TERRE DES HOMMES
LAUSANNE

EVALUATION REPORT ON THE COMMUNITY BASED NUTRITION PROJECTS IN KATHMANDU METROPOLITAN CITY AND LALITPUR DISTRICT OF NEPAL

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SECTION 1

1.1: Introduction: Brief summary of Tdh Lausanne in Nepal

The experience of Tdh in Nepal has a history of 20 years, with a large proportion of this period focused on the *Hospital and Rehabilitation Centre for Disabled Children* (HRDC) in Kathmandu. This project was handed over by Tdh to their local partners, *'Friends of the Disabled'* in 1992. Currently Tdh fund 30% of the HRDC activities, namely work that is associated with out-reach community care for children affected with physical disabilities.

A partnership was formed in 1996 until 2000 with the *'Centre for Victims of Torture'* whereby children of imprisoned parent(s) were supported and maintained in the community, as opposed to languishing in captivity alongside their carers.

During late 2000 the direction of Tdh Nepal took initiatives to work with local Nepalese NGOs on *Nutrition Projects* within defined areas of Kathmandu City and the rural location of Lalitpur.

More recently Tdh Nepal has been involved in specific and interlinking researches directed towards - *Female Trafficking*[1]*; Conflict and its affect on Children*[2] and *Aid to Displaced Children in Nepal*[3].

This evaluation report is concerned with the community based urban and rural nutrition interventions, which commenced in September 2001. Accordingly the project proposals[4] indicate that: -

> The overall goal is that the 'nutritional status of women and children in wards will be improved' in defined urban and rural areas'.
>
> In turn the goal encompasses the key objective of 'improving knowledge, attitude and practice in issues relating to nutrition of children under three and pregnant women' in the defined localities.

The focus by Tdh Nepal towards improvement in nutrition derives momentum from the known fact that malnutrition and long-standing poor nutrition has a serious impact both on mothers and the health and development of their children.

1.2: Maternal and Child Health Situational Analysis – National Context

Data from UNICEF[5] denotes a Maternal Mortality Rate of 540/100,000 live births from 1985 – 2003, thus indicating that Nepal maintains the highest MMR in South Asia. (*However, the MMR adjusted figure of 740/1000 (2000) is significantly higher*). Antenatal care coverage (1995 –2003) was 28% and skilled attendant at delivery was 11%. (UNFPA state that home

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[1] A Study on the '*Destination Side' of the Trafficking of Nepalese Girls to India'* (Start date Dec.'03. Completion February 2005).

[2] A Study on the ' Nutritional Status of Children Victims of the Armed Conflict in Nepal'. Tdh and the International Alliance of Save the Children. (Start date December 2004 – Completion June 2005)

[3] '*Aid to Displaced children – victims of the armed conflict in Nepal*'. Implementation by Dominated Community Awareness Forum (DOCFA). (Start date May '05 – Completion May '06)

[4] Project Proposals for Kathmandu Metropolitan City and Lalitpur District – Sept. 2001- Dec. 2004

[5] UNICEF data via www.unicef.org

births account for more than 50% deliveries). Total Fertility rate (2003) was 4.2, a slight decrease from the 1998 figure of 4.45. Contraceptive prevalence remained unchanged from 1998 at 39%.

In the 1998 'Nepal Nutritional Survey'[6] 24.7% of women were found to have a low BMI, thus denoting the poor nutritional status of women, as females and as mothers. During pregnancy the incidence of iron deficiency anaemia was 74.6% > 3 times higher than that of non-pregnant women.

In respect of children UNICEF data for 2003 gives the IMR as 61/1000 live births. It is worth noting that this IMR figure is not broken down into Neonatal and Perinatal mortality, although it is well recognized that a high proportion of infant deaths occur in the first month of life. Unpublished data from WHO (2003) give an estimated annual number of neonatal deaths in Nepal as 35,640 from a total IMR of 43,740[7]. In respect of perinatal mortality, an estimated figure of 70/1000 (1999) was given for deaths occurring in late pregnancy, at birth, or during the first week of life.[8] LBW = 21% for the period of 1998 – 2003.

For the <five year olds the mortality rate (2003) was 82/1000 live births. Moderate and severe malnourishment for 1998 – 2003 is given as 48%, with 13% covering the category of being severely underweight. For the same period the disturbing long-term affects of malnourishment are reflected in the 51% of <fives who are suffering from stunting.

A 2005 'State of the World's Mothers' report denotes that Nepal is rated **103 out of 11O** countries. The index ranks the status of mothers and children and is based on ten indicators relating to health and education, whereby '*the quality of children's lives is inextricably linked to the health and education of their mothers*' and '*in countries where mothers fare well, children fare well; in countries where mothers do poorly, children do poorly*'[9]. The given literacy rate of Nepalese females in 2001 was 43%; in 1981 this was a mere 12%. The difference between females and men in literacy and educational achievements remains a constant 22% over the same period.[10]

At a more local level and at the onset of the two programmes a KAP study was undertaken in KMC and Lalitpur in May 2001 and July 2002 respectively. The findings reflected the concerns expressed regarding MCH and indicated that ANC and PNC attendance required improvement, along with Iron and Vitamin A Supplementation, Exclusive Breastfeeding, Appropriate Complementary Feeding and Feeding and Care of the Sick Child.

1.3: Conflict Situation

Compounding the reality of lives for women and children within Nepalese society has been the escalation of conflict in effectively all regions of the country, but particularly in the predominantly rural districts. Since the Maoist rebellion erupted in February 1996 it is reported that at least 400 children have died as a result of conflict related violence, involving both Maoists and government armed troops. Additionally about 12,000 people have been killed, of which most will have been civilians.[11]

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[6] 'Nepal Micro Nutrient Status Survey' 1998.

[7] WHO unpublished data from a SEA regional committee report dated September 2003 – '*Health of the Newborn*'.

[8] WHO: Publication in the Regional Health Forum – Vol. 6. No.1. 2002. '*Making Pregnancy Safer in Southeast Asia*'.

[9] Save The Children USA: '*Mother and Child Health: State of the World's Mothers 2005*'

[10] UNDP: Nepal Human Development Report 2004. '*Empowerment and Poverty Reduction*'.

[11] Editorial Report from the BBC News (UK Edition) dated 26th July '05. '*Children suffer in Nepal Conflict*'

According to *'Global IDP Project'*[12] the figures relating to internally displaced people as a result of the conflict are unreliable. However, *'the most realistic estimates put their number at between 100,000 and 200,000'… with 100,000 IDPs in Kathmandu alone'*. Interlinking with this national crisis is the impact on economy, whereby the country's GDP growth for 2005 is falling to 2.1% in comparison to a population growth of 2.24% a year. Several factors feed into this situation, not least the cessation of key foreign aid, amounting to more than $215 million, since February 2005[13].

The impact of a conflict situation on children's right to education has been highlighted by UNICEF's Regional Director for South Asia who describes the reality of fear and violence as eating away at the future of children; the conflict is urged to stay out of the classroom.[14] However, the latter is not the case, as schools are continually being targeted, with the abduction of teachers and children, the closures of schools, either temporarily or permanently, together with the introduction of a 'pro-peoples' form of education within Maoist controlled schools. Furthermore a Guardian newspaper report, dated 25/8/05, states that the result is '*massive education deprivation*, with wealthier families fleeing to cities whilst poorer children will lack education altogether. For girls, in particular, a further eroding of their right to education does not bode well for them as future mothers.

On February 1st 2005 the government was dismissed, a state of emergency declared and absolute royal power assumed for a period of three years. This action was swiftly followed by a six-month embargo on the freedom of information, with strict guidelines dictating news that could be reported. During early September '05 the Maoists declared a unilateral ceasefire, however media coverage remains ambivalent about the outcome.

Low-intensity conflict is insidious in the way it spreads and affects all it touches. It damages physically and psychologically. Especially damaging are the effects on children, who witness events they never should see; who are denied education and work opportunities; who are recruited as child soldiers; who experience splintered and fragmented family life; who are forced to migrate and/or become victims of trafficking for primarily economic purposes.

It is against the above background that the urban and rural programmes strive to achieve improved nutrition for women and children in KMC and Lalitpur District.

This evaluation report will cover the key findings in accordance with the defined Tdh 'Terms of Reference' (See Annexes). Where similarities of TOR occur they will be combined and reported accordingly. It is intended that this evaluation report and its findings will consider the two programmes separately, although commonalities of approaches will be merged. The following scenario depicts an example of the latter.

1.4: A brief scenario of the Urban & Rural Nutrition/Health Programmes

The implementation and management strategies within the UNP and RNP have been adopted and adapted according to programme locality; one in the heart of KMC and the other situated in Lalitpur District, approximately 40Kms away from the Nepalese capital. The distance does not sound far, but the reality of life in urban and rural locations are starkly different.

From fascinating antiquity, congestion of people, traffic and city pollution to scattered villages set amidst beautiful hilly terrains; from comparative ease of travel and access to

[12] Global IDP Project (Nepal). Via internet and dated 8th September 2004

[13] Source via the Internet: Kathmandu Post dated Friday 22/7/'05.

[14] Source via the internet: UNICEF Press Release dated 1/4/05 – '*UNICEF appeals for fear to be banished from Nepal's classroom'*

health facilities to areas where walking long treks is the norm for the local populous if they want to reach a main government health post. Therefore, for many, there is reliance for basic health care on SHPs and ORCs.

Within KMC the UNP has focused its work on the support of a large number of trained community volunteers who stem from their own neighbourhoods and are supervised by paid CFs. These volunteers are a core component of the urban projects. A similar stance was taken by the RNP, but without the use of volunteer support; this approach was impractical given the necessity of close supervision and the reality of distances to be covered from base to targeted villages. Therefore, the liaison of rural CFs with government health workers (paid & unpaid) was viewed as essential, in order to advance a sustainable system of basic nutritional health care for women and children.

The main emphasis for both programmes has been towards community health training and behaviour change. Health education, particularly on the cooking of cheap, readily available nutritious foods, GM of <3-year old children and home visiting to malnourished children are core principles of the two programmes.

At the urban team level volunteers and community facilitators are sensitively taken through a training system of self-discovery relating to their own personal life experiences in respect of becoming a mother, being a mother and correspondingly to their care of infants/children. This enables them to see similarities and differences in their lives. Training for the volunteers introduces them to the necessary skills and knowledge that are needed to support antenatal/postnatal mothers and young children who reside within the volunteer's own neighbourhoods.

Similar training is undertaken within the RNP, but the formation of mothers groups for training purposes, alongside growth monitoring, has been a focal point of the RNP work. More latterly training was extended to groups of men and to schoolchildren. In turn the children conveyed health messages and information onto peer groups and to neighbours.

Each programme has embarked on alternative strategies to support and empower women in the targeted wards of KMC. The UNP has introduced Adult Literacy Classes (x 2) and Child Care Centres for working mothers (x 2). Additionally, grants are given to volunteer groups to support Community Self-help Savings Group (x 29) and associated income generating activities. At the request of mothers who have been trained through the RNP the formation of 'Mother's Strengthening Groups' has emerged, along with their choice of income generation schemes.

