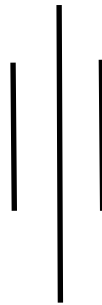


# Monitoring Report

July 2008-June 2009 and July 2009-June 2010



**Nepal Family Health Program II**  
**Monitoring and Evaluation Team**

**September, 2010**



NFHP II

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# Analysis of Monitoring Data

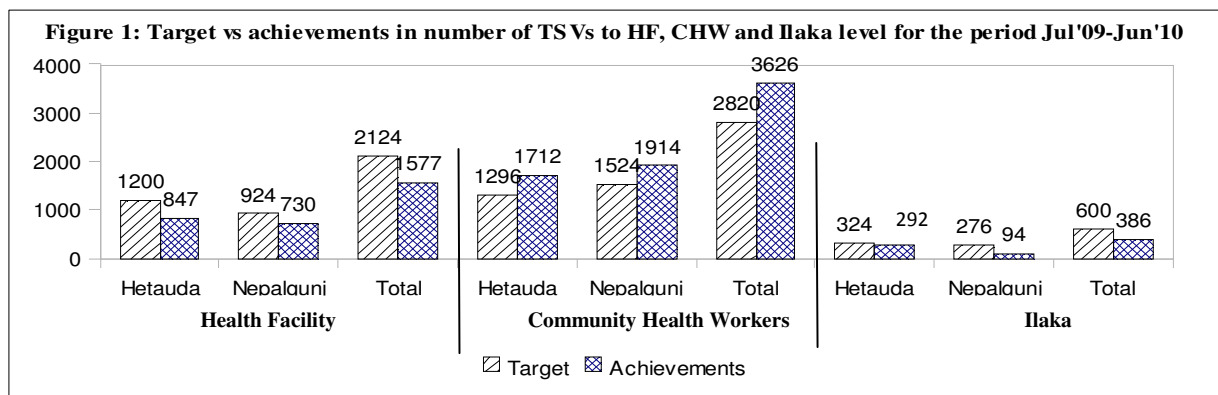
## 1.0 Background

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 one in order to monitor 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. 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 MIS.

This report includes analysis of TSV data collected on monthly basis from the NFHP-II districts for two periods: July 2008 to June 2009 (first year) and July 2009 to June 2010 (second year). This is a comparative report of the 20 Core Program Districts (CPDs) that fall under the two NFHP II Regional Field Offices; Hetauda and Nepalgunj. Therefore, the trend in data has been compared between Hetauda and Nepalgunj FO. Total achievements for all NFHP II districts have also been provided. In addition to integrated TSV data, this report also includes analysis of monitoring data of special projects such as Community-Based Maternal and Neonatal Health (CB-MNH) including Chlorhexidine (Kawach) and Neonatal Vitamin A Supplementation (NVAS), Health Facility Management Strengthening Program (HFMSP) and Literacy/Life skills (LLS).

**TSV Target Vs Achievements:** Figure 1 presents the target vs achievement on TSVs to HFs, Community Health Workers (CHWs) and Ilaka meetings disaggregated by the two field offices during the period Jul'09-Jun'10 i. e. for one year. Overall, in the CPDs of NFHP II, TSVs to CHWs has been higher than that targeted but the TSVs to HFs and Ilaka meetings is lower than that targeted. TSVs to Ilaka meetings are much lower than the targets, particularly in Nepalgunj. The achievements are satisfactory but the field office should try to make balance in the frequency of TSVs provided at different levels.

The focus of NFHP II's TSVs is to provide a quality and supportive TSVs to the HFs, CHWs and to the Ilaka meetings rather than increasing the frequency. Therefore, in the future NFHP should continuously try to provide facilitative TSVs at all levels and at the same time also review the targets.



The key findings of the integrated TSV data analysis are presented in the following table.

**Table 1: Key findings of the integrated TSV data**

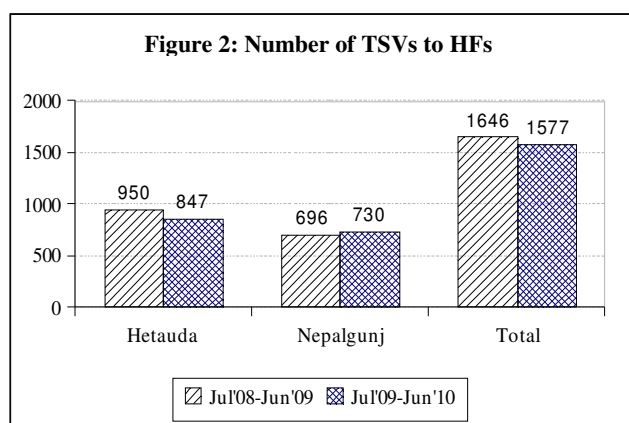
Key Indicators	Hetauda		Nepalgunj		Total	
	July2008- June2009	July2009- June2010	July2008- June2009	July2009- June2010	July2008- June2009	July2009- June2010
Number of TSVs to HFs	950	847	696	730	1646	1577
Number of Ilaka Meetings Attended	240	292	81	94	321	386
Number of TSVs to CHWs	1,474	1,712	1,460	1,914	2934	3626
<b>Family Planning/Maternal Health</b>						
Percentage of pregnant women with swelling examined among the observed ANC cases	82	93	86	90	84	92
Percentage of pregnant women who received TT during ANC or who were confirmed by health workers that they received it in the past	86	95	85	97	86	96
Pregnant women who were advised for delivery at a HF or by a SBA	47	70	63	80	55	75
Percentage of pregnancy ruled out before giving contraceptives among observed cases	50	80	70	50	59	66
Percentage of new FP clients helped for voluntary decision making	74	92	82	85	79	88
Percentage of FP clients asked about side effects of FP methods being used	62	77	62	86	62	81
Percentage of FCHVs who referred pregnant women to HF for delivery services	52	59	57	57	55	58
Percentage of FCHVs who talked to PP mothers about FP	71	76	75	79	73	78
Percentage of FCHVs who discussed preparedness with pregnant women	85	87	70	87	77	87
<b>Child Health</b>						
Percentage of pneumonia cases treated correctly among the observed OPD case	67	68	74	77	70	73
Percentage of cases marking consistent age dose and 3 <sup>rd</sup> day follow up	96	97	93	94	94	96
Percentage of FCHVs with knowledge of three or four home rules of diarrhea	73	82	62	75	67	78
FCHVs knowledge of Zinc dose for 6-60 months child	90	91	76	93	81	92
<b>Infection Prevention</b>						
Percentage of health facilities with clean environment	51	74	60	81	55	77
Percentage of health facilities that used sterilized equipments	15	28	20	50	17	38
<b>Logistics/Supplies</b>						
Percentage of health facility with all 3 (pills, injectable, and condom) contraceptives	92	96	89	94	90	95
Percentage of health facility with all 4 (iron, ORS packet, cotrim, vitamin A) commodities	83	89	86	88	84	89

Key Indicators	Hetauda		Nepalgunj		Total	
	July2008- June2009	July2009- June2010	July2008- June2009	July2009- June2010	July2008- June2009	July2009- June2010
Percentage of health facilities with Informed Choice (IC) poster displayed in a visible place	65	96	53	96	60	96
Percentage of FCHVs having functioning timer	84	88	85	92	84	90
APercentage of FCHVs having of 3/4/5 key commodities (ORS, condom, pills, cotrim , iron)	38	57	42	58	40	57
<b>System</b>						
Percentage of health facility that held staff meeting in the last month	55	55	25	31	42	43
Percentage of ilaka level meetings that discussed on data quality	90	94	91	87	90	92
Percentage of ilaka level meetings that had updated Monthly Monitoring Worksheet	35	42	40	41	36	42
Percentage of health facilities where MMW was reviewed in ilaka level meeting	27	35	30	32	28	33
Percentage of PHC/HP that were supervised by DPHO during last three months	67	76	63	64	64	70
Percentage of FCHVs who reported the conduct and participation in trimester meeting	97	99	98	99	97	99
Percentage of FCHVs who used FCHV fund or received cash/kind support from community	79	94	56	65	66	77

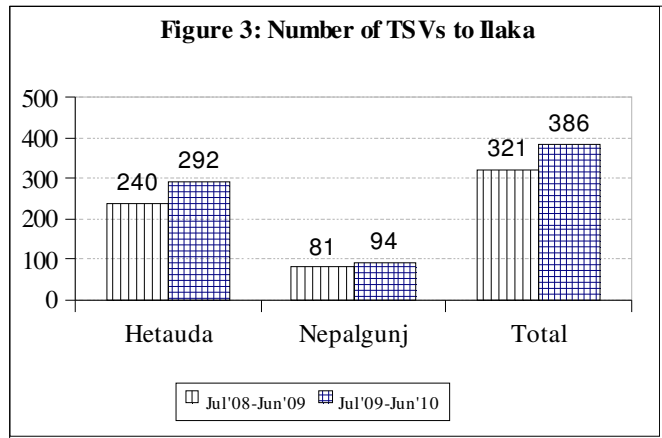
The narratives for the above table are presented in the following sections.

