piloted in 3 districts; Jhapa, Banke and Kanchanpur and then expanded in other districts. Currently MNH covers 9 districts (Sindhuli, Banke, Kanchanpur, Jumla, Kalikot, Dailekh, Rolpa, Mugu and Bajhang). Since the beginning of the pilot program it is being intensively monitored and evaluated. Even though the program is in 9 districts, here the data is presented for only 6 districts because Kalikot and Dailekh have limited data to report, and Jhapa is in maintenance phase therefore data is not presented for these 3 districts. Since not all these 6 districts have data for the current SA period, the data is presented for the preceding SA period (April-September, 2010). The comparison periods of MNH districts is not same for all districts since MNH program was implemented in Jumla, Mugu and Bajhang in FY2066/67. So, these districts have limited data to present for the SA periods.

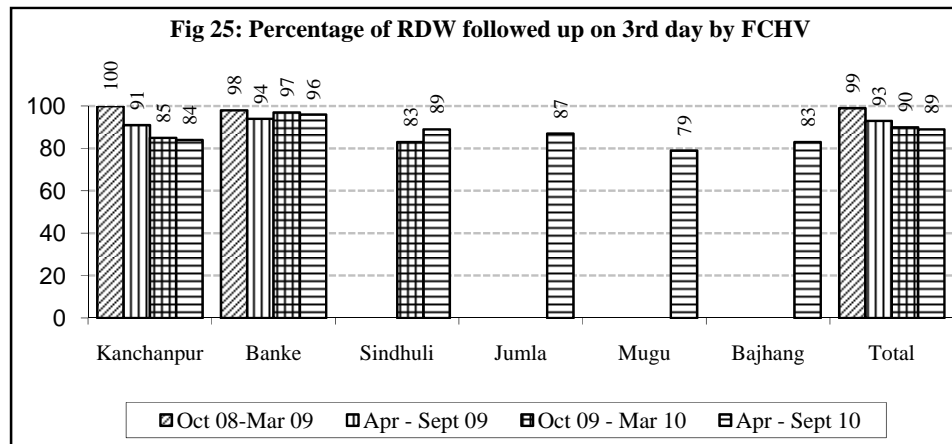


Forms Closed: The total number of expected pregnancies for the period April-September 2010 (6 months) in the 6 MNH districts was 21,527 (Banke-5,652, Kanchanpur-6,732, Sindhuli-4,470, Jumla-1,410, Mugu-650 and Bajhang-2,613). Of these expected pregnancies, only 41% pregnant women (PW) in Kanchanpur, 69% PW in Banke, 45% in Sindhuli, 55% in Jumla, 35% in Mugu and 63% in Bajhang districts were registered in the MNH Register, with overall registration in the 6 districts being one-half. While there has been some increase in Banke (19%), it has slightly declined in Kanchanpur (Figure 24). Similarly, Mugu has lowest registration (35%) which needs a greater effort to reach the recently delivered women (RDW) by the program.

RDW followed up on 3rd day by FCHV: Among forms closed, 89% RDW were followed up on 3rd day in the SA period April-September 2010 (Figure 25). Comparatively, the percentage of RDW followed up on 3rd day has increased in Sindhuli where as remained almost constant in Kanchanpur and Banke in the last two SA period compared here.

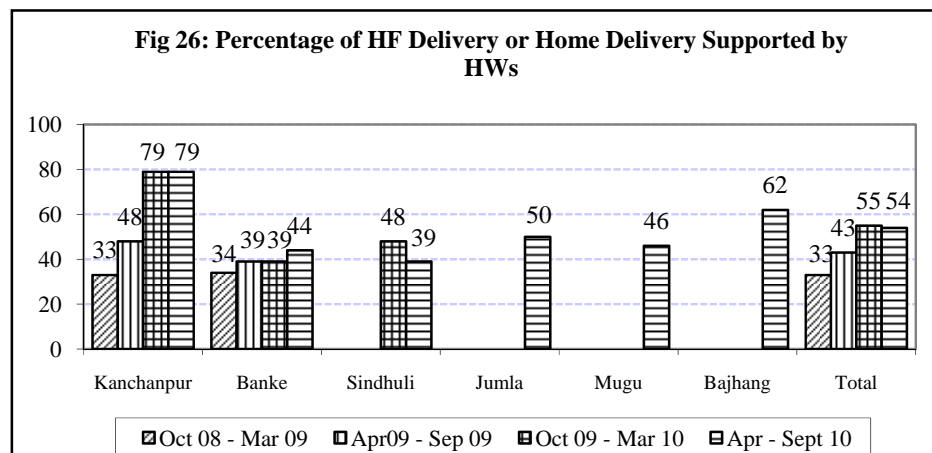
Coverage of Post-partum Iron among PW:

Among forms closed, overall, 94% of PW received post-partum iron in the SA period Apr-Sept 2010 which is almost consistent with the previous period. Percentage of PW receiving post-partum iron in Kanchanpur and Jumla has slightly increased in SA period (Apr-Sept 10) than the previous, where as slightly decreased in the Banke district.



Health Facility Delivery or home delivery supported by HWs:

Among the forms closed, overall in 6 MNH program districts 54% of PW delivered at a health facility or at home with support of a health worker during the last SA period (April-September 2010), and this remains almost constant when compared with the previous period (Figure 26). Kanchanpur has highest figure followed by Bajhang.



Sindhuli witnessed decline in institutional/HW deliveries while Kanchanpur has constant and Banke has gained. In order to reduce maternal mortality, institutional deliveries or deliveries assisted by a health worker have to be increased which still remains a big challenge in these districts.

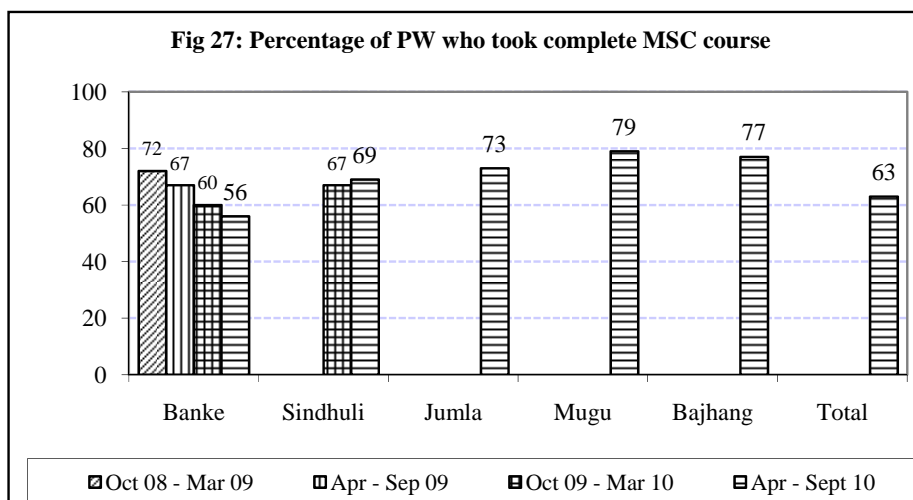
Coverage of MSC:

MSC distribution as part of MNH program is also in place in order to save women's lives after delivery caused largely by postpartum hemorrhage (PPH). Out of 9 MNH program districts, MSC has been introduced in 8 districts. Because of the incomplete data of Dailekh, Kalikot and Rolpa, their data is not presented. Moreover, MSC is in place in the districts in different time periods therefore some of the districts have data for 4 SA periods (Banke) whereas some has only for two SA periods (Sindhuli) and some have for only one SA period.

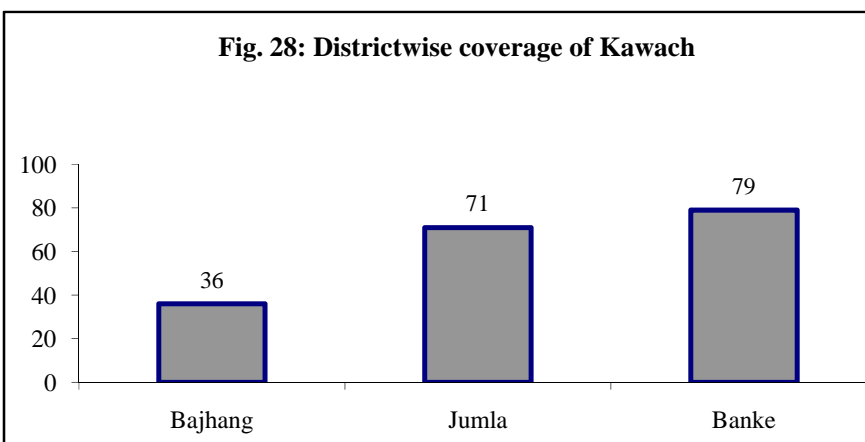
RDW completing MSC course:

During SA period April-September 2010, 7,977 MNH forms were closed in the 5 districts of which 7,066 (89%) RDW received MSC. Of those who received more than 6 in 10 (63%) (4,478) PW took complete course of MSC. Trend data for four SA periods of Banke is discouraging as there has been decline in percentage of women taking complete course of MSC. The decline is by 16% points in the last SA period from that of first SA period of comparison

(Figure 27). Women who delivered at home without assistance of a health worker but took 3 MSC tablets are considered protected from PPH.

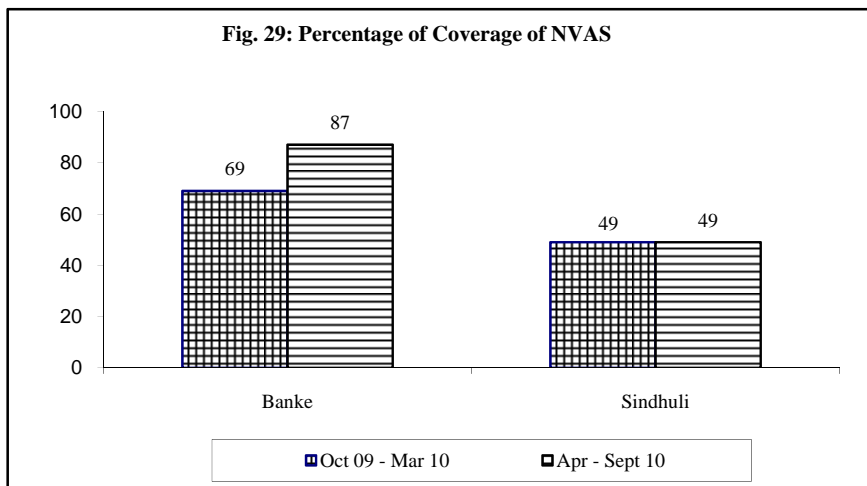


Coverage of Kawach: Kawach (Chlorhexidine) was first piloted in Banke in FY 2066/67, and further expanded in Jumla, Rolpa, Dailekh and Bajhang. Most recent data is presented for the SA period April-September 2010 after which complete data is unavailable. Even for this SA period monitoring data is lacking for Rolpa and Dailekh hence their data is not presented here. Coverage of Kawach is calculated among the expected live births of the districts. Of the 3 districts Banke has the highest coverage (79%) followed by Jumla (71%) and Bajhang (36%). Figure 21. It should be noted that in addition to application of Kawach at home births, coverage also includes application of Kawach to those newborns that were born in the hospitals of the districts but excludes hospital births of other districts.



9.0 Newborn Vitamin A Supplementation (NVAS)

NVAS was piloted in the FY 2066/67 as a component of MNH activities at community level. There are two program models being currently tested for supplementing children with newborn vitamin A (50,000 IU). The FCHV Model was piloted in Banke where FCHV herself dose to the newborns making household visit immediately after the birth of the baby. The Mother/caretaker model is being tested in Sindhuli. In this model mothers/caretakers during their pregnancy (8 months) receive Vitamin A either from a FCHV or from a health worker/HF. The mother herself or the family member has to supplement their newborn (within 48 hours) after birth .



Coverage data for the two districts has been given in Figure 29 for two SA periods: October 2009 to March 2010 and April to September 2010. Of the total expected live births in the district nearly 9/10 in Banke and ½ in Sindhuli were supplemented with newborn Vitamin A within 48 hours of birth (Figure 29). Note that the coverage during the periods of comparison remains unchanged in Sindhuli while it has increased considerably in Banke (from 69% to 87%).

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Combined data for the two SA periods (October 2009 to March 2010 and April to September, 2010) on the mode of newborn vitamin A supplementation has been presented below. The reach of the two models seems almost same as nearly half of the babies received from the models being tested in the district, although a slightly higher proportion of newborns received Vitamin A from mothers/caretakers in Sindhuli (53%) than that from FCHVs in Banke (49%) (Figures 30 and 31). Therefore, more period of observation may be required to reach any definite conclusion on defining the most appropriate model to scale up.