Impoverishment is prevalent in both rural and urban areas. Likewise, societal norms are entrenched in caste, culture and tradition and, in particular, relate to the low status of women in Nepal and the influence and consequences that all these factors have on nutrition and health care practices. However, as described by Weyermann, the '*position of woman in the family and community varies according to the social group to which she belongs.*' Therefore…' *the limited opportunities for a woman and the expectations that she herself and her community have of her, play a crucial role in the family dynamics.* It is this theme of family dynamics and their impact on a child's development, growth and nutritional status that led to a holistic stance from the urban and rural programmes.

From the onset, the nutrition programmes have sought a wider rationale for the causes of poor maternal and childhood nutrition, other than assuming poverty, lack of food, or a lack of awareness about appropriate foods as being the only causes. Alongside the basic approach, that aims to catch all <3 year olds for growth monitoring/health promotion within the targeted areas, an intensive aspect of the programmes emerged, particularly with the UNP. The intensive aspect involves a **'psychosocial approach'** for carers of malnourished children.

Families are followed up by home visits from CFs and volunteers; these families often unfold complex problems, which impinge on the carer's ability to provide appropriate care.

The previous Tdh Delegate and staff from the UNP undertook action research with 22 families with malnourished children who received home visiting from the UNP team. From their study, '*Unravelling Malnutrition*'[15], the relevance of appropriate household care practices, such as breastfeeding, complementary feeding, and appropriate treatment during childhood sickness are recognized as harnessing '*food security and health care into a child's growth and development*'. These actions are reliant on supportive care factors within the household

A very brief description of the study and health care approaches undertaken within the UNP is given below: -

'*Unravelling Malnutrition*' discusses and explores how 'negative' family dynamics and household stresses can impact on the normal process of childhood development, including that of acceptable weight gain and growth. The main focus was with the mother, but could include other members of the family.

The realization that tackling the issue of malnutrition requires more than conventional mechanisms of health promotion/education also meant considerable changes for the health promoters. It was not just a question of providing information and advice to mothers on how to improve nutrition and household practices. During their contact with mothers/carers it was necessary for the health promoters to acquire good listening skills, plus an acknowledgement that solutions to family problems, which impinge negatively on childcare and affect a carer's coping abilities, could not readily be provided. However, having someone to listen to problems and provide continued support through home visiting has the potential to enable positive change within families, which could lead to an improvement in a child's nutritional status.

Equally relevant is that volunteers and UNP staff needed to overcome their own feelings in relation to their perceived status in society. The programme has a strong non-hierarchical structure, where all are considered as equal. The psychosocial approach remains a functional and ongoing aspect of the two programmes.

The Urban and Rural Nutrition Programmes aim not only to address identified needs of the beneficiaries, but also to promote a <u>rights based approach</u>, thus enabling families to understand their basic '*right to health and against healthcare exclusion*'. This philosophy is in line with the Tdh Sectorial Strategy for Mother & Child Health and Nutrition[16]. As will be seen from this report the findings reflect the empowering of women as a result of the two programmes.

SECTION 2

2.1: Urban Nutrition Project

SAGUN, a local NGO, began implementation of the Tdh funded UNP in November 2000. From an initial coverage of Wards 19 and 20 in Kathmandu Metropolitan City (KMC) the

[15] 'Unravelling Malnutrition, Challenges of a psychosocial approach: Report by Barbara Weyermann, Dated September 2003.

[16] Mother & Child Health & Nutrition: Tdh Sectorial Strategy. Final Version, March '05

project expanded to a further five wards, namely 14, 18, 28, 30 and 35 and as from June 2005, now reaches a total population coverage of **17,209 HH.** Within this same timeframe a total of **385** volunteers were actively participating in the monthly GM and health promotion sessions.

Breakdown of Household Coverage as of June 2005

Total HHs according to		Programme Coverage		Active Volunteers
Population Census of 2001		**HH**	**%**	
Ward 14	7846	2819	35	68
Ward 18	1730	1669	96	35
Ward 19	1477	2098	100	55
Ward 20	1701	2057	100	43
Ward 28	1088	1186	100	32
Ward 30	2041	1536	75	32
Ward 35	8716	5844	67	120
TOTAL	**24599**	**17209**	**70**	**385**

From SAGUN to Chhimeki

A fundamental change began to take place during 2004 with ownership of the programme being envisaged by the volunteers and CFs. This catalyst for change arose not just from a desire for autonomy, but was fuelled by organizational differences between Tdh and members of the SAGUN Board, plus a deterioration of clinic involvement in the UNP. It is relevant to note that the integration of clinic staff into the nutrition programme was viewed as a route to sustainability of improved MCH. It will be clear from data that contact lessened over time and the reasons underlying this situation are explored later.

Therefore, and towards the end of Phase 1, there was a strong desire from volunteers that their activities should continue, especially as the migration rate into Kathmandu continued to gain momentum, with the anticipation of more pregnant women and malnourished children arriving into KMC.

Since January 2005 a new partner organization, known as Chhimeki (meaning neighbour), is in place and was formed by community volunteers during 2004. This was duly affiliated with the SWC and registered with the CDO. The first General Assembly led to an election process with 208 Chhimeki members (total membership 284) voting in a 9-person board following a period of ad hoc administration. The board members stay in their elected position for 2 years. For instance the current chairperson will not be able to continue in this post indefinitely.

Currently, vital and intensive support comes from the 5 technical staff, fully employed by Tdh, but based at the Chhimeki office.

However, this change to a community owned programme has created a rift between Chhimeki and the Ward Clinics and the KMC Public Health Director. This rift has particularly affected Chhimeki board members and CFs. The underlying causes and consequences are explored within this report.

2.2: Main findings of the UNP Evaluation

A breakdown of indicators and statistical findings from June ’02 to June ’05 are given below: -

<u>**Objective**</u>

Knowledge, Attitude and Practice regarding key nutrition interventions for pregnant women and families of children under three in (defined Wards – now x7) has improved.

<u>Indicators</u>

Appropriate intake of iron supplements for pregnant women:
Target given as 60%

It was not possible to give a percentage of coverage[17]. For accuracy it is necessary to know the exact number of pregnant women within the catchment areas. Nevertheless, since Sept. ’04 until June ’05 a total of 382 women were seen ante-natally, of which 85.3% took iron supplements adequately. The remaining 14.7% either took iron inadequately, or not at all.

High movement in and out of areas and the social inclinations of women not to disclose, or discuss pregnancies, contributed towards this ‘difficulty’.
Clinic staff reported an increased flow of ANC patients to their clinics.

Intake of Vitamin A Supplementation by postnatal mothers delivering at home
Target given as 100%

Achieved coverage for postnatal mothers delivery at home = 63.4%. This data could be inaccurate, as volunteers may not be checking up on the intake of Vitamin A intake during their later contact with postpartum mothers. (*In Kathmandu it is more the norm for women to give birth in hospitals, but out of the figure of 382 given above there were still nearly 25% of women delivering at home*).

For the period ’02 to ’05 > 91% of women who delivered in hospital received Vitamin A. Questions are raised about this data, as the government protocol is for ALL women to receive Vitamin A immediately post-delivery, which should be available in maternity hospitals.

80% of women have access to information on appropriate feeding of sick children

Again this target has not been easy to determine, but can relate into the % of children seen at GM. Information will also have been gained from neighbourhood volunteers and CFs during their contact with mothers outside GM sessions.

60% of all mothers breastfeed exclusively up to six months

A 24-hour recall in June 2005 indicates 51% are breastfeeding exclusively up to 6/12
However, there are queries about this figure, as women frequently mentioned they had given water to their infants at some stage. It is also noted that government policy at the onset of the project was for exclusive breastfeeding up to 5/12 of age and only recently changed to 6/12.

80% of families with children <3years of age have access to information about appropriate complementary feeding.

This target has also been related to GM, as health promotion on this issue is primarily given at weighing sessions. It is concluded that this result is an <u>average</u> of 59-60%. However, information is available at other times from volunteers and CFs when contact is made with mothers outside GM sessions.

[17] NB: Chhimeki & Tdh technical team feel that better tracing of pregnant women is now being achieved since May 2005. A figure of 200+ was given from them for this short period.

90% of children <1year are fully immunized
The result for 2004 = 87.5%: There has reportedly been an uptake of children attending for immunization at the Ward Clinics. It is noted that the National Immunization Rate is 80%

Result 1
A community network of social nutrition/health volunteers is operational in Wards of KMC. The network includes neighbourhood volunteers (1 per 30-50 HH) and project staff.

Indicators

Volunteers have improved their own practices relating to nutrition
YES, clearly evident.

80% of volunteers participate in Growth Monitoring
Findings are variable: 71% for June 2003: 57% for June 2004: 66% for June 2005
Expected target not being fully realised.
Factors contributing to difficulties were: - Conflict situation: lots of strikes leading to loss of communication for days and the transition period from SAGUN to Chhimeki. Also, a loss of volunteers, with movement out of ward areas, plus less activity from some volunteers.

80% of children <3 years in working areas go for monthly growth monitoring
On average 59-60% are seen at GM. Note that the national average for 2004 is a mere 2.8% of children receiving growth monitoring.

60% of underweight children in the working areas gain weight during the period of home visiting
Gaining weight has exceeded expectations:
2003 = 71%: 2004 = 68%: First six months of 2005 = 62%
Reportedly, children who gained weight, or crossed the 80th Centile Line, generally maintained this status.

Mothers in working areas have access to Sarbattom pitho (*Food prepared from maize, wheat and soya bean – also referred to as Super Flour*)
There is access and local production of Sarbattom pitho, especially with production by the volunteers. Selling takes place at various sites, such as Ward Clinics, Child Care Centres and directly through neighbourhood contacts.

Result 2
Key nutrition protocols are implemented at the Ward Clinics: Iron Supplementation for pregnant and lactating women, Vitamin A Supplementation for lactating women and children, Growth Monitoring at each contact for all children under 3 and for pregnant women, de-worming.

Indicators

ANC Cards are available at all times
Reportedly, they are available

Road to Health cards are available at all times and filled in properly + GM at each contact
In respect of staff seen at just 3 ward clinics there has been limited input from them in respect of growth monitoring, however Ward 28 Clinic did participate more in the community GM (up until the end of 2004), plus weighing children at the clinic.

Protocols are available and displayed on walls.
From the three clinics visited there was limited visibility of protocols, although provided by the UNP team. Key protocols relate to IMCI, Vitamin A and Iron Supplementation: Antenatal Care: Breastfeeding: Diarrhoea Diseases & ORS treatment. Reportedly, protocols on IMCI, Vitamin A and Diarrhoea are available from the DOH. There had been misplacement of protocols, in some cases due to movement of clinics.

All clinic staff know how to implement protocols.
Clinic staff implied that they knew how to implement protocols. There were none available for de-worming of pregnant women; treatment was given on presentation of symptoms.

Required drugs are available at all times (Iron, Vitamin A capsules)
Reportedly available: However, although the supplements should be free, some clinic staff are requesting payment of Rps 7 as registration fee from pregnant women.