### TSVs to HFs, Ilaka meetings and CHWs:

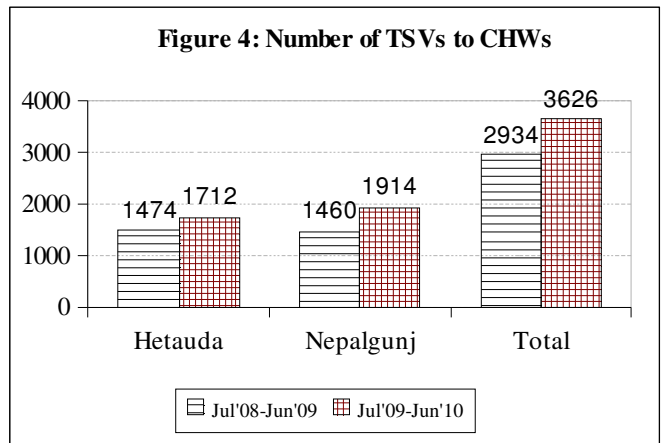
Figures 2, 3, and 4 displays the number of TSVs conducted to HFs, Ilaka meetings and CHWs, respectively during the two year periods disaggregated by Hetauda and Nepalgunj Field Offices. Overall, TSVs to Ilaka meetings and CHWs have increased in both the field offices in the 2nd year compared to the first year but TSVs to HFs have increased only in the CPDs of Nepalgunj but not in the CPDs of Hetauda during the second year. In Nepalgunj, the total number of TSVs to the HFs has increased by 5% (from 696 to 730) during the two years period whereas in Hetauda the total TSVs to the HFs have decreased by 11% (from 950 to 847). Overall, in the 2nd year, TSVs to HFs decreased by 4% than in the first year (from 1,646 to 1,577).



Every month all the Sub Health Post (SHP) In charges under an Ilaka should meet at their respective Ilaka to discuss on the Health Management Information System (HMIS) reports and submit it. Participating in these meetings has been one of the important parts of regular monitoring. In the CPDs of Hetauda field office there are 134 Ilakas and in the CPDs of Nepalgunj FO, there are 113 Ilakas. The number of TSVs conducted at Ilaka meetings is shown in Figure 3. It is seen that TSVs to Ilaka meetings has increased. In Hetauda it increased from 240 to 292 and in Nepalgunj it increased from 81 to 94 over the two years period. Overall, there was 20% increase (from 321 to 386) in TSVs to Ilakas.



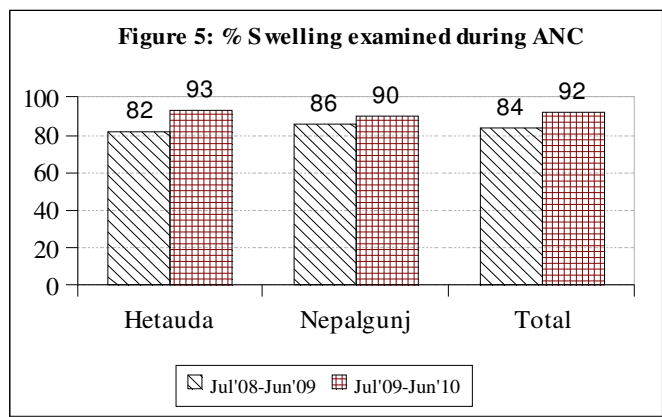
Assessing the knowledge and skills of CHWs on child health, family planning, maternal and newborn health is important to ensure the delivery of FP/MNCH services at household level. Therefore, providing TSV to these cadres is an important task for NFHP II. It is very encouraging to note that the overall TSVs to CHW level have increased remarkably (24%). Between the two field offices, the percentage increase is greater in the Nepalgunj field office (31%) than in Hetauda field office (16%). See Figure 4. In Nepalgunj, a total of 1,914 CHWs were provided TSVs in the 2nd year while it was 1,712 in Hetauda.



## 2.0 Programs:

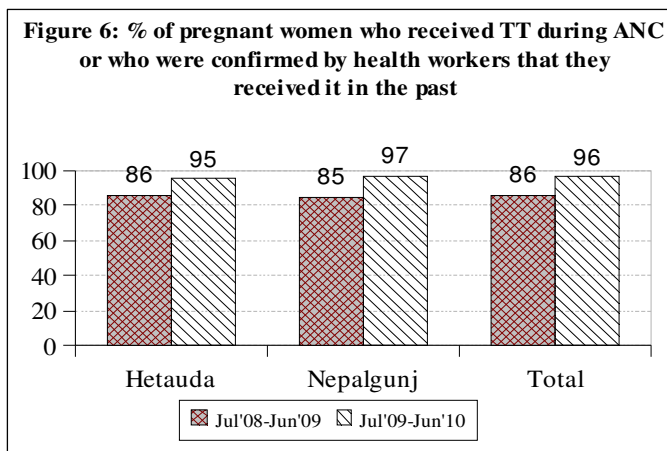
### 2.1 Maternal Health

**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. Monitoring data shows that the proportion of pregnant women who got health workers to

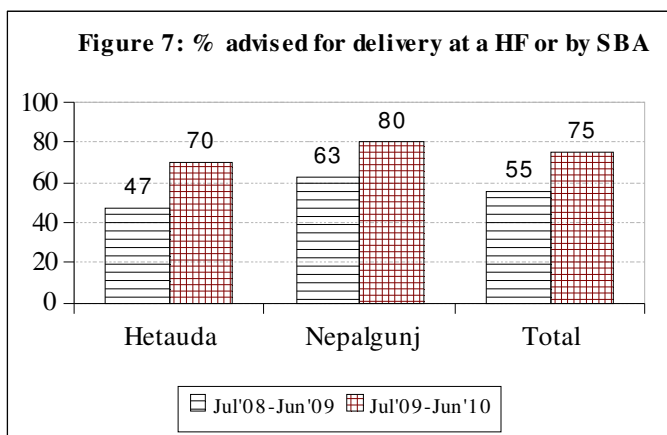


examine the presence or absence of swelling has increased slightly in both the offices during the two years period. In Hetauda, it increased from 82% to 93% and in Nepalgunj it increased from 86% to 90% over the two years period, with overall increase being 8% points. Refer to Figure 5.

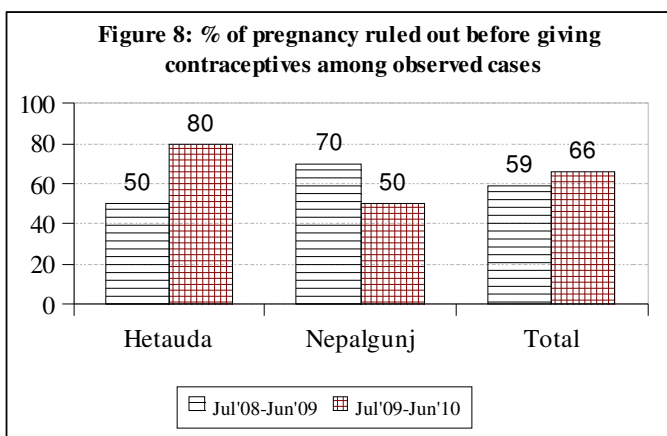
**Tetanus Toxoid (TT) provided during ANC:** Figure 6 shows that the proportion of pregnant women who received TT vaccine or were confirmed that they had received TT was high in both the offices during the comparison periods. The graph also shows that during the period July 2009-June 2010, a greater number of pregnant women received TT or were confirmed that they had received TT vaccine than in the previous period in both the field offices. Overall, in the first year 86% of the pregnant women got TT or were confirmed that they had received it, which increased to 96% in the second year. Though the current achievement is encouraging, NFHP II needs to put efforts to maintain it in the future.



**Advised for delivery at a HF or by a SBA:** ANC service provider should advise pregnant women to deliver in a HF or seek assistance of a SBA. Monitoring data shows that in the period July 2009 to June 2010, the proportion of pregnant women who were advised by the ANC service provider to go to the health facility or to a SBA for delivery increased in both the field offices which is very encouraging. Overall, the proportion of pregnant women advised for delivery at a HF or by a SBA increased from 55% and 75%. See Figure 7. In Hetauda, it increased from 47% to 70% and in Nepalgunj, it increased from 63% to 80. Health workers should continuously encourage women to use the delivery services from a health institution or from a SBA.