There appears to be a problem with iron supplies, this relates to an increased demand coming from mothers who are now more aware of the importance of iron during ANC & PNC and also because of the increased population flow into the KMC. This particularly applies to the KMC maternity hospital. However, there is no shortage of actual production from wholesalers.

<u>Result 3</u>
A sustainable community based participatory approach to address urban malnutrition through the Public Health System of KMC has been demonstrated.

<u>Indicators</u>

Regular meeting between volunteers and clinic staff take place
Initially, in 2003 (x 6 Wards), the uptake was relatively high and 51 meetings took place. This started to decline in 2004 to a total of 30 meetings and during 2005 there have been nil.

Quarterly review meetings with project co-ordination committee
A similar situation as above, with regular meetings declining and none in 2005.

Increased attendance at clinics
Patient flow increased to clinics – reported from the in-charge persons at the 3 clinics visited.

Regular outreach activities by clinic staff and volunteers
A gradual decline was noted.
2003 - clinic involvement for GM = 36 attendances. For Volunteers Training = 36
2004 - clinic involvement for GM = 23 attendances. For Volunteer Training = 20
2003 - volunteer training from clinic staff and follow-up for volunteers = 36 & 8 respectively.
2004 – volunteer training from clinic staff and follow-up for volunteers = 20 & 8 respectively
2005 – NIL
Training for Volunteers and follow-up from clinic staff did not come from all the targeted ward clinics.

Result 4
A clear understanding of the complexities of urban malnutrition at the family level has been gained and disseminated.

Indicators

Children of home visited families gain weight – Children gained weight.

Results on difficulties of home visitors with complex family situations are published
Publication of 'Unravelling Malnutrition' in September 2003

Video about urban nutrition situation disseminated – Fulfilled

The above has provided a statistical breakdown of whether the intended indicators in terms of percentages have been met or not. It is clear that in percentage terms the indicators have not been achieved in all instances. This could be due to a lack of available data, or because accurate recording did not take place. However, the reality of setting percentage indicators at the onset of a programme can be ambiguous and many influences will impede on whether they are achievable or not. However, it is the considered opinion of the evaluators that the achievements are considerable, especially in relation to the weight gain of underweight children, which has exceeded the 60% target.

In order to seek the underlying reasons for successes and 'failures' of the UNP the evaluation team met with key stakeholders in KMC. Over the course of 8 days (2 of these planning days) a total of approximately **180** people were met, including the Tdh team. Visits were also made to a growth monitoring session, an adult literacy centre and two child-care centres. With larger group meetings, in particular, similar questions were asked in order to validate the indicator findings. However, there was always flexibility alongside 'fixed' questions and it was found that people were only too willing to express their thoughts and feelings.

2.3: Successes flowing from management and organization

The following highlighted points are some of the key identified reasons that underpin successes noted in the UNP; they are not in any order of priority, as all interlink and contribute towards the effectiveness of the programme; they also contribute towards any reported impact.

A very strong team spirit, based on a non-hierarchical structure is a key feature of the UNP. Since its concept the SAGUN team took a strong stance on these core principles, which has led to similar values being naturally carried through into the formation of Chhimeki. Working within a society where hierarchy flows from a caste system then the issue of non-discrimination (in any form) was viewed as essential in order to break down existing or potential barriers of communication.

Positive support from the Tdh team (formerly staff of SAGUN) is immediately noticeable within the Chhimeki organization; this was also confirmed from meetings held with the Chhimeki Board and later with other team members, who expressed feelings of **autonomy and flexibility** within the UNP. The Tdh technical team maintain their advocacy for Chhimeki and provide the necessary constructive input on two main strands.

Firstly, the technical issue of the project, which involves continuing the community work commenced with SAGUN. Secondly, the organizational development and capacity building of Chhimeki, in order that the team will eventually gain levels of competencies in all areas relating to management and training and ultimately be able to run their own organization. The 11 CFs are now paid Chhimeki staff and continue to support the ward volunteers. The amount of work required to handover the organization to Chhimeki is concentrated and rigorous. Having experienced the initial stages of forming a new community organization it is now a period of consolidation, with the aim of independency through a process of continuous learning and working together towards sustainability.

Positive support from the Tdh office has also flowed from the Tdh Delegate and Programme Manager. This was especially evident when the concept of volunteer ownership of the UNP first arose. The delegation enabled volunteers to actually visualise and believe that managing their own organization could be achievable.

Teaching and supporting a whole range of management skills is an ongoing task, not least of which is budgeting and accounting. The latter experience is encapsulated within the recent '*Capitilization Report*[18]' where a description is given of how the budget of Fr.50, 000 can be quite unimaginable for volunteers to handle – for them 30 laks rupees is a large amount of money. To overcome this difficulty, plus a public perception that creating an organization is equal to making easy money, the board members and staff calculated the cost of each activity, in order to learn where the money would go; that none of it was free for private disposal and that accountability and transparency of all financial transactions was vital.

Three CFs have been selected for management training and two of these are destined to be potential trainers. Although at an embryonic stage, they will be exposed to the planning of teaching sessions before the end of 2005. Careful supervision will be given from the Tdh team throughout the whole process of training trainers

Good guidelines and clear working protocols are available, which contributes towards both transparency and work ethics. Additionally, posters are visible in the Chhimeki office that details ALL the activities taking place over a given timeframe. All are colour coded which enables even those volunteers who do not have literacy skills to understand short and long-term planning. The use of a laminated Centile Chart enables GM to be plotted out on a monthly basis, using blue for those who are above the 80th Centile line and red for those children who fall below this line. Details are analysed and recorded and then the whole process starts again for the following month. The Road to Health chart is a key tool in recording appropriate data for each child, such as introduction of complementary feeding, and episodes of childhood sickness. The volunteers keep a duplicate copy in case mothers mislay their personal chart.

Participatory and effective training on MCH issues that are based on volunteers' real life personal experiences helps to unify them and, most importantly, assists them to gain an understanding about the commonality of their problems. They train for 10 days and are paid pro rata at 100Rps a day. Female volunteers have been selected on the basis of showing an interest in the programme; to have time available for training and to give subsequent support for their communities; ideally the women should have young children and have a similar socio-economic background as the majority of their neighbours. Selected women may have literacy skills, but their literacy status is not a criterion for selection; they may also be known as local (owning their own home), or as renters. The latter term is misleading, as renters are also known as 'migrants', which may apply to IDPs.

Realistic expectations from volunteers' involvement are of prime importance. In community health programmes the expected workload and payment for recruited volunteers tends to be a contentious issue. This is not surprising given that health volunteers come from similar poor backgrounds, but are expected to give considerable time to promote health in their areas, whether paid or unpaid.

The UNP works on the basis that volunteers will not be expected to work more than 3 hours per week and that no payment is made for the limited time that they give to the programme. Volunteers from Wards 19, 20 and 28 confirmed that they work approximately 2½ hours per week[19] on GM sessions and home visiting; this does not include meetings. They work in

[18] Urban Nutrition Project Kathmandu/Nepal: Capitalization Report 2005 by Barbara Weyermann.
[19] The Tdh technical team stated that they intend to explore the amount of time being worked by

clusters within their own neighbourhood and are generally in close contact with other families. This approach to volunteer work is also very cost effective as the impact of a large unpaid force of volunteers represents a saving of 25 full-time staff = CHF 57,000, or US$ 43,000 > (From Tdh Delegate).

Support and Supervision for volunteers is very dependent on CFs. They are each responsible for 30-50 volunteers who are individually contacted at least once per month in order to discuss any difficulties that are being experienced; this takes approximately 5 days a month of the facilitator's time. It is planned that the amount of volunteers per facilitator is to be cut to a maximum of 40, especially as they are heavily involved in home visiting, with or without volunteer input. The CFs also follow-up groups of volunteer every month to discuss GM, Road to Health charts, <wt children, antenatal and postnatal women.

Social Mapping of ward coverage is done by volunteers and overseen by CFs. This action is essential in order to keep track of the rapid movement that takes place in and between the targeted wards. The provision of Road to Health charts for children < 3 years of age also enables HHs to be identified. However, the effort to gain complete coverage is not infallible as, reportedly, a few children never come for GM and are not registered; they are however known to the team.

Regular meetings and discussion of case studies take place in respect of families with <weight children who are being followed-up with **home visiting**. The complexities of family dynamics and problems are shared and discussed amongst the team. **External support** for the CFs comes from the '*Centre for Mental Health & Counselling-Nepal'*. A clinical psychiatrist and psychologist provided initial training over a 3-day period, followed by bi-monthly meetings, which are now extended to 3- monthly contact. This support has been essential in order to avoid 'burn-out' with the facilitators who had expectations of having to resolve all the family problems confronting them – thus hopefully leading to weight increase of children. In part, the high expectations arose from their job descriptions and anxiety about not achieving results, coupled with concerns arising from families.

Motivation is high within the UNP and stems from all the factors noted above, plus '*learning and doing thing together*', which helps to promotes support for each other. Involvement in **external training**, such as earthquake awareness, child abuse, and income generating skills has also provided incentives, plus the fact that new information is always shared amongst the whole team. Motivation is strengthened enormously by the respect and trust shown to them from communities, this comes not just from mothers/carers, but also from Ward and Club officials, who also support and motivate materially with, in some instances, the provision of accommodation for GM sessions.

2.4: IMPACT as a result of the programme

The following findings arise from the evaluators' observations and from the responses given from the people who were interviewed. The evaluation team separated for focus group discussions with volunteers and mothers, although each had an opportunity to change over, to ensure that a similar approach was being taken. Three aspects are considered, namely > the impact on improved nutrition for mothers and children: women's empowerment and wherever possible, a rights based approach.

i) Impact on improved nutrition for mothers and children

From meetings with mothers, volunteers, including those who were AN or PN women, CFs, Chhimeki Board, community leaders, clinic staff, government directors of health and from pure observation at GM and health promotion sessions there was clear demonstration that

volunteers.

improved micro and macro nutritional behaviour was being practiced. It has been previously noted that over 60% of underweight children have gained weight and continue to gain weight, but HOW actually have practices changed and WHY?

Awareness and improved KAP for nutrition and health related issues have been increased in the seven target wards. Volunteers are also considered as beneficiaries, alongside mothers/carers who live in their neighbourhood. Examples are given of the most common responses: -

From volunteers, either pregnant or postnatal mothers, from all wards.

From Laxmi, a volunteer for 1 year: a mother of a 4 yr old and a 3-month old baby.
'*Before, following birth I was not allowed to eat green leafy vegetables as this was said to lead to colds. Now, I know from training that it is OK to eat. Before I did not take Vitamin A, but now, following the birth I took it from Patan Hospital. Before, for personal hygiene I was not allowed to take a bath, now I taken often. Before I gave syrup to the elder baby, this time only exclusive breastfeeding'***.**

From Baguati, a volunteer for 3 years: a mother of an 11 yr-old child and a 2 year old.
'Before, with the elder son I did not eat certain foods during postnatal period. I could not breastfeed properly and child was often sick. Now, I learnt about foods and after 10 days I ate anything. Breast-feeding well and less sickness with this child. I keep quite when the family gives advice.