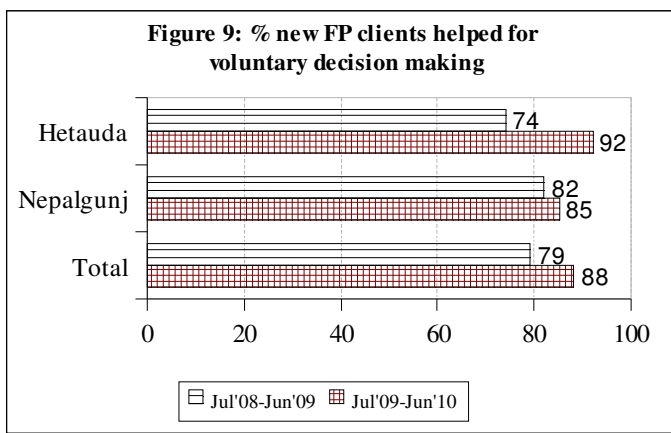


**Ruling out pregnancy before giving contraceptives:** Confirming whether a woman is pregnant or not before giving

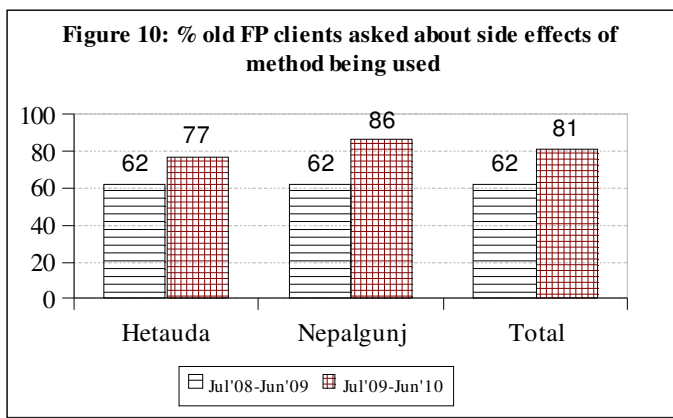


contraceptives is essential in family planning. Overall, among all the observed cases of FP, the proportion of pregnant women ruled out before giving contraceptives increased from 59% to 66%. Refer to Figure 8. Although the pregnancy ruled out has increased, the increase has been noted in Hetauda (from 50% to 80%) while it has decreased in Nepalgunj (70% to 50%).

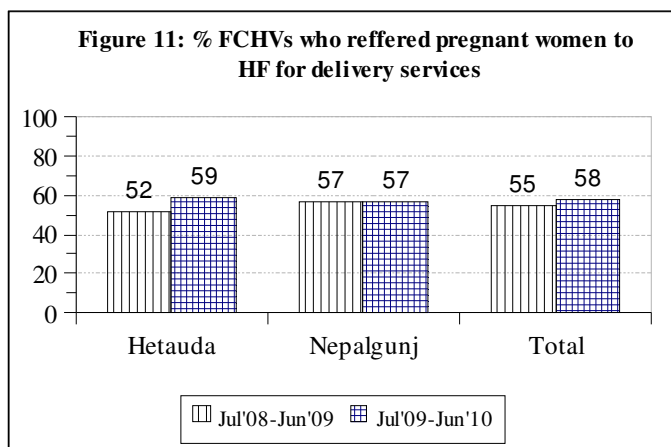
**Voluntary decision making in contraceptive use:** As a part of quality control NFHP II also monitors the quality of counseling services provided to the FP clients. The monitoring data shows (Figure 9) that there is a remarkable increase in helping clients to make decision about FP in Hetauda over the two years period. The first year figure shows that in Hetauda during July 2008-June 2009 about three-quarters (74%) of the clients coming to the HF for FP were helped by the service provider in voluntary decision making which increased to 92% over the next period (July 2009-June 2010). However, in Nepalgunj, the proportion of clients who were helped by service providers in decision making is almost constant over the two years period.



**FP clients asked about side effects of FP methods being used:** With respect to asking the FP users by the service providers about the side effects they have had, TSV data shows that there have been remarkable improvements as it increased from 62% to 81%. Nepalgunj made more progress than Hetauda over the two year period. In year one the proportion of clients who were asked about the side effects was 62% in both the field offices which increased to 86% in Nepalgunj, and 77% in Hetauda in year two. Refer to Figure 10.



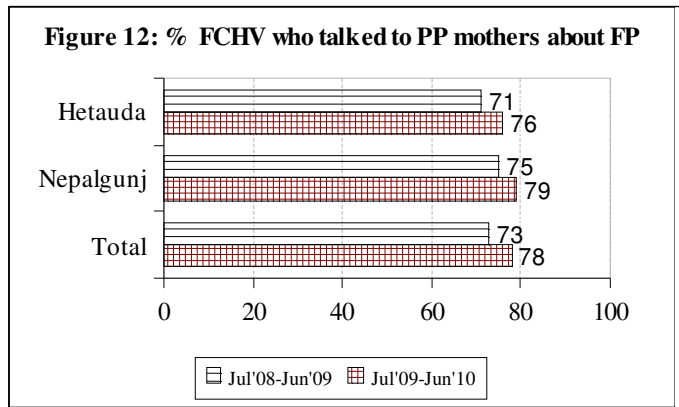
**FCHV referred pregnant women to HF for delivery services:** NFHP II has been encouraging FCHVs to promote HF delivery. Figure 11 displays that in both the field offices the percent of FCHVs who referred pregnant women to HF for delivery is almost half and have stayed almost constant over the two years period indicating a need to advise FCHVs to refer



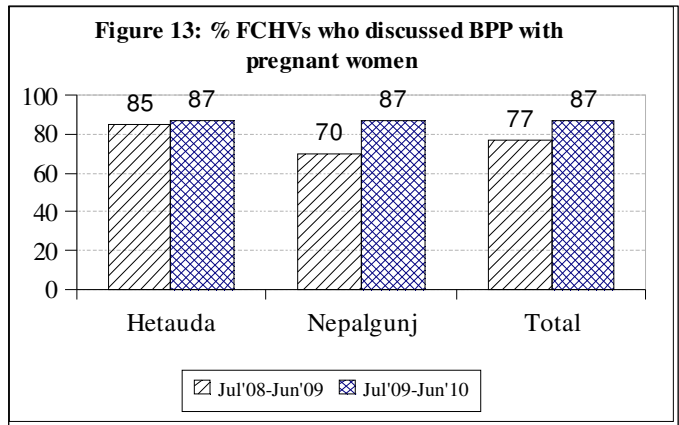


pregnant women to go to HFs for delivery. Therefore, NFHP II staff should put more efforts that FCHVs advise women to HF for delivery during forums like review meeting and TSVs.

**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. In both the field offices there has been slight increase (4% to 5%) in the proportion of FCHVs who talked about FP with PP mothers over the two years period. In the first year, 71% and 75% of the FCHVs in Hetauda and Nepalgunj claimed that they talked to PP mothers about FP which increased to 76% and 79% respectively in the second year.

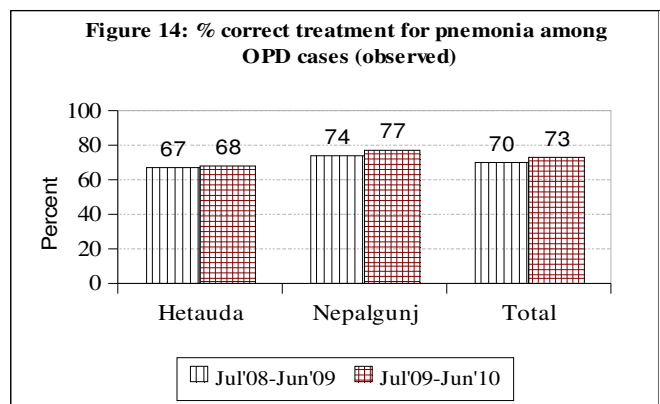


**FCHV discussed birthpreparedness with pregnant women:** Preparing for birth during pregnancy is very important for the healthy delivery of a baby and good health of the mother. Overall, the proportion of FCHVs who discussed BPP with pregnant women increased from 77% to 87%. The percent of FCHVs who discussed birth preparedness with pregnant women has remained almost constant in the CPDs of Hetauda during the two years period while in the CPDs of Nepalgunj it has increased considerably over the same time period (from 70% to 87%). Figure 13. The current trend is satisfactory but NFHP II staff needs to ensure that the achievement is maintained in the future.



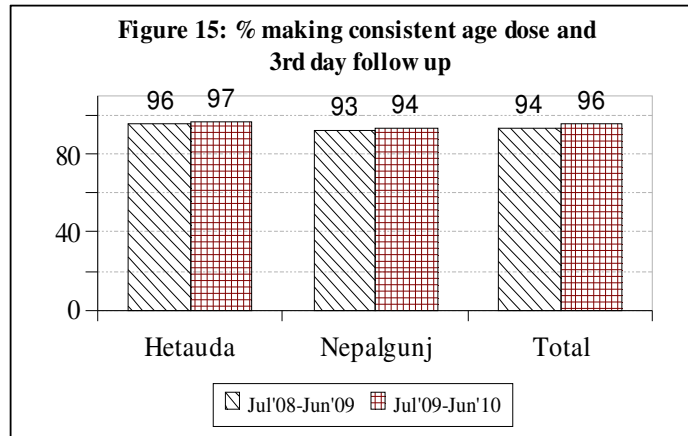
## 2.2 Child Health

**Correct treatment of pneumonia among the observed OPD cases:** During every TSV to HF, NFHP II staffs try to observe the assessment, classification and treatment of one pneumonia case by the service provider. A total of 347 and 244 cases were observed in Hetauda and Nepalgunj respectively in the second year which is slightly more than that

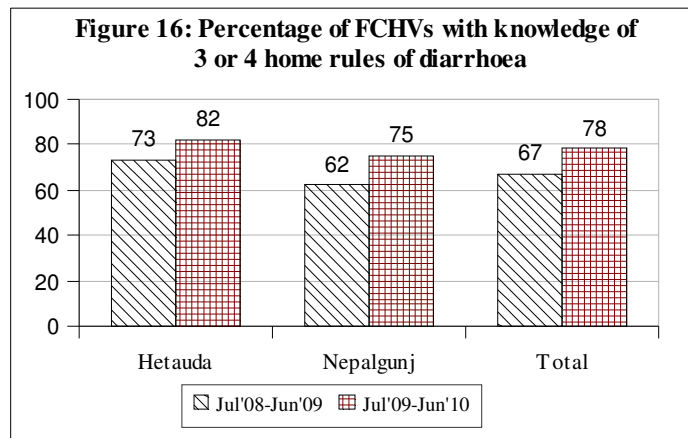


observed in Hetauda (343) and remarkably more than that observed in Nepalgunj (207) in the first year. Figure 14 presents the proportion of pneumonia cases from OPD that were treated correctly by the health workers, which is almost constant in both the field offices over the two years period. It is concerning that in Hetauda about one thirds of the pneumonia cases and in Nepalgunj a quarter of the pneumonia cases observed were not treated correctly. These findings suggest that the program need to focus on the ways to improve correct treatment of the pneumonia cases. Using IMCI classification card during assessment of cases is important, which should be encouraged.