From Sarala, a volunteer for 3 years: a mother of a 6 yr old child and a six-month baby
Before, I went for antenatal check-ups, but threw the iron away as it made me feel sick. I now learnt about the importance and took iron and took care of food during pregnancy. I now know to weigh my child monthly and can see progress on the road to health chart. Before, (with elder child*) I only weighed at hospital visits.*

From Sumila, a volunteer for 1 year: a mother of a 6yr old child and now six months pregnant
'With my first child I had no elders at home and did not know what to do. I went to the clinic often. I did not know what to feed and gave lots of formula milk and Ceralac. Now, with this pregnancy I go for ANC and feel more confident. I also know how to better feed my child when born. Before I did not know the importance of fluids in relationship to breast-feeding.'

From Samjhana, a volunteer for 3 years: a mother of an 8 yr. old child and a five-month baby
'Before, I was ashamed to go for ANC and did not take iron. Now, whatever the doctor suggested I took, such as iron and vitamins. I attended for ANC six times. The clinic is in the same area as volunteer training, so made my ANC visits easy. After two-weeks post-delivery I went for check up. Vitamin A was given the day of delivery in hospital'.

How training changed KAP for volunteers from Ward 35, 14, 19, 20,28

- Can cut vegetables properly (this refers to washing before cutting)
- Using more sprouted beans
- Taking jeevan jal (ORS) during diarrhoea and more food
- Can prepare nutritious jaulo (green vegetable, rice, dal, potato, tomato and other seasonal vegetables)
- Importance of colostrum - not to throw colostrum away
- Initiating breastfeeding as soon as possible following delivery
- Not to give the baby even water up to six months
- Every time breastfeed for 10 to 15 minutes
- ANC has increased

- Know about immunization
- Learnt how to respect each other
- Learnt so many things that I could teach others
- During breast-feeding to sit down and relax
- Learnt to prepare complementary feeding and about frequency of feeds
- Avoiding snack foods for children
- Personal hygiene improved – washing hands before eating food
- Simple traditional remedies for coughs and colds now used

And for volunteers from Wards 30, 18 and 11

From Jamuna, a volunteer with a child aged 2 years
'I had a very good lesson. When my son was born I was jaundiced and in hospital and breast-feeding was stopped. At the beginning of training I learnt that if the mother is sick she can still continue to breastfeed'. (NB: this volunteer had not taken iron during pregnancy and became anaemic)

From Anjana, a volunteer with a child aged 19 months
'This training helps to learn about breast-feeding. Before, I fed for only 3 months and then introduced porridge. With this child (now 23 months old) I breastfed for six months – no water was given'.

From Sunita a volunteer with a child aged 14 months'.
'We were eating food anyway, but through training I learnt more about different types of food. Also I used to hit children, but learnt that it is not good for them. I do so less now, beating has stopped, but I still shout.' (Other mothers said they also had stopped smacking, or had reduced it)

From Binita, a volunteer with a child aged 14 months
'I learnt, through training, that Cholostrum is very important for the baby. Also I did not complete immunizations for my child, now aged 2¼. The doctor did stress their importance. When I learnt, I completed the vaccines'.

The above responses from volunteers, who are also beneficiaries of the programme, are also indicative of how they are **motivated** to work for their community. The benefits are clear and again link into motivation, as change of KAP takes place in an environment where benefits are realised, both at the practical level and by people internalising the processes involved.

Details of actual changes in KAP came from mothers interviewed in Ward 35. Changes mirror the volunteer's comments. It should be noted that mothers might not have known the volunteers since the birth of their youngest child. This is likely to have been the case with other mothers interviewed.

From Sita, mother of a 5 yr old child and a baby of 13 months. She met a volunteer when her second child was about 5/12 old.
'With my first child I did not breastfeed for six months. I did not take iron tablets during that pregnancy, as I was worried about a big baby and difficult birth'. With her second pregnancy she took iron. Weights were compared > the first baby weighed 2.4kgs and the second 3kg. Via volunteer contact she breastfed until six months and makes SP herself.

From Jannki, mother of a 2½ yr old child. She met a volunteer when child was 8/12 old.
'From the volunteer at GM Clinic I learnt about jeevan jal (ORS), as my child had diarrhoea. I also followed advice given to my questions as to why my child did not gain weight'. This mother knew the importance of iron during pregnancy and post-natally. Breast-fed from birth, but gave some water at about 3-4 months.

From Sukmini, mother with 1 child (? Age). She met a volunteer when her child was 7/12.
'*I had started my child on Lito* (prepared Sarbottom Pitho*) from 3 months onwards. My child is difficult to feed, wants to play a lot. I am trying to feed frequently. I was encouraged from the volunteer to eat and drink more to increase my milk supply. It has helped, as milk supply is OK now. I eat lots now'.*

From Goma, mother with a 8/12 old baby
'So many changes, as I did not know much. When I became pregnant I learnt about iron tablets. I took them and also post-natally for 45 days. I breastfed up to 6 months, but did offer some gripe water and once in a while I also gave water, but the volunteer advised me not to. I am making Jaulo and giving to my child, plus Sarbottom Pitho'

From Ambika, mother of a 2½yr.old child. She met a volunteer when her child was 9/12 old.
'I had not taken iron during pregnancy (Birth weight of baby was 2.300gms). I breastfed for six months, but also fed water from 3/12. At nine months the volunteer explained about growth monitoring and feeding. I am very happy to see when my child grows, but sometimes not growing so well. I also learnt about feeding my child during sickness and to give more frequent soft foods and liquids.

And changes in KAP identified by Mothers from Wards 19, 20, 28 and 14

- If a child is gaining weight the mothers feel happy, if weight is lost they discuss why this is happening (at GM sessions).
- The mothers know how to make nutritious Jaulo and Mothers have learnt to feed their underweight children more frequently (4-5 times daily) with Lito and Jaulo.
- The mothers know how to prepare SP: sometimes they will buy the produce and sometimes they prepare it themselves.
- Mothers have learnt about appropriate complementary feeding.
- Awareness on the importance of food and drink for the breast-feeding mother.
- Mothers were aware about the 'Road to Health' chart and linked this into learning about the status of their child's health.
- Mothers stated that they received a lot of counselling and even if they did not go to the ward clinic volunteers will visit them at home.
- Mothers stated that they had learnt a lot about breast-feeding.

Volunteers were asked HOW they saw changes taking place within their neighbourhoods in order to further determine the mother's responses.

Changes observed in the community by volunteers from Wards 30, 18, 11, 19, 20 & 28.

'One thing observed is that mothers, because of weighing, are happy with weight gain. They also ask what to do when their child does not gain weight'.

'Mothers put more effort into giving more food to their children. They are very conscious of their child gaining weight. They feel it is important that the child gains weight'.

'In my neighbourhood, initially they (mothers) did not listen. Later, they co-operated, like one mother came to my home for advice, now we are good friends'.

'Over the years the mothers are convinced to go to GM. They are asking what to feed the sick child and they also take their sick child to clinic, before they often went to traditional healers.

More mothers are going for ANC check-up and taking iron and more food'.

'More mothers going to clinic, from there to hospital. They did not know the clinic was for them'. (Also related into ANC)

'We are near and mothers feel confident to come and ask about advice. A child with dysentery – her mother came at night'.

'There was a child with lots of skin problems – the mother came to me first and I referred her onto the clinic'.

Volunteers said that they knew these changes were taking place because they see changes during home visiting and at GM sessions; this could relate into iron intake for pregnant & postnatal women, breast-feeding and appropriate complementary food. All the volunteers from Wards 19, 20 and 28 stated that their learnt experiences provided opportunities for them to support breast-feeding mothers.

Changes observed in the community by Volunteers from Wards 35 & 14.

- The community has become more aware, as people come to ask about diarrhoeal sickness and other sicknesses for children
- They ask about problems of the uterus
- The community know how to prepare nutritious jaulo
- The community have learnt how to prepare Sarbottom Pitho and know about its importance
- Mothers (more) come for growth monitoring every month
- Complementary feeding is now 4 to 5 times daily
- If the baby is crying they (carers) used to beat the children a lot, but now they pacify them
- ANC has been increased
- Mothers are more positive and will now accept home visits.
- Mothers aware of the importance of iron supplements

The above selected responses from a variety of sources have demonstrated HOW and WHY the UNP has impacted on lives positively, plus also clear evidence that practices have changed through supportive interventions from volunteers, C.Fs. and the Tdh technical team. It is pertinent to emphasize that home visiting has really supported families and their malnourished children. The Clinical Psychologist, Pashupati Mahat, who has been involved with the programmes for more than a year, stated that the CFs now have the ability to generate different 'solutions.' The outcomes are reflected in growth charts, where improvement is noted.

ii) Impact of Empowerment for women as a result of the UNP

Reference has already been made about the sense of empowerment and achievement that Chhimeki feel on forming their organization. It is no mean achievement and echoes how women have changed as a result of the UNP. Weyermann aptly described aspects of empowerment within her '*Capitalization Report*' of 2005 and her observations in relation to personal, social, cultural and economic empowerment provide a theme for considering HOW women's empowerment was perceived during this evaluation.

Personal Empowerment

The issue of motivating factors arose during sessions with ward volunteers. Some related this into the acquisition of new knowledge, which proved beneficial to them in making HH changes within their family. Taking this stance alone is positive, as young Nepalese women more often than not face an environment where they either lack, or have limited control over HH decisions. The fact that so many women expressed how they transferred learning into positive health practices reflects an empowerment process for them. The adult literacy

classes also enable women to personally develop, which could lead onto social and economic empowerment for them.

Social Empowerment

Other volunteers, like the women from Ward 14, overwhelmingly indicated that they had gained so much confidence from their involvement with the UNP. Confidence translated into acquiring new friends and the ability to use their experiences and pass knowledge onto others. The training received by these women has positively impacted on their social lives >

> '*When the CF came she wanted me to go for training. I was doing nothing at home, so went for training and learnt to build up my confidence. Before, say in front of about 6 people I was nervous. Now I can speak to a big crowd with confidence. Feel OK talking with the group, more so than at home'*.
> This quote reveals a volunteer's confidence at a personal and social level, but there is a hint that her status in the home may have been less enhanced.

A spokesperson for the CFs stated that motivation came from wanting to serve the people, to be able to work in their own community and to have work that was interesting. '*We are very happy. Most of us are mothers and we work with mothers and children and want this to continue'*. Social empowerment stemmed from a belief that they were relatively unknown at the commencement of the nutrition programme, but now they were very well known and gained a lot of respect from the community.

Economic Empowerment

The most striking example of economic empowerment came from 6 Volunteers in Ward 35 who are amongst the 29 groups of volunteers who have savings schemes through an initial grant of 5,000Nrps. In this instance the women are making SP and over a period of three years they have added a further 16,000Nrps to their bank account; this will earn an additional interest of 3% pa. Withdrawal of money is a group decision, but as yet no volunteer has taken money out. With six of them working on SP production they can individually earn 150Nrps per day; they sell the prepared food at ward clinics, child-care centres and GM sessions, and sometimes from their own home. The women appeared well organized and confident, thus given emphasis not only to an improved economic status, but also personal and social growth.

Women's' economic empowerment is also enabled by the 2 child-care centres that are run in Wards 20 & 35 by paid volunteers. The centres cater for approximately 26 children, who are provided with up to five meals a day, plus benefiting from play and stimulation. The centres enable mothers to work, which often involves several jobs in one day. They are expected to pay some contribution towards childcare.

Just three themes of empowerment have been discussed, as these were the 3 most obvious examples observed during the evaluation. Nevertheless, an assumption is made that cultural empowerment is taking place in a climate of non-discrimination.

iii) Aspects of the programme that proved beneficial for the Ward Clinics

In spite of programme problems with the Ward Clinics, staff from 3 clinics reported an increased flow of patients into the Ward Clinics as a result of the UNP. This is noted in two particular respects from the Health Assistant i/c of Ward 18 Clinic.

> '*Comparing to before, when there was no UNP, the mothers and children began to come to the clinic and the flow increased for antenatal women, as well as children for immunizations. We find that the nutrition education from us has increased.*

Before (relating to UNP programme*) when we tried to advise the mothers they did not listen properly, but now they do. Antenatal women are also asking more questions.*'

This last comment is important, as it indicates that women now show some willingness and confidence to engage more inter-actively with trained health staff and hopefully to take their own health care initiatives.

The other two health i/c personnel also stated that benefits from the UNP had been achieved to a lesser, or greater level. According to the Health Assistant at Ward 14 more children have been seen overtime at the clinic for immunizations. He also viewed GM as beneficial and the development of Chhimeki as very positive. Ironically, when asked why he did not work with the organization now, the HA implied that '*if something good is good, it is not necessary to be involved*'. He had not noted a specific increase of ANC patients, as the clinic catchment area was described as small and a little bit remote and women go elsewhere to PHC centres.

From Ward 28 Clinic, reference was again made to the increased contact with mothers and children as a result of the programme. Additionally, it was reported that the MCH health status had improved; this related to referral onwards from community GM sessions to curative clinic health care and also to ANC and PNC check-ups, plus family planning. Frequently this HA stated that the programme was very good and that if the volunteers request advice then it is given to them (there was not a perceived problem with the volunteers, as they came from her own community).

iv) Changes, as noted by Ward/Club Members from 35, 18, 28, 20 & 19.

The interviews with five male members of wards and clubs enabled a different perspective to be taken. Generally there were positive comments about the benefits and impact arising from the Chhimeki urban programme. All the men reported observed benefits in their communities, from increasing co-ordination between the volunteers to raised awareness on food practices and the importance of growth monitoring, knowledge about ORS and treatment of sick children and improved personal hygiene. Also of significance was the following comment: -

'I have heard with my own ears from another woman that because of the UNP and Chhimeki women are enabled to come out from the domination of husbands and mother-in-laws'.

He also viewed the *'Savings Group as very good. I would like all in the community to be involved and to have individual savings by women, say into a co-operative bank'.* (Currently it is only the volunteer groups who have savings groups)

Source: Rajesh Shrestha: Member of Club Sahid Sucra.

At the same time there was an expressed need for full coverage of wards, even for areas where there is reportedly full coverage. Discussion also ensued about their perceived need for occasional medical coverage at the growth monitoring sessions. It was felt that a curative aspect would attract more mothers and promote further interest in the programme. Additionally, there was concern raised about the co-ordination between Chhimeki and other stakeholders, namely Ward Clinic Staff and the Public Health Director, KMC.

2.5: The above-mentioned concerns lead onto some of the key obstacles that were observed and/or reported during the evaluation. They are not given in any order of priority.

Community Concerns

It was reported from volunteers and CFs that problems had occurred with community target beneficiaries who at times demonstrated a real lack of understanding about the UNP. People had conceived ideas that volunteers received payment and it appeared genuinely hard for mothers/carers to believe that this was not happening. Mothers also expressed a wish for curative care to be offered during the GM sessions. Ultimately, such 'dissatisfaction' could impact on the programme's intention to catch all <3 yr old children from the targeted wards.

Comment

The UNP has never been considered as a curative programme and their expertise is taking shape in the field of nutrition. Resistance to pressure to become involved in curative care is advised, as there are alternative resources for families to use, both in the government and private sector. It is evident that once mothers recognise and appreciate the value of GM and Health Promotion sessions then difficulties begin to resolve.

It is unclear whether the mothers requesting curative care are those with underweight children, or not. The input into families with malnourished children is significant, but maybe families with children who do not come into this category feel that more support could be offered to them. This also raises questions about the provision of enhanced health promotion/education for women who attend GM and constitutes the BASIC approach to reach all mothers & children <3yrs of age. A balance is needed between the time given to families of malnourished children and maintaining the health and well-being of the remaining children, in order to promote preventative health care.

Shifting Families

Family life is frequently fragmented and migratory and although children may improve they fail to have continuity of follow-up through GM and health promotion. Facilitators do not always know if families have moved away and while figures are noted in monthly updates they may have inaccuracies, as volunteer activity and consistent follow-up of families are less reliable in some areas.

Available data shows that 75 children shifted in 2002: 422 in 2003 and 568 in 2004. Clearly family movement is considerable and may potentially be attributed to the instability of IDPs coming into the city. Affirmation of the IDP problem came from Dr.Jyoti Raj Shrestha, Chief District Public Health Officer who states that refugees are quite visible (he could tell by their features etc) and that IDPs are to be found in all areas of Kathmandu. During an immunization campaign held this year there was a huge demand for vaccines, which far exceeded the anticipated number of children.

Comment: There are two main issues faced here.

a) The reality that family movement is increasing is not within the control of the programme, but it can impinge on the activities being undertaken. It is recognized that programme targets could be affected and that frustration occurs with volunteers and CFs when continuity of support is abruptly stopped. It is also recognized that given an influx of IDPs the number of <wt children could increase. Acknowledging this situation puts even more stress on the need to streamline monitoring towards realistic and achievable targets.

b) A lack of HH update is being attributed to the inactivity of some volunteers. For instance, it has been noted that Ward 19 has particular problems, where there is less participation from both volunteers and community mothers, plus a frequent change of CF. This fact relates more to the original volunteers rather than those newly trained. Ward 19 is one of the first wards that the UNP worked in and, reportedly, it is the ward where difficulty, from the onset, has been experienced with clinic staff.

Also evident is that volunteers are also shifting and figures shown for June 2005 indicate a loss of approximately 15% trained women, from 457 to 385. Over half of the volunteers are termed as '*renters*' as opposed to '*locals*' and whether this situation provides a climate of more rapid movement from renter volunteers can only be assumed. Loss of volunteers has to be an accepted 'hazard' of the UNP. However, if these same volunteers take their knowledge and acquired change of practices into other areas and then start to influence their new neighbours, then shifting out can be viewed positively.

From issues raised during the evaluation there is a perception that nothing will change without volunteers being actively mobilised again. Not all have gained confidence and active volunteers feel that there is an unfair burden of work imposed on them, i.e. because they are more vocal and literate they are always invited to meetings. These volunteers suggested that a system of encouragement should be introduced to less vocal and less active colleagues.

Certainly there is a need for this situation to be investigated further in order to diffuse a defined problem, which might increase over time. A series of smaller group meetings with volunteers could enable concerns to be explored, as well as determining how identified problems may be effectively tackled. If a lack of literacy skills emerges as a key problem it would be advisable for Chimmeki to seek support for additional adult literacy classes.

Failed initiatives

Mothers Groups were started for those with underweight children. It was intended to promote maximum contact and dissemination of appropriate nutrition/health information, coupled with socializing of mothers, especially as volunteers often did not find time to visit families. The groups ran for one year, but because of the multiple problems of families it proved unsuccessful and the hoped for social contact actually highlighted differences, rather than similarities. The mothers groups ceased to run one year ago and CFs resumed a key role of visiting and supporting 'hard to help' families and their <weight children, either with or without volunteer input.

Comment

The failure of the mothers group is another lesson learnt and given the high mobility of families the concept of mothers groups was probably not appropriate. The home visiting element of the UNP, especially to complex families, is increasingly within the domain of CFs. It is envisaged that this current situation cannot continue indefinitely. Ideally, if volunteers have the time and skills to provide effective home visiting this could relieve some of the pressure on the CFs. However, as already discussed there are already issues about home visiting and volunteers. An alternative is for Chhimeki to employ more CFs, which although involving additional finances could be an appropriate route to take.

Documentation

Noted to be overwhelming! The positive side is that information is recorded and generally available, but the downside is the amount of time required to accumulate intensive data. Given that Chhimeki will overtime become responsible for management it is considered that streamlining of the data collection is important. The opportunity is there within this second phase to refine targets/indicators and suggestions are given later.

Referrals to Nutrition Rehabilitation Home

A source of concern for the UNP has related to problems encountered when children who are malnourished fail to improve and require referral to the NRH. Although the NRH will permit a mother to come with the <weight child, plus one other child the system fails on a practical level when there are more than two children, or if the husband does not allow his wife to leave the HH, often because there is no extended family to assist with childcare. An example of such a case was seen during the meeting with mothers from Ward 35.

Comment
Would childcare centres be able to help out in these situations?

Clinic Staff

Mention has already been made of the difficulties that now exist between Ward Clinic Staff and the Chhimeki team. In particular this situation affects Board Members and CFs, as volunteers are generally perceived as acceptable by clinic staff. There are several reasons underlying a breakdown of relationships.

A key reason is because SAGUN and Tdh included financial remuneration at the programme implementation stage; this agreement formed part of a separate arrangement made when the first MOU was signed. The contribution of 3,000 Rps per month was paid to the in-charge of ward clinics within the urban project area[20] and was viewed as compensation for the support of clinic staff in volunteer training. Although reportedly undertaken with reluctance by SAGUN and Tdh, the payment was deemed necessary in order to secure active involvement from clinic staff, which was viewed as the path to sustainability.

With the handover from SAGUN to Chhimeki, which is basically a volunteer community organization, the issue of payment to clinic staff was impossible to maintain based on the previous arrangement. Furthermore, the gradual decline of ward health staff in key programme activities, especially during 2004, did not enhance relationships between clinics and the UNP. This situation remains unresolved, but has not deterred the growing strength of the UNP.

Compounding the problem has been the reaction of Dr.Babu Ram Gautam, Chief of KMC Public Health Department. Until this date he has refused to sign the new MOU and for him there are other issues of concern besides payment to clinic staff. He wishes to see clear transparency and a breakdown of budget activities, but generally he was very concerned with a perceived defamation of his character. Where this concern stemmed from was difficult to ascertain, but it was implied that the UNP were taken credit for the ward clinic work. Likewise, there were indications that the doctor disliked the attitude of Chhimeki, which seemed to relate to the projects drive towards a '*rights based approach*' for communities.

There is a desire by Dr.Gautam to meet again with Chhimeki, Tdh and clinic staff, but one left the interview wondering how effective a renewed meeting would be, as a state of impasse seemed to have been reached. It is an unfortunate lesson learnt that regular payment to government clinic staff has ultimately been one of the factors leading to a complete breakdown of effective communication since the onset of 2005.