**Consistent age dose and 3<sup>rd</sup> day follow up:** NFHP II also reviews the 10 most recent cases of ARI from the treatment book of every CHW interviewed. Monitoring 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 years period in both the field offices. This results is very encouraging and there is a need to continue follow up of the activity. See Figure 15.

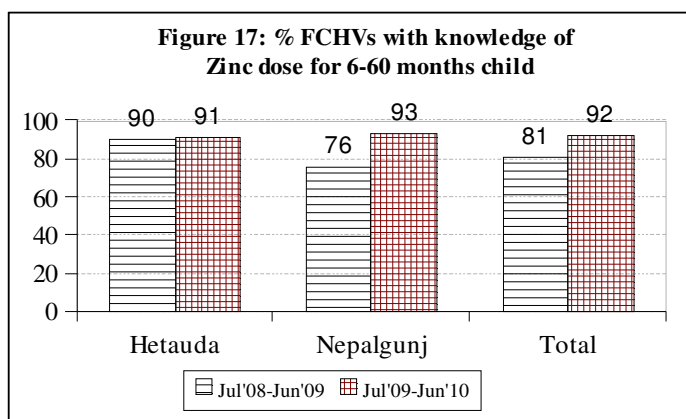


**FCHVs knowledge of three or four home rules of diarrhea:** Diarrhea is one of the common problems among children. FCHVs contribution to prevent diarrhea is noteworthy. FCHVs should have knowledge of the following home rules for treating diarrhoea: continue feeding, giving plenty of liquids, giving Zinc tablets, and signs for referral (frequent diarrhea, frequent vomiting, and, too thirsty, uninterested to eat, fever and blood in stool). Among the FCHVs interviewed during the period Jul'08-Jun'09, the knowledge of 3 or 4 home rules of diarrrahea was prevalent among 73% and 62% of the FCHVs in Hetauda and Nepalgunj respectively which increased to 82% and 75% of the FCHVs in respective field offices during year 2. Overall, it is in increasing trend and reached above 78% in the later year. Figure16.



### FCHVs knowledge of Zinc dose for 6-60 months child:

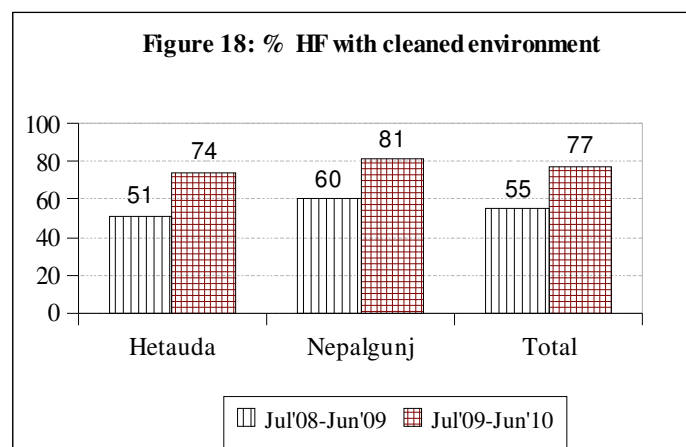
Figure 17 displays the knowledge of Zinc dose for 6-60 months child among the interviewed FCHVs. Above 90% of the FCHVs in the 2nd year in the both field offices had knowledge of zinc dose for 6-60 months child, which is a noticeable increment from the previous year particularly in Nepalgunj. However, in Hetauda, it has remained almost constant over the two years period.



## 3.0 Infection Prevention:

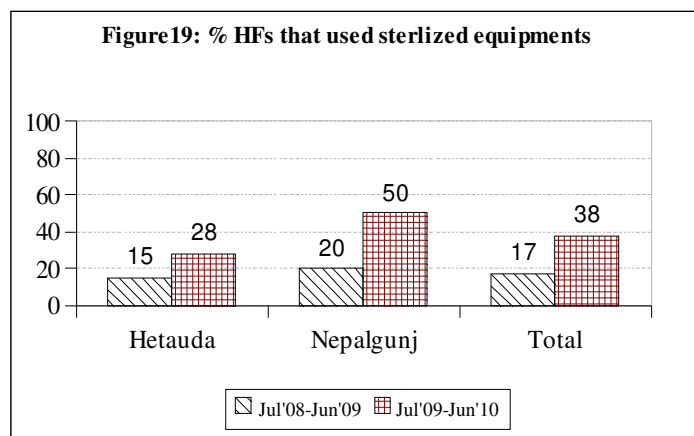
### Health Facilities with clean environment: NFHP II also monitors infection prevention (IP) activities at

health facilities. One of the activities under IP is that NFHP II staff observes the cleanliness inside the health facility and its premises. Overall, about half of the HFs maintained clean environment in the first year which increased to three-quarters in the second year. Refer to Figure 18. In Hetauda nearly three-quarters (74%) of the HFs that were visited had clean environment during the period July 2009-June 2010, which is a remarkable increase from 51% reported during the period July 2008-June 2009. In Nepalgunj, four-fifths (81%) of the health facilities had clean environment during the period July 2009-June 2010 while in July 2008-June 2009 only three-fifths (60%) had clean environment.



### Health Facilities that used sterilized equipments:

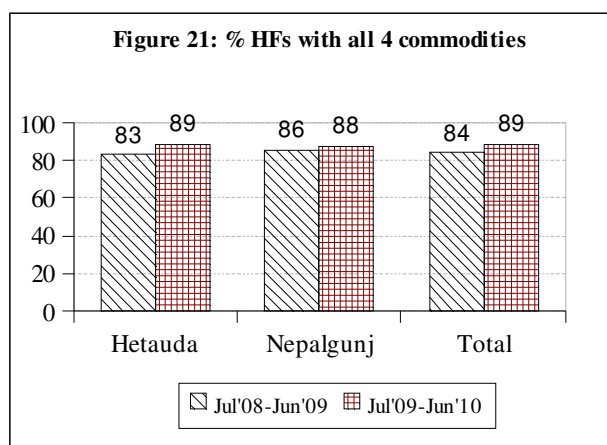
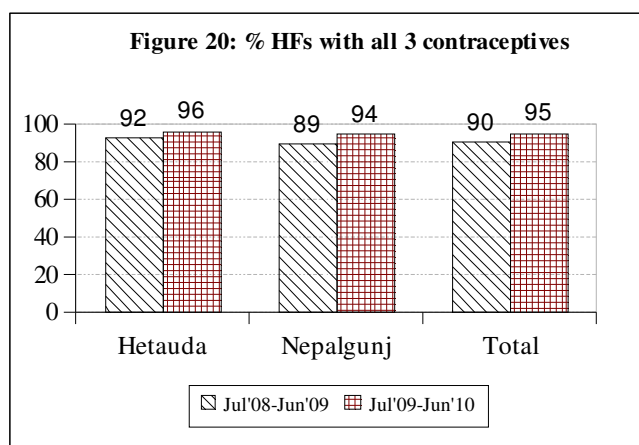
Another area which NFHP II monitors for infection prevention is the use of sterilized instruments in the health facilities. Overall, use of sterilized equipments has improved considerably- from 17% to 38%. Comparatively the improvement is much higher in Nepalgunj than in Hetauda. See Figure 19. In Nepalgunj, the percentage of health



facilities that used sterilized equipments increased from one-fifth to one-half where as in Hetauda, it increased from 15% to 28% during the period of comparison. Despite improvements, the current achievements are not satisfactory. Therefore, there is need to focus on this indicator because every HF's need to use sterilized equipments for preventing infection.