2.6: Monitoring and Evaluation

Having considered all the findings given in this report the evaluators suggest the following actions in order to improve M & E and to reduce the impressive, but time-consuming collection of data. During discussions on M & E the visit and suggestions of the consultant nutritionist to the UNP/RNP in May 2005[21] were also taken into account. The suggestions are taken from differing perspectives, but are agreed upon as ways forward.

For Chhimeki to focus on three key monitoring systems and to cover:

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[20] Financial support also came to clinics through the donation of equipments/medicines and for three Ward Clinics (20, 18 & 19), funding was given for clinic/community building construction = Rps 3.40,000.

[21] 'Draft Reports (in particular Part C: Project Monitoring and Evaluation) from Mary Lungaho, Consultant Nutritionist.

- Exclusive Breastfeeding up to 6/12 - Continue to use the 24-hour breast-feeding recall questionnaire every six months.
- Appropriate Complementary Feeding: Use a re-call questionnaire regularly for M & E purposes. The KAP 2000+ provides an updated format, which is adaptable to Nepalese foods, based on available and cost-effective ingredients. (*My copy was left with Mrs.Pandey, but can easily be downloaded*).

Care of the Sick Child – sufficient food and drink given, plus management of fever. Monitoring can be done simultaneously with the re-call for complementary feeding, but the recall period for care of the sick child will need to be viewed over a two-week timeframe. It is suggested that both be done six monthly.

- Iron and Vitamin A - it is suggested that volunteers provide these supplements, in order that they can work according to national protocols and also provide data for the DHO office. Supplies are from the DHO office and CFs to be responsible for collection and supply chain to volunteers. Taking this step could enable a more accurate monitoring of both Iron and Vitamin A intake for pregnant and post-partum women.

In the rural areas the supply and distribution of supplements is already within the remit of FCHWs, who are unpaid workers supporting health posts and sub-health posts. Therefore, the concept of having volunteer involvement within KMC is not viewed as a problem. Nevertheless it is acknowledged that Clinic Staff may not be happy with the arrangement.

Other issues relating to M & E

- Vitamin A given to women following a hospital delivery still appears to have a shortfall (according to UNP data). Basically there should be 100% coverage. It is suggested that this issue is again taken up with maternity hospital staff, as errors may occur through a lack of accurate recording on a women's ANC/PNC record.

- The monitoring of volunteer movement and work should be continued as before; this appears especially relevant in view of the difficulties previously mentioned.

- The data recording on the 'Road to Health' to remain as before. This has proved useful for the UNP, as collection of appropriate information, in addition to the routine growth recording, remains on one card. It is relatively easy to use and as a 'tool' to work with alongside mothers its value has been proved.

2.7: Mechanisms & Approaches to share lessons from the UNP with a wider audience.

- Advocacy meetings to be held with teachers, both male and female, from government schools, ward members and informal ward leaders.
- To invite same persons to growth monitoring and health promotion sessions. (*It is noted that some ward members already take an interest*)
- For schoolchildren to observe growth monitoring
- Produce more video films and aim to have television coverage on different channels. Also use the medium of radio.
- Promote interviews with Chhimaki staff

- To develop the volunteers –say 2-3- to give a talk to other wards about their work and the results achieved.
- To demonstrate the making of SP in other non-targeted areas.
- At the time of government Vitamin A distribution (every 6/12) volunteers and CFs could hold growth monitoring/health promotion and food demonstration sessions.
- For Chhimeki and Tdh to engage with other NGOs and INGOs who are likely to be empathetic to the UNP.
- At the Tdh HQ level – for awareness to be raised about the emergence of Chhimeki, from a purely volunteer status to that of a registered community organization. There are lessons to be learnt from this achievement for other TDH community based programmes.

2.8: Recommendations and Suggestions

Regarding Health Promotion and Education

- Expand health promotion and health education to a wider audience in the community. Currently the concentration is mainly at GM sessions. Group meetings with mothers might enable the programme to take an increased pro-active stance towards improved nutrition and preventative health care.

- For the team to aim for more innovative methods of promoting raised awareness on nutrition and health related issues. This could also help to attract more people to the regular food demonstrations, as well as probable group education sessions.

- The above also applies to women's health, where advocacy could be initiated from Chhimeki during national campaign days, such as 'Safe Motherhood Day'.

- Additional effort into the promotion and support of exclusive breast-feeding appears necessary. Mothers are given additional water to babies <6 months as part of a traditional culture, particularly following massage. Given that there is a known problem with clean water in the city it is even more important that purely exclusive breast-feeding is encouraged.

- For First Aid Training to come from outside sources, especially for staff working in the childcare centres.

Programme activities

- Expand adult literacy classes. These classes could also include some sessions on health promotion/education. Also expand child-care centres, where possible.

- For Chhimeki to explore underlying reasons for the identified volunteer inactivity and, where possible, seek ways of resolving concerns that might be expressed.

- For Chhimeki to continue expansion of the areas not completely covered. Currently there is a 30% shortfall over mainly 3 Wards.

- Allow time for Chhimeki to become established and efficient as an organization, but consider expansion into new wards by about mid 2006. (Ideally ensure that existing wards are fully covered with trained volunteers).

- Consider implementation of UNP in new municipalities within Kathmandu District, other than KMC. Seek local and empathetic NGOs as potential partners.

Location of new programme areas would need to be within reasonable access to NRCs. For the technical and organizational skills of the Tdh team to provide a catalyst for change and improved nutritional and health practices – based on their previous experiences.

- Maybe some local monitoring senior person could review the forms currently being used by Chhimeki; this would enable a direct link to DHO and thus provide useful data for them.

Programme Activities relating to sharing lessons learnt

- During the national review meeting of FCHVs it is suggested that Chhimeki could demonstrate (in Kathmandu and Lalitpur Districts) how to prepare Jaulo, Sarbottam Pitho and Lito; also for them to talk about how GM sessions are managed in their targeted KMC wards. Chhimeki would be role models for others and enable potential volunteers to learn about the programme, plus assisting the government in their goal of improving complementary feeding.

- It is considered that ALL Ward Clinic staff requires infant and child nutrition training. The MOH Nutrition Sector could take the training lead, but with organizational support coming from Tdh. The known difficulties between the UNP and clinic staff in the targeted wards are recognized, but opening up opportunities to all PHC personnel could be a positive move towards improving relationships.

2.9: UNP in KMC: General Summary and Conclusion

As a result of a holistic approach to nutrition and malnutrition this report has identified how the acquisition of knowledge and the application of improved nutritional practices have benefited trained volunteers and their neighbours - mothers and carers of children below the age of 3 years and of course the children themselves. Many <3year olds have maintained normal growth; others have made strides, reached and exceeded the 80th Centile Line, whilst others manage to maintain an upward growth, but below the 80th line. There are those who struggle and are malnourished and for sure this situation is not going to disappear.

It has been shown how home visiting is intensified when children are malnourished, with much of this work falling on the CFs. The additional support given to the CFs from external resources has enabled them to put the psychosocial approach into perspective and made them consider how they view solutions. They can now really appreciate how good listening skills provide support for mothers and families and they also recognise there own limitations, that they cannot always improve, or change, the difficult family dynamics that mothers are trapped in, which in turn ‘disable’ their caring abilities for their children. To some extent this recognition may help to lessen the stress (but not necessarily the sorrow) that working with ‘hard-to-help families induces.

Knowledge is being passed from one to another and in many instances taboos have gone in relation to food practices. Awareness has been raised on the need for mothers to seek appropriate medical care for their sick children, as opposed to traditional faith healers and there are clear indications that mothers are improving nutritional care for sick children. Immunization uptake has improved and exceeded the national level.

Women are taking more care of their own health during pregnancy and post-natally and are mindful that Ward Clinics are actually for them to use, particularly for ANC and PNC. The latter situation could have arisen because of culture and caste, whereby those from a ‘lower

caste' system did not assume they had the same rights as women from a higher caste. It appears that women are beginning to question their rights to medicines, such as Iron, Vitamin A and ORS for their sick children. If not actually questioning, they appear more conscious of their rights.

With the women we had the privilege to meet, trained volunteers, CFs and mothers of children <3yrs of age, there was a sense of growing personal, social and, in some instances economic, empowerment. This was very evident with many of the volunteers and they were quick to state that this came about as a result of their training and work with the UNP. Therefore, credit has to be extended to the hard-working Tdh team (formerly SAGUN) who unstintingly give their technical skills and time to promote community teamwork and individual/group skills. This support continues, as they aim to fulfil the ambition of Chhimeki to become self-sufficient in their management, organizational and training abilities. Self-sufficiency is not inclusive of finances, as long-term external donor funding is essential.

The above-mentioned facts are positive. Mechanisms and approaches to share lessons learnt from the UNP with a wider audience have been suggested. It is hoped that movement towards gaining public attention and spreading the work of Chhimeki can take place very soon.

At the same time recognition has been given to Obstacles/Failures identified during the evaluation; they have been explored and comments provided, as appropriate. It is unfortunate that the hoped for sustainability through the Public Health System has not yet come to fruition. However, this has not inhibited the urban team in their determination to support mothers and children towards improved health and nutrition. Practical steps have been suggested towards streamlining the M & E processes, followed by Recommendations and/or Suggestions on ways forward for the UNP and Chhimeki organization.

Internally Displaced Persons

Finally, the TORs request that consideration be given to the IDP situation within Kathmandu City. During the course of this visit there has been no opportunity to really assess the plight of people who are compelled to leave their rural homes, but it is recognized that families are scattered, as opposed to living in a camp type situation. However, anecdotal information has been gained through various meetings, especially in relation to how IDP migration implicates the UNP.

The strongest point to be singled out has come from the Tdh Delegate, when he stated that many of the IDPs appear to be lone women and their children. Without actually speaking to such women it would be presumptuous to assume what their needs are, however the following suggestion is made: -

If funding is available, for Tdh to consider opening up a series of 'Drop-in Centres' for IDPs, in particular to cater for women (lone or not) and their children. It is not so much a question of providing health care, but rather to support the women in ways that are appropriate for them. Such support may actually prevent more harm coming to them, as they and their children could be at risk of exploitation, either inside Nepal or in other countries.

It is envisaged that other organizations could be involved, in order to address a potential wide span of needs and rights that will emerge from the IDP women and children. The UNP has already demonstrated that the skills to tackle complex problems is achievable, but more skilled CFs (and volunteers) would be required if an initiative such as 'Drop-in Centres' is undertaken.

SECTION 3:

3.1: Introduction to the RNP in Lalitpur District, Nepal.

A brief scenario of the Rural Nutrition Programme was included within the main introduction (Point 3 – pps 4-6). The following resume provides more specific details.

Background

The RNP flows from a partnership formed in September 2001 between RICOD (*Rural Institution for Community Development*) and Tdh Nepal. The aim of RICOD is to support communities through the raising of awareness in rural areas on basic subjects, like education, health and environment; the enhancing of prevailing community knowledge and the development of skills to enable acquired knowledge to be put into practice[22].

The main thrust of the RNP is directed towards '*Village Development Committees,* with each VDC comprising 9 Wards. Four VDCs have been targeted during the first phase of the programme, namely Bhattedanda, Ikudol, Malta and Sankhu. The number of wards covered totalled 24 by the end of 2004. A Tdh report[23] (2002) described the HPs and SHPs as generally providing inadequate health care service and delivery; a key intention of the RNP is to enhance these same services.

The system within the VDCs appears at first glance to be quite complicated and this was certainly the reaction during a first exposure to the rural health system during July 2002. Basically, trained health staff are located at the main health centre in Bhattedanda, with SHP served by a VHW and MCHW. Every Ward has a FCHV and a trained TBA, regardless of whether the VDC has the facility of either an SHP, or HP. Out-reach clinics provide a first point of call for mothers and at the onset of the programme there was a shortfall of 5 clinics and the existing 3 necessitated reviewing.

At the time of this report the RICOD staff are comprised of 5 CFs, with one of them taking a lead road as a Senior CF. Unlike the UNP, which has a work complement of only females, the RNP has a male CF and a male Project Co-ordinator. The team are based in facilities adjacent to the main HP in Bhattedanda. The nutrition programme also operates in a district where Maoists have considerable control and, as the report reveals, has impacted on the work of the RNP.

The evaluation of this rural programme took place over 3 days, including travel to and from the area and a meeting in Chapagaun, with Board Members. Meetings in Bhattedanda took place with the RICOD team, staff from the health posts, women from mother's training and mother's strengthening groups, schoolchildren and men from the male training group. The following gives a summary of project coverage: -

Breakdown of RNP Household Coverage as of June 2005
From Wards where Mother's Training Groups & Outreach Clinics exist

Total HH according to Pop. Census 2001		HH. Coverage	Pop. Coverage	%
Bhattedanda	408	350	2027	85
Ikudol	381	217	1227	57
Malta	370	263	1473	71
Sanku	426	399	2213	93
TOTAl	**1585**	**1229**	**6940**	**77.5**

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22 From: Profile of RICOD brochure

23 Lalitpur: Strengthening existing structures – dated 20.6.02

3.2: Main findings from the RNP Evaluation

The following is a breakdown of the key indicators and statistical findings from June 2002 to June 2005. It should be stressed at this stage that there was a lack of time to fully appraise all the data and registers associated with the RNP documentation, plus a lack of electricity in the evenings restricted access to records.

Result 1
Improved knowledge, attitude and practice on issues related to nutrition of children under three and pregnant women in 4 VDCs of Lalitpur.

Indicators

70% of families have access to information on importance of iron during pregnancy and post-natal period.
Out of 305 pregnant women a total number of 241 (**79%**) received iron during ANC. A further 64 women were identified after their delivery by FCHV/TBA and by participants from mothers' training.

80% of women who attended ANC receive Vitamin A after delivery
All 305 women received Vitamin A and iron postpartum, which equals an uptake of **100%.** All 305 women were registered with both RICOD and HP/SHP registers; 64 of them in areas where the project reached late in 2004 and where mothers training is now being undertaken.

60% of families have access to information about proper feeding during sickness
A total of 1,432 children <3 years of age were reached/assessed over the period of 2002 – 2004. They were seen at mother's training and outreach clinics. There might have been some duplication of data during 2002 when the gathering and recording of information was in its infancy. The exact number of young children living in the target areas is not yet known, but on the basis of 77.5% coverage it is assumed that the target set has been achieved.

70% of mothers breast-feed exclusively up to 6 months
A 24-hour re-call in June 2004 indicates that 72% are breastfeeding exclusively up to 6 months. Like the UNP it was revealed that women gave water to their infants at some stage during the first six months.

60% of mother/families have access to information about appropriate complementary feeding.
Again, in view of the HH coverage it is assumed that this target has been achieved.

Result 2
Communities have been empowered to understand malnutrition and take action.

Indicators

Change of practice among participants of mothers' training.
YES. The number of mothers trained from 2002 – 2004 = 480. IMPACT to be reported later.

Number of children show positive trend of upwards growth.
Figures are given from 2003 and 2004 = total number of children seen for weighing during this period = 1066**.**

2003 – From 535 children 135 of them (25.2%) were identified as <weight. From this figure 89.6% showed upward growth. A breakdown indicates that 33.3% crossed the 80th Centile Line and remained above: 56.2% continued an upward growth, but below the 80th line:
10% of children were referred to the NRC, of which 2 children were repeatedly admitted.

2004 – From 531 children 60 of them (11.3%) were identified as <weight. From this figure 85% showed upward growth. A breakdown indicates that 45% crossed the 80th Centile Line and remained above: 40% continued an upward growth, but below the 80th Centile Line: 15% of children were referred to the NRH.

NB: Children still <80th line were carried over from '03 – '04, but recorded as old <weight children in 2004. No data on weights for 2002, as the programme commenced only after the KAP study in July'02, but it is known that 101 children attended for weighing.

High Attendance of outreach clinics by ANC/PNC mothers with children under three.
From 2002 – 2004 a total of **604** mothers attended ORCs: this was from a total number of 1084 mothers seen at ORCs and Mothers' Training.

Result 3
Key nutrition protocols are implemented at HP and SHP: Iron supplementation for pregnant and lactating women, Vitamin A for lactating women and children under five, growth monitoring at each contact for all children under three and for pregnant women, diarrhoea and ARI treatment, protocols are followed.

Indicators

Protocols are available and displayed
YES (Supplies of Vitamin A, iron, de-worming medicines and curative medicines are said to be available)
NB: in 2003 the MOH de-worming policy was for children up to 1-3 years of age, but in 2004 the age range was extended to 5 years by integrating Vitamin A distribution with de-worming medication.

All health staff know how to implement protocols
Although protocols are present there are reported problems with a lack of appropriate monitoring and support of higher health authorities to fulfil protocols.[24] There are also important post vacancies at the SHPs.

ANC Cards available at all times and GM at each contact
Reportedly – Yes on both accounts.

Result 4
A sustainable approach by the health system to address malnutrition is established.

Indicators

Four co-ordination meetings per year between HP-in charge and SHP staff.
YES, taking place.

[24] Rural Nutrition Project, Lalitpur: Annual Report 2004 (Dated February 2005).

Monthly GM in outreach clinics
GM is usually done in ORC by VHW and MCHW – sometimes by the RICOD team who accompany Health Post Staff to ORCs. However, the conflict situation has affected the teams' mobility to the VDCs.

HC are operational
Five new ORCs have been established and 3 have been reviewed.

It is noted that record keeping by HP staff has improved overtime and that clinic staff now share information they have gained from training. Peer sharing continues to take place between the RI COD team and HP staff.

NB: Ward Implementation Committees comprising respected members of the community, (including a TBA and FCHV) have been reformed and re-activated as Ward Health Management Committees in all 4 VDCs.

The above data indicates that achievements have been gained over a timeframe, which encompassed an increase of conflict. As reported early, the doctrine of Maoism has continued to spread over the past nine years and, in turn, this has impacted locally on RICOD's aspirations during the first phase of the RNP. According to the Annual Report of '04 the occurrence of 'r*egular strikes imposed in rural areas were also one of the main obstacles to swiftly fulfil the Operational Plan.'* It is again reiterated that the terrain being covered by the team requires extremely lengthy and tough treks to reach families, communities and health facilities. Additionally, language barriers are encountered with ethnic groups who live high in the mountains, as Tamang is the dialect of just 2 of the team members.

During the course of 2½ days in Bhattedanda the evaluation team met with 33 key stakeholders in the area. The same stance taken in the UNP, namely a series of group interviews and occasional individual discussions, was adopted throughout the visit. Prior briefing had been given from the Tdh Programme Manager and the following discussion views successes, impact and obstacles in more depth.

3.3: Successes flowing from management and organization

Team Spirit: One of the major strengths of the RICOD team is that they are cohesive and have a strong sense of team spirit and friendship, which certainly promotes their support to each other and is evidenced by a **non-hierarchical** team structure. In fact this point is vital, as they not only work together on a daily basis, but live together 24 hours a day, 7 days a week, hence work and social life are intertwined. This factor led to another key success for the team, namely their sense of **autonomy** and the ability to be **flexible** in their work approach.

Strong support from the Tdh Office was noticed: this relates to present support from the Tdh Programme Manager, but also to the past contact from the former Tdh Delegate. (It is noted that the Programme Manager is likely to assume more work in the Tdh office, which could curtail input with the RICOD team in the future).

Until approximately a year ago the team comprised only local females who had very little knowledge about urban life and different cultural situations. The Tdh Delegate considered that exposure to 'alternative' cultural settings would enhance individual self-confidence. Hence, during their monthly visits to the Tdh Office (in Patan) the young women were encouraged to be involved in activities other than pure programme issues. It is a personal observation to see how the female team had changed, from first seeing them in July '02, and again some 3 years later. Although confidence has been gained as a result of their increasing

work expertise it is equally important to recognise that confidence has also stemmed from other sources.

Protocols and guidelines are in place, which has enabled the team to work effectively. It was admitted that following the KAP survey of '02 they were just not clear about what was expected from them. Undoubtedly the setting up of clear work guidelines has overtime enabled a resolution of this problem. The issue of protocols applies not just to the RICOD team, but also to ALL government health staff – wherever their bases might be.

Regular Meetings and good relationships with HP Staff are an essential feature of successes within the programme, this includes liaison with ORCs and SHPs. At the onset of activities the motivation to change and appreciate the input of the RICOD team was less evident from HP staff, but again, overtime, this has been transformed and credit needs to be extended to both the consistency and hard work of the team and also to health staff who have adopted positive work practices.

Regular discussion of case studies takes place and this has helped the team towards an appreciation of the **psychosocial** approach, which is prevalent in the UNP. The RICOD team attended the 3-day CMC training (with UNP), plus regular follow-up supervision from the clinical psychologist.

Transparency of work with communities, along with a mutual respect and trust between the team and communities is a key feature that emerged from the meetings held in Bhattedanda, as will be shown in point 2.2.

All of the above factors have contributed towards strong **motivation** from the team members, together with the opportunities to learn new skills, such as budgeting. Furthermore, CFs derived motivation from > continuous learning in the project, being able to support their own community, or a new community in the case of the male CF, and most importantly, the positive and rewarding relationships with communities.

3.4: IMPACT as a result of the programme

The following findings arise from the evaluators' observations and from the responses given from the people interviewed. Apart from a splitting of interview with mothers and a single session with three team members, all other meetings were shared. Like the UNP, there were three aspects being considered, namely > the impact on improved nutrition for mothers and children: empowerment of communities, and wherever possible, a rights based approach.

i) Impact on improved nutrition for mothers and children

It is noted that the micronutrient intake of Vitamin A and Iron is reaching more women through improved antenatal and postnatal care, plus the availability of supplies. There were a significant number of malnourished children, but this was seen to be less during 2004, compared with the previous year. However, out of the 195 children identified as <weight during '03 and '04 some 25% required referral to the NTH.

From meetings with the RICOD CFs, HP/SHP staff, mothers from training groups, schoolchildren and men who had received training through the male groups it was shown that awareness and improved KAP on nutrition and health related issues have been raised in the 4 targeted VDCs. The following responses indicate HOW and WHY.