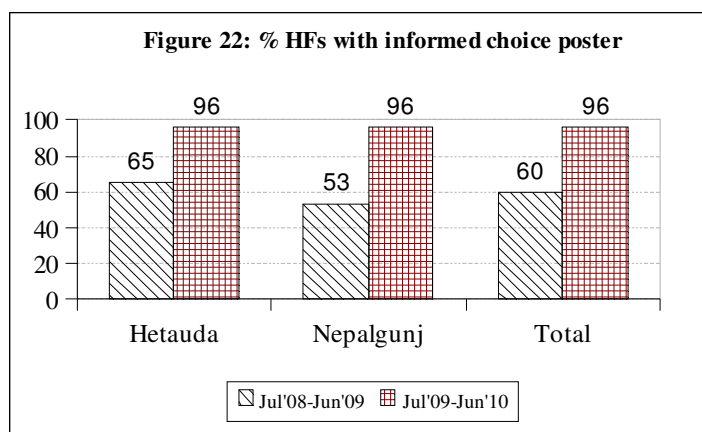
#### 4.0 Supplies/Logistics:

**Key Commodities at Health facility:** It is important that all the health facilities have a stock of three contraceptives: oral pills, injectable and condom and four other commodities: iron, vitamin A, cotrim and ORS throughout the year. In both the field offices, availability of all three contraceptives was more common than the availability of all four commodities. Data shows that about 95% of the HF's in both the field offices had all three contraceptives in the 2nd year which was slightly less (90%) in the first year. With respect to the availability of all four commodities there is some improvement in Hetauda field office but not in Nepalgunj field office. Unlike LMIS data which monitors year round availability of the commodities, the TSV data only provides commodities availability at a point in time. See Figures 20 and 21.



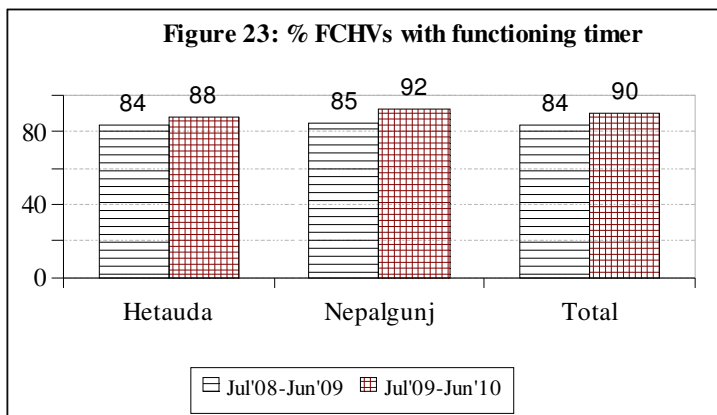
#### Availability of Informed Choice poster:

NFHP-II has been monitoring the display of Informed Choice (IC) poster in a visible place at health facility level, which is also in compliance with the Tiahrt amendment. A very remarkable increase in the proportion of health facilities displaying IC poster in a visible place has been observed in both the field offices during the period of comparison. In Hetauda in the first year, two-thirds of the HF's (65%) had displayed IC poster in a visible place and in Nepalgunj only half of the

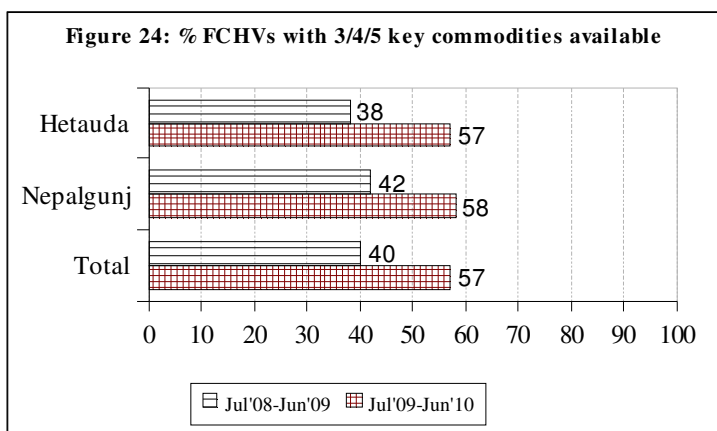


health facilities (53%) had done so. In the following year, 96% of the HF's in both the field offices displayed IC poster in a visible place. See Figure 22. Monitoring the display of IC poster should be continuously focused.

**Availability of functioning timer with FCHVs:** Fig. 23 shows that among the interviewed FCHVs, around 90% have functioning timer in both the field offices in the second year, which is a slight improvement from the first year. Though the achievements are high, NFHP II need to focus on monitoring it because without a functioning time FCHVs cannot identify pneumonia cases.

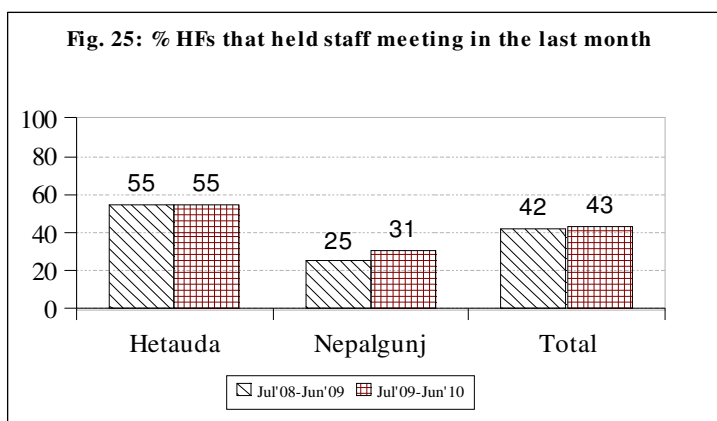


**Availability of 3/4/5 key commodities with FCHVs:** The availability of 3/4/5 commodities (ORS, oral pills, vitamin A, cotrim, and iron) is also monitored during TSVs. Though the percent availability of 3/4/5 key commodities with FCHVs has increased in the second year than in the first year, Fig. 24 show that the availability is still not satisfactory (57%). Therefore, ensuring the mechanism to re-supply the key commodities to FCHVs should be a part of regular monitoring for NFHP II staffs.



## 5.0 Systems

**Health Facility Staff Meeting:** Staff meeting is an important aspect of performance monitoring as it reflects a strengthened system. The monitoring data shows that there is much difference in the proportion of health facilities that organized staff meeting in the previous months between Hetauda and Nepalgunj. See Figure 25. In Nepalgunj



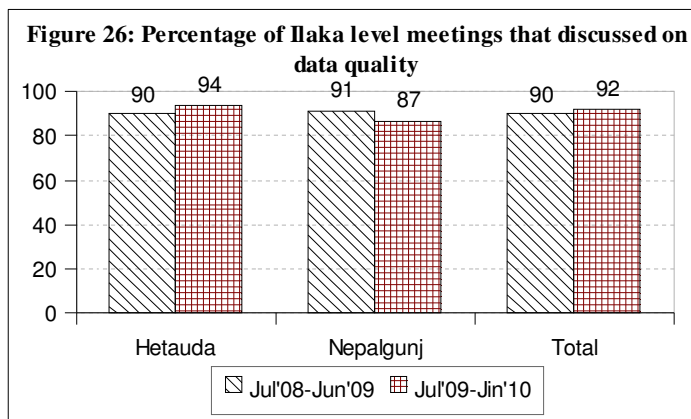
fewer HFs organized staff meeting than in Hetauda during both the periods. In Hetauda, though higher proportions of the HFs organized staff meetings, the achievements stayed constant (55%) over the comparison period whereas in Nepalgunj slight increment (from 25% to 31%) was noted. This indicates that the practice of organizing staff meeting in HFs in not very common in the CPDs. Therefore, regularizing monthly staff meeting at HFs needs to be focused more in the future.

**Discussed on data quality during ilaka level meeting:** NFHP II supports ilaka level meeting by directly participating in it and also encouraging

district supervisors to have their active participation. Every month all the SHP in charges of an ilaka meet in the ilaka health facility to discuss on and submit the monthly report. Participating in ilaka level meetings has also been one of the important activities of NFHP II. Overall, more than 90% of the health facilities interviewed mentioned that data quality was discussed which is very encouraging.

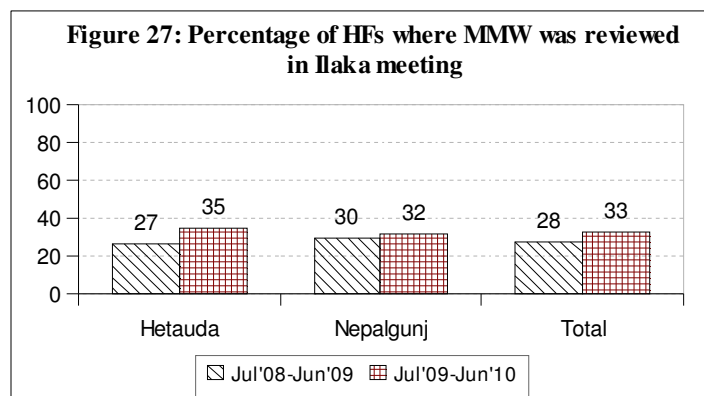
Between the two field offices, the trend in

ilaka meetings where discussion on data quality was held is better in Hetauda than in Nepalgunj. In Hetauda the percentage of ilaka meeting where data quality was discussed increased from 90% to 94% over the two years period whereas in Nepalgunj, it decreased from 91% to 87% over the same period (Figure 26). Hence, NFHP II staff should ensure that the practice of discussing on data quality should not be neglected.



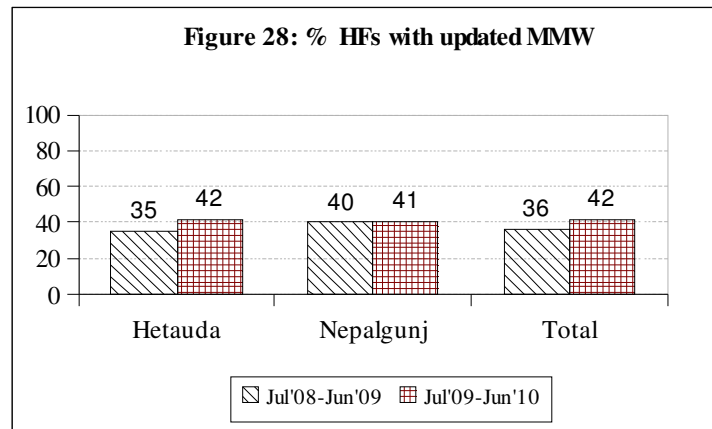
**HFs where MMW reviewed in Ilaka level meeting:** Another aspect of Ilaka meeting which NFHP II

focus during TSVs is that the participating HFs reviews the monthly monitoring sheet (MMW). Figure 27 shows that the practice of reviewing MMW during Ilaka level review meetings is not satisfactory as only one-third of the health facilities staff reported review of MMW. During first year, 27% of the HFs in Hetauda and 30% of the HFs in Nepalgunj reviewed MMWs which went up to about 35% and 32% in year two. Therefore, there is a need to focus on reviewing MMW at Ilaka level meetings.

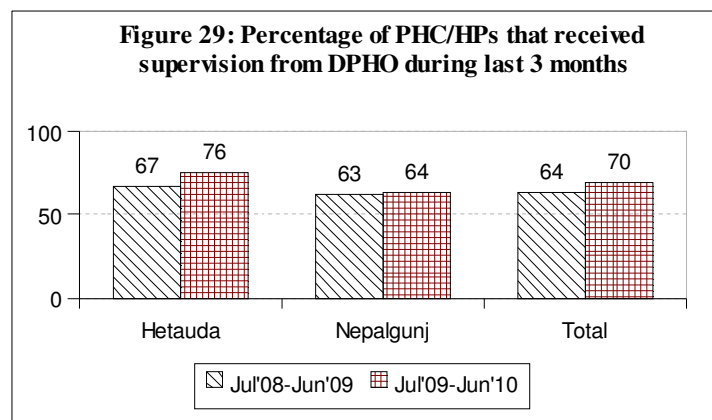




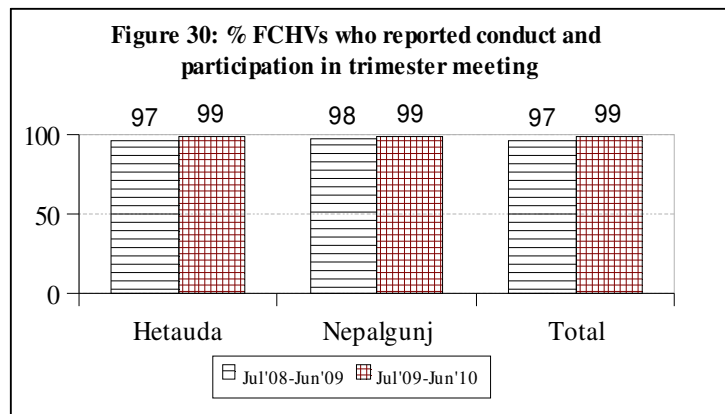
**Updated Monthly MMW:** Comparative data on updating MMW indicates there has been some improvement, from 36% in year one to 42% in year two. Figure 28. Between the two field offices, the achievements for the indicator are similar and low during both the periods. In Hetauda, updated MMW increased from 35% to 42% while no visible change occurred in Nepalgunj field office. Data shows that over the last two years there have been only slight increase in the practice of reviewing MMW in NFHP-II districts, therefore, more efforts need to be done to set the practice of updating MMW.



**PHC/HPs that were supervised by DPHO during last 3 months:** Figure 29 displays the status of supervision from district to the ilakas. An improvement has been noted for this indicator as it went up to 70% in the 2<sup>nd</sup> year from the previous level of 64%. It is seen that 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.

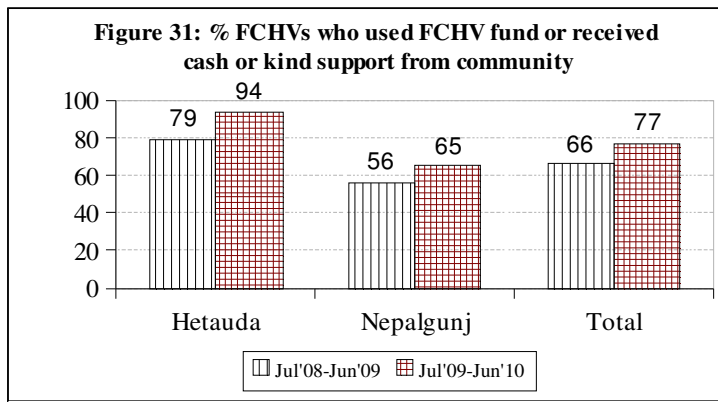


**FCHVs trimester meeting:** NFHP II has been ensuring the conduct of FCHVs trimester meeting as a part of regular monitoring. Figure 30 shows that the percent of FCHVs who reported the conduct and participation in the trimester meeting in both the field offices is nearly universal in both the years, and which has been maintained very well. This shows that the FCHVs are more aware about trimester meeting.



**Support to FCHVs from Community:**

As Figure 31 displays, FCHV fund utilization or community support to FCHVs has improved by 11 percent points under the NFHP II CPDs (66% to 77%). Between the two field offices, this indicator is remarkably higher in Hetauda than in Nepalgunj. In Hetauda 79% of the FCHVs in year one reported that they had received such supports which increased to 94% in year two. The corresponding figures for Nepalgunj are 56% and 65%. Therefore, NFHP II staff in the CPDs of Nepalgunj field office needs to focus on this activity and create awareness among community people to get better result on this activity.

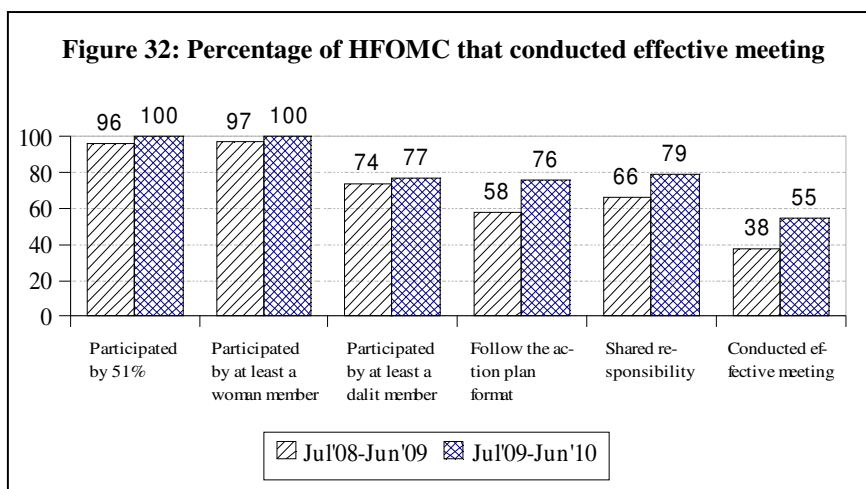


**6.0 Health Facility Management Strengthening Program (HFMSp)**

This program was implemented in 55 selected VDCs of four districts: Banke, Dang, Kanchanpur and Surkhet and NFHP II had a good monitoring system in place to monitor and evaluate the program performance. Though there is no intensive program to strengthen HFMOc in the remaining 16 CPDs, NFHP II has been monitoring the conduct of HFMOc meeting in these districts. The following data has been derived from the HFMSp program areas only.

During the period July 2008 to June 2009, TSVs to 371 HFMOcs were provided which increased to 497 during the period July 2009 to June 2010. Interestingly, in both the periods 86% of the visited HFMOc were found to have conducted monthly meetings.

**HFMOc meeting:** Figure 32 displays the different aspects of HFMOc meetings. In the 2nd year the proportion of HFMOcs that conducted effective meeting increased to 55% from 38% reported in the first year. Effective meeting in HFMSp should be understood as meeting that is participated by 51% of the total members including at



least a dalit and a woman member, action plan developed and responsibility shared among the members. Though, there has been increase in the practice of conducting effective meeting, the current achievement



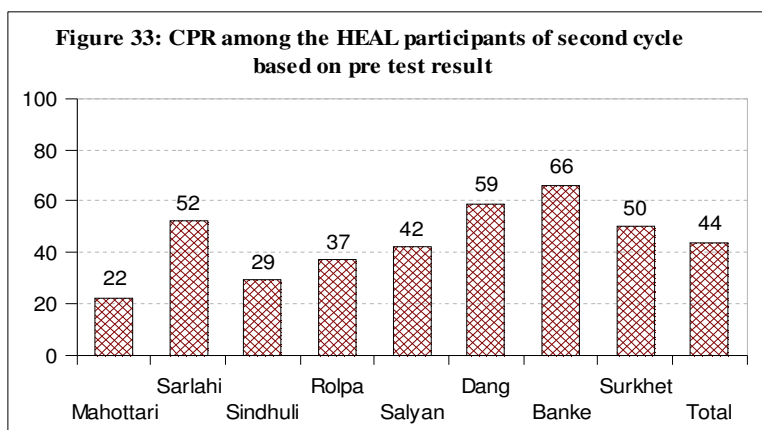
cannot be considered satisfactory. Therefore, NFHP II staff should monitor the conduct of effective meeting on a regular basis.

Figure 32 also displays that among all the aspects of a HFOMC meeting, participation by 51% of the members and participation by at least one woman is maintained over the two periods which reached 100% in the second year. This is an encouraging result; however, there are other aspects of the meeting which need to be focused too. The data therefore indicates that the program efforts should now be on increasing participation of dalit members; follow up of action plan and sharing of responsibilities in the meeting.

## 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 cycles (LC).

**HEAL:** HEAL program is being implemented in eight districts: Mahottari, Sarlahi, Sindhuli, Rolpa, Salyan, Dang, Banke and Surkhet, with a total of 4,173 enrollees in **2nd cycle** of HEAL classes. As per the M&E plan a pretest was conducted among these participants which showed that the overall contraceptive prevalence rate (CPR) for any methods among the 2nd cycle of HEAL participants is 44%. The disaggregated data by district show that the CPR is highest in Banke (66%), followed by Dang (41%) and Surkhet (50%). The lowest CPR (22%) was reported in Mahottari district. See Figure 33. In these districts, female sterilization is the most popular contraceptive method followed by injectable.



**GATE:** The program is being implemented in seven districts: Sindhuli, Mahottari, Sarlahi, Rolpa, Dang, Surkhet and Salyan. The **first cycle** data for the three districts: Mahottari, Sarlahi and Rolpa are available which shows that there are a total of 679 GATE students (Mahottari-248, Sarlahi-244 and Rolpa-187). Of all these, in

	Mahottari	Sarlahi	Rolpa	Total
<b>Total GATE students</b>	<b>248</b>	<b>244</b>	<b>187</b>	<b>679</b>
% GATE Drop outs	22.6	13.9	0.0	13.3
Grade joined in a formal school (excludes drop outs)	N=191	N=210	N=187	N=589
Less than Grade 3	0.0	11.4	20.9	10.7
3	30.1	39.0	25.1	31.9
4	24.1	12.4	3.3	13.2
5	8.4	2.9	1.6	4.2
5+	5.2	0.0	0.0	1.7
Did not join	31.9	34.3	49.2	38.2

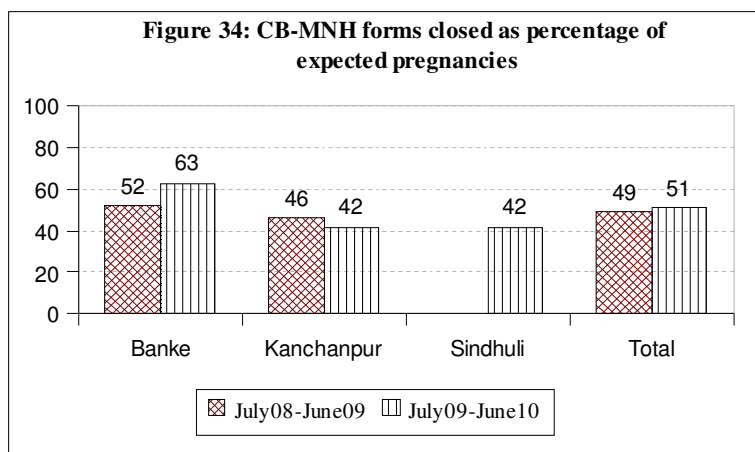
Mahottari and Sarlahi, age of majority of the girls range from 11 to 13 years while in Rolpa most girls are above 14 years. In Mahottari, the proportion of girls who passed the final exam is 72% which is slightly less than in Sarlahi (77%) and in Rolpa (100%). (Data not shown).

Overall, 13% of the GATE students of *first cycle* dropped out the GATE classes with highest drop out being in Mahottari (23%) followed by Sarlahi (14%) (Table 2). Interestingly there is not a single drop out in Rolpa. When drop out students from the GATE classes are excluded in the analysis, the percentage who joined a formal school is 62 with lowest being in Rolpa (51%). Of those completing GATE classes, a highest proportion of students joined grade 3 in a formal school.

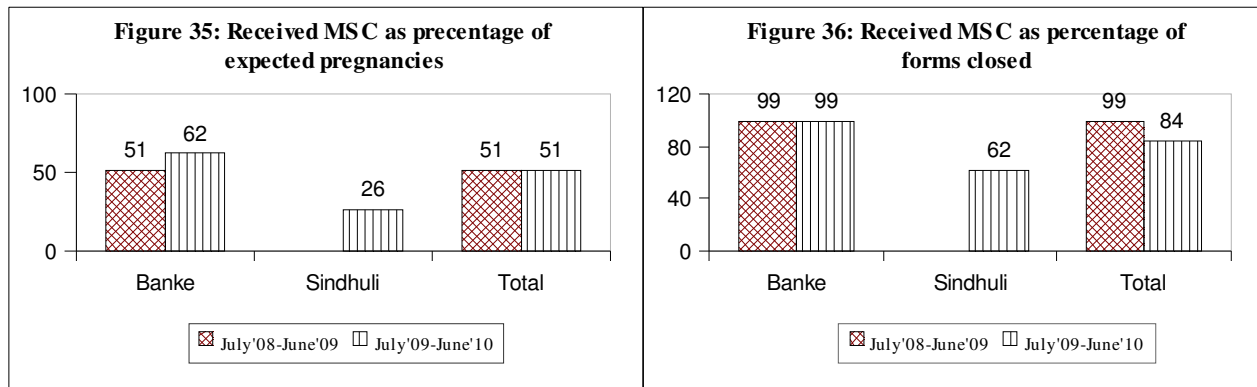
## 8.0 Community Based-Maternal and Neonatal Health (CB-MNH) Intervention

The CB-MNH intervention is in place in four districts: Banke, Jhapa and Kanchanpur and Sindhuli at different times. However, in Jhapa the intervention is in maintenance phase, therefore, the current analysis does not include data from this district. In addition, in the current analysis data for two periods (July'08-June'09 and July'09-June'10) is considered for Banke and Kanchanpur but for Sindhuli data for only one year period (July'09-June'10) has been included as the intervention in this district began during the later year.

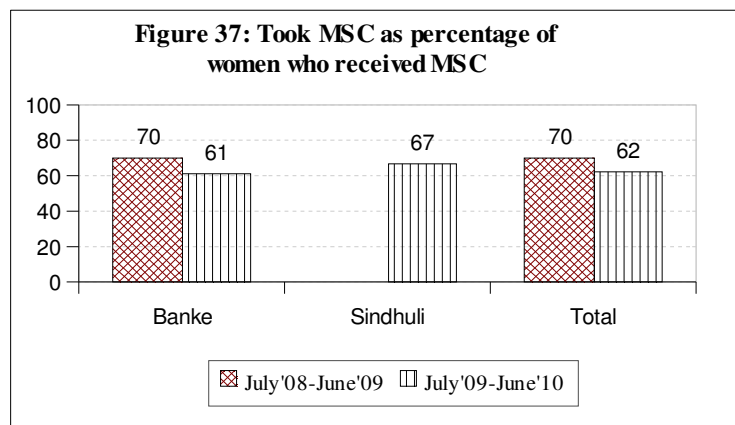
**Women enrolled by FCHVs:** The proportion of forms closed, i.e. the proportion of pregnant women who were registered by FCHVs among the total expected pregnancies has remained consistently one half of the expected pregnancies in both years of comparison. In Banke, there has been a considerable increase in the proportion from the first year to the second (from 52% to 63%) whereas in Kanchanpur there has been slight decline in the proportion of women who were registered (from 46% to 42%) by the FCHVs. In Sindhuli, 42% of the pregnant women were registered during year two. The monitoring data shows a need to increase the registration of pregnant women in all the districts; however, the need is greater in Sindhuli and Kanchanpur, where the coverage is below 50%. Refer to Figure 34.



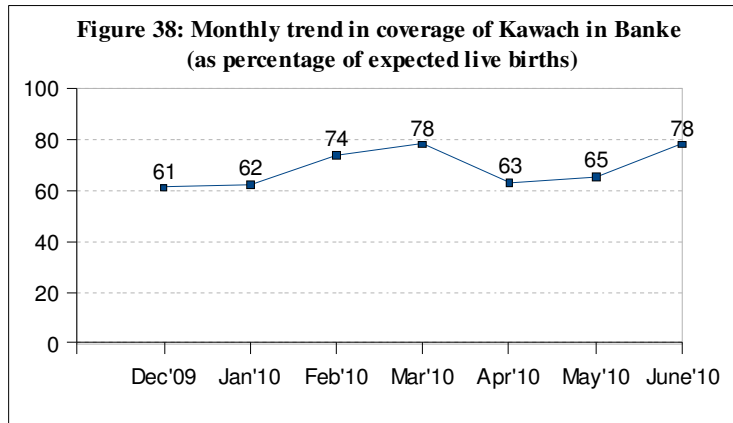
**Received MSC:** Misoprostol known as Matri Surkshya Chakki (MSC) helps in the management of postpartum hemorrhage (PPH) thereby to protect from maternal mortality. Therefore, MSC is being distributed to the pregnant women in Banke and Sindhuli districts (but not in Kanchanpur). This report includes the proportion of pregnant women receiving MSC calculated as percentage of expected pregnancies and as percentage of forms closed. See Figures 35 and 36. Overall, amongst the expected pregnancies, half of the pregnant women received MSC during the period July 09 to June 10. Between the two districts, its coverage is far better in Banke (62%) than in Sindhuli (26%). Among all the women whose forms were closed, majority (84%) received MSC in the most recent year, which is slightly less than in the previous year (99%). It should be taken into account that data of Sindhuli for the period July'08-June'09 is not included as the program was not started, therefore the total achievements for the period July'08-June'09 appears to be higher. In Banke, the proportion of pregnant women receiving MSC among those registered has remained consistently high (99%) during both the periods. In Sindhuli, only about three-fifths (62%) of the women who were registered received MSC, indicating that the distribution of MSC should be increased in the district.



**Use of MSC:** The monitoring data show declining trend in consumption of MSC amongst the women who received it. Overall, in year one, 70% of the pregnant women who received MSC had consumed it which decreased to 62% in the 2<sup>nd</sup> year. Data of Sindhuli for the first year has not been included in the report as there was no program introduced in that year. But in Sindhuli in the recent year, two-thirds of the women receiving MSC took it. In Banke, the trend is declining with 70% of the women taking MSC in the first year which went down to 61% in year two. The decreasing trend in use of MSC is very concerning for CB-MNH intervention, therefore, NFHP II need to continuously follow up the program in these districts.

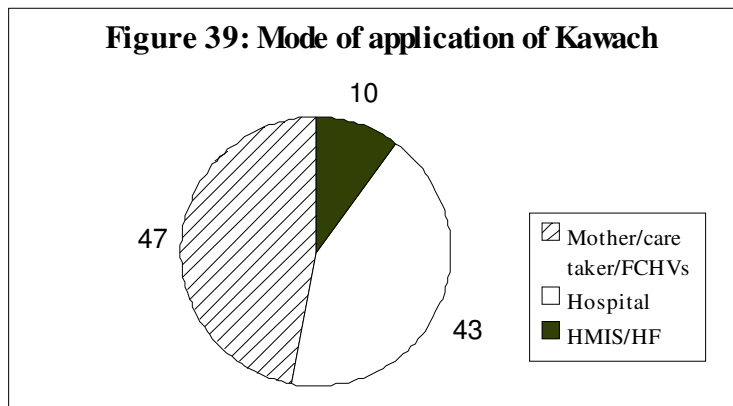


**Coverage of Kawach (CHX):** The topical application of antiseptic cream 'Kawach' on the umbilical cord stump of newborn babies has been started in Banke from the fiscal year 2066/67. The seven months monitoring data is available for Kawach, which shows that the current coverage is 78% which means out of the total live births in the district 78% had received Kawach. The monthly trend analysis reveal that in the first month, the coverage was three-fifths (61%), which gradually increased in the following three months and reached to a peak of 78% in March 2010.



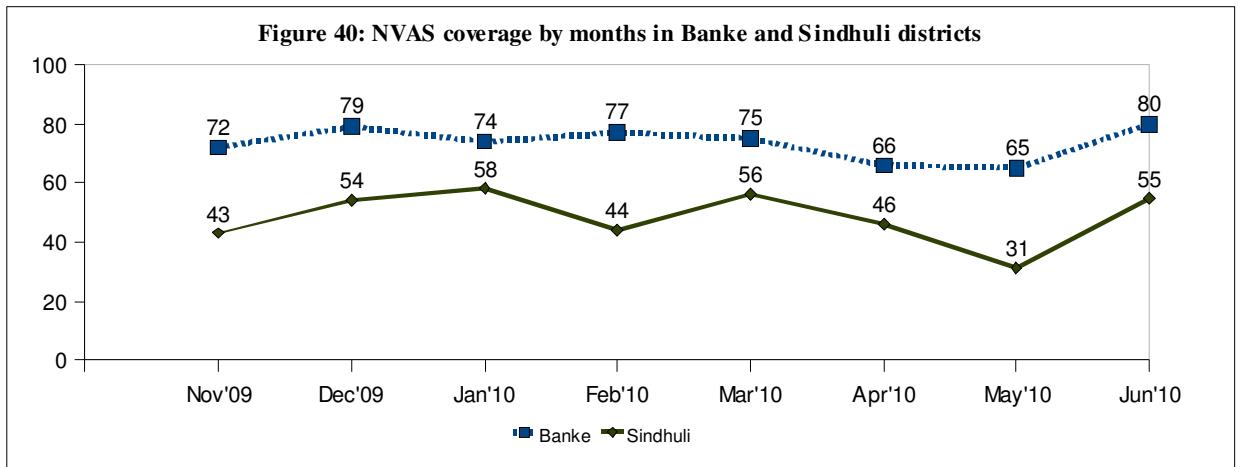
However, the achievement was not maintained during April and May 2010 and declined to two-thirds (65%) in May'10 (Figure 38). Encouragingly, in June'10 the coverage again increased to 78%. Such a fluctuation in monthly coverage of Kawach should be carefully monitored, if the program is to meet its expectation.

**Mode of application of Kawach:** Figure 39 displays that in Banke, the contribution of mothers, care takers and FCHVs in applying Kawach to the newborns is highest (47%) followed by hospital (43%). Overall, the contribution of HFs in Kawach application is only 10%. See Figure 39.



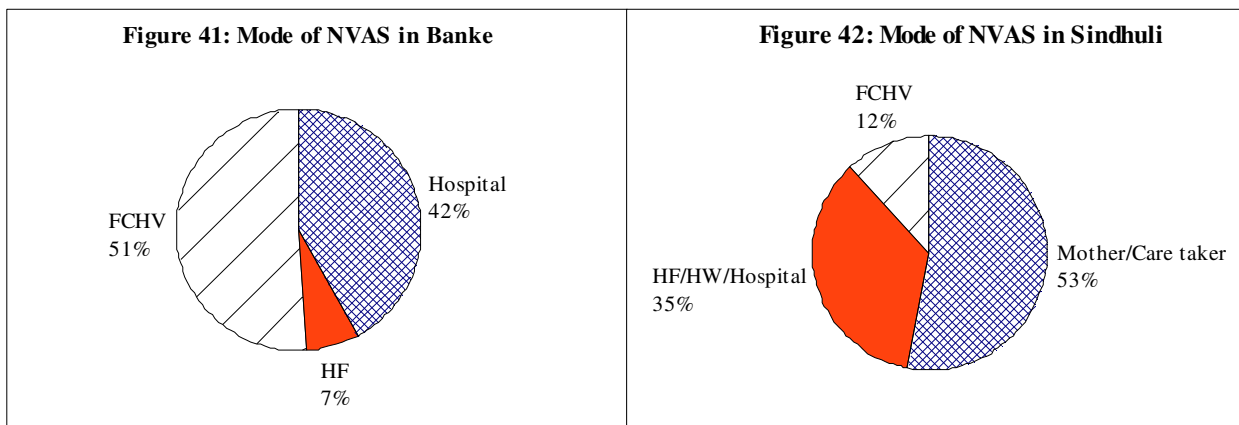
## 9.0 Neonatal Vitamin A Supplementation

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 through to June 2010. The trend in coverage of NVAS is presented in Figure 40, which shows that there is much fluctuation in coverage in Sindhuli than in Banke. In Banke, the coverage were about three-quarters up to March'10 but declined to two-thirds during April'10 (66%) and May'10 (65%). However, in June'10, the coverage increased to 80% which is quite encouraging and needs to be maintained.



A higher fluctuation in monthly coverage has taken place in Sindhuli than in Banke. In Sindhuli, the NVAS coverage reached nearly three-fifths (58%) in January'10 but then declined to 44% in the next month. In March'10, it increased to 56% but then declined constantly in the following two months. In May'10, the coverage was reported lowest (31%) but again increased to 55% in June'10. 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 monitoring data depict that 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. See Figures 41 and 42. Moreover, as an institutional delivery is increasing, more neonates have been supplemented with vitamin from the hospitals. However, it should be taken into account that the coverage in Banke is much higher than that in Sindhuli.



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