From mothers in Bhattedanda VDC, including a TBA and WHCM member

'The benefit is that we learnt certain things about health issues. Learnt about ANC check-ups. I did not know about taking rest'.

*'We learnt about malnourishment. If only one person knows it is difficult to convince others, but as a group (*who also had training*) it works better. I learnt how to make SP.*

'During pregnancy I learnt about the need for additional foods, I am pregnant and now doing this.'

*'Being a TBA I did not know about the importance of a PNC check up at 45 days. It (*the programme*) is very wonderful, as before we had to come some distance for advice, but now the girls are there.'*

'At first it was difficult to do the cooking. Before I did simple cooking, but overcame this because it was important. Before it was difficult to tell others nutritional information, but now I do because it is important'.

'It was difficult to begin with, as people did not believe me. Now, because it is the other women in the community saying the same thing, it has changed'

'Sometimes because of the work it is difficult to weigh my child monthly. My mother-in-law goes instead.'

'I remember I did not take so much interest in SP, but now I know how to cook it and give to my child. He is thin, but would be thinner without the extra food'

All of the 6 women seen are making SP for themselves. They tried to sell in Kathmandu, but this was not possible.

Another group of 5 women who had received training indicated KAP change

- By appropriately treating children at home when they have coughs and colds.
- By preparing jaulo and by learning about nutritious foods and trying to change (food practices)
- Learnt about only giving breast-milk up to 6/12 and after that to give breast-milk with complementary food up to 24 months – even beyond.'
- Learnt to increase frequency of feeds for the malnourished child.
- Leant about iron during pregnancy and Vitamin A after the baby is born.
- Learnt about yellow card (Road to Health Chart) and conscious that a child will be malnourished when the child is below the path.
- Learnt about methods of breast-feeding and early start of breast-feeding.

Verification of the women's responses came from HP staff. Observed changes were: -

From a male auxiliary health worker, now acting i/c at Bhattedanda HP.
'Because of mothers' training there is an increased flow of pregnant women to clinic.'

'Before RICOD the mothers only came for immunizations in ORC, but now the mothers give importance to GM'

'RICOD is helping us for preventative activities. Forming mothers groups is very good, plus promoting GM and preventative health. The team are helping antenatal mothers to attend clinic at least 4 times (during pregnancy) and to take iron'.

'RICOD helped organize ORCs and most important is that they are helping in recording GM and with health education during GM Sessions – leading to an increased flow.'

From a VHW working in Bhattedanda
'Changes are not seen so quickly. After training you can see the child look cleaner and healthy. I ask, what are you feeding the child and they respond – Sarbottom Pitho, Jaulo and other foods. Sometimes they forget one or two things.'

'You can see the changes in mothers' breast-feeding practices, now they give time to feed.'

From a VHW in Ikudol
'Personal hygiene has also improved.'

From Health Committee Member in Bhattedanda
'RICOD do health education and refer a child to Nutrition Centre if needed. When the child improves it is visible in the community'. This last comment was also expressed from another HP member, who felt that referral to NTH had made a real impression on the community.

When staff were asked if they had learnt anything from RICOD about health promotion and health education, a Bhattedanda VHW stated that knowledge was already with them, but their problem related to a lack of adequate staff to fulfil health education. RICOD has helped and now HP staff feel they are able to do more.

Compatibility has been shown between what mothers are saying in relation to changed KAP and observations from HP staff. Likewise, the CFs from RICOD state similar points and linkage is made to an improvement in the nutritional status for mothers and children. Changes were noted in food practices, such as storage of food for later, as opposed to selling or eating immediately (*this latter must be dependant on whether a family has sufficient food to store for later*). It was also noted that cooking practices had improved, plus giving additional foods to children, other than biscuits.

The team also document a decline in Diarrhoea Diseases; this relates to 2004 where 47 cases were reported compared with 67 in 2003. At this stage a decline of 30% is encouraging, but the trend requires further tracking in order to draw hard conclusions. Over the same period the number of ARI has shown an increase, but again requires tracking over time. The increase in known ARI cases could be attributed to a raised awareness on the part of mothers (*as a result of the RNP training*), who actively seek earlier diagnosis and treatment for their sick children.

The supply of medications has been influenced by the work of the RNP, as there has been an increased demand from women, especially for Antenatal and Postnatal supplements.

Of key importance is the building of trust between the RICOD team and the communities. Without this vital element any chance of the CFs creating a climate for change would be lost. The team reported that '*even on conflict days, like now, we can stay in people's homes*' and now they have become as friends to the mothers. The latter is a coupled with a reality that community people are becoming more demanding; this demand also comes from areas outside of target areas, but is not linked into provision of supplies, such as medicines. The RICOD team provide supportive measures in the ORCs by encouraging clinic staff and showing (*by example*) the need for appropriate health education during the GM sessions.

ii) Community Empowerment: demand for rights

Benefits to the community have also been achieved with the establishment of 5 new ORCs within the 4 VDCs and the renewing of 3 existing clinics. This improvement directly arose from discussions undertaken by the team with women who were not attending ANC and PNC (*related into distance of SHPs from their localities*). Subsequently the women lobbied the WHMC who pursued the matter with the HP and eventually resulted in the establishment of new clinics, as evidenced below from a mother living in Ward 4, Bhattedanda: -

> *'With the training (through mothers group) I understood the importance of growth monitoring we (group mothers) demanded an ORC in order to have growth monitoring services'.*

The ORCs have enabled an increased flow of children to GM, which in turn has raised awareness of mothers on the relevance of the 'Road to Health' Chart and health promotion. Along with observing the plotting of their child's growth the mother's now feel confident to ask questions from ORC staff and, when present, the RNP team.

Personal growth through mothers' group training and ORCs came from other women:

> *'I was touched by what I learnt. If you want to help your family you have to stand on your own feet. The training helped and influenced me'*
>
> and
>
> *'I think the training helped me to talk to my in-laws about growth monitoring and its importance. Since the ORC is now near it is easier to convince them to let me go'.*

Mothers also declared that although previously shy they could now talk confidently in front of other people. The fact that the women walked for at least 2 hours to join in a focus group discussion and were able to express themselves self-assuredly with strangers is evidence to the above. The mothers felt that older people appeared to resent their relevant freedom of movement and communication with others.

The afore-mentioned examples are indicators of how personal, social and probably cultural empowerment for women are very slowly being realised.

Economic empowerment began to evolve following the end of training for mothers. Women wanted to remain together in groups, in order to support each other towards improving their family situation, childcare abilities and also to promote income- generating activities. The formation of '*Mother's Strengthening Group'* commenced in February '04. Initially 2 groups were each given 5,000Rps, from which every member purchased young goats for rearing and eventual sale. Groups have developed their own policies, rules and regulations and saving schemes. Mothers met in Bhattedanda described how they all have goats and recently born female kids have been passed onto friends. Now the mothers want to buy a healthy male goat.

On a slightly smaller scale it was reported from a Bhattedanda VHW that women had kept 500Rps, which was a gift from a celebration the previous year. The money went into an interest free fund for emergencies, such as pregnancy care.

Reaching other community members

Development has also come from other sources and was observed during meetings with schoolchildren and men who received nutrition/health training from the RNP.

Schoolchildren

The evaluation team were impressed with the responses given from 4 teenagers as a result of their training from CFs. The selection process is based on a 50/50 split between boys and girls

aged 11-18 years; a boy and girl are chosen from each ward. The training of these youngsters appears to be inclusive, with children encouraged to choose and research a topic from a 'set curriculum'. In turn, a child has the opportunity to discuss a topic during a training session. The CF's worked on the basis that children are naturally curious and want to learn. Raised awareness on a variety of nutrition and health issues was shown to increase personal growth for the 3 boys and 1 girl interviewed. They also revealed how they shared their newly acquired knowledge within their community: -

'In the village we taught the pregnant woman who eat mud not to do so, that she has to take iron tablets and to eat a balanced diet'. Pregnant women frequently believe that eating mud is good for them.

After the training the girls told us to spread the information into the community. So I talk to peers and also to neighbours. I talk about different types of malnourishment. I went to different homes in the community and asked them (mothers) to go to GM and I also talk to them about nutrition'.

'I like what we learnt. It has built up our confidence on issues, like pregnancy. I can talk and be a little bit frank now'. This also applied to another teenager who no longer thought the topic of condom use was a laughing matter; this related to topics on HIV and AIDS.

Some 130 schoolchildren have received training, but through peer sharing another 80 children have been reached with health messages, therefore benefiting 210 children. Currently training from the CFs is ongoing in both Primary and Secondary Schools. The education of these young people is considered to be very important and wherever possible should continue, in order to build a generation who are aware of their right to health care and who are armed with nutritional and health knowledge, for themselves and for their future children.

Male Training Groups and Male Orientation Days

The training of men from the targeted VDCs commenced in 2003 and is continuing until now. Initially 250 men were given a short orientation on nutritional issues. Reportedly,[25] this step towards raising awareness amongst men has made real impact on the number of women participating in mother's training.

Following this success a curriculum was devised for a male training on MCH and nutrition, but also included topics on domestic violence, and human and child rights. The intention is to sensitise fathers/husbands on the importance of family health and how to support their families through a better and healthier lifestyle. In total 67 men received this more lengthy training and 8 of them were seen during the evaluation. When compared with the mothers' responses the men showed some similar awareness on nutrition, ANC, PNC and care of the sick child; in turn this seems to have changed their practices towards their wives. In respect of women's rights: -

From a farmer in Ikudol

'Before (training) the culture is not to let the women go out. Now I know that women have a right to go out to ANC and check-ups.'

He also implied that it is the women who suppress other women and he tries to discuss disputes separately with his wife and his mother.

From a farmer in Bhattedanda

'*We talked about alcohol problems and the affect of men's behaviour (*following drinking*) on women.*

25 RNP Lalitpur: Tdh/RICOD Semi-Annual Report for 2004 and Annual Report dated February 2005.

This same farmer suggested that men and women should hold combined meetings approximately 3 months following their training activities, in order to discuss changed attitudes. Other men wanted more information for families on family planning; this was linked into large families and food distribution.

All the men confirmed that they felt personal change as a result of the training and that there were '*so many health issues to be learnt.'* Individuals demonstrated a real concern to support change, even to the extent of one farmer providing space in his homes for mothers training, plus inviting the mother of a malnourished child to attend; she came and the child is fine now.

These scenarios of male involvement in trainings are positive and, like the work being done with schoolchildren, require continuation and expansion.

3.5: Obstacles encountered and the affect of conflict on the RNP

Health Posts and Sub Health Posts

Problems encountered during the early days were associated with the co-ordination between HP/SHP staff and the RNP team. There were less clinic staff present and the local communities wanted a RICOD team member to stay in the ward areas. This problem has been resolved now, due to the hard work and commitment of the team, plus a change of attitude from clinic staff. The findings from the evaluation show that a shortage of staff remains, especially in the SHPs and the reality remains that most of the FCHVs are elderly, with no more being trained.

Comment

It was suggested that recruitment and training up of smart women from the mother's group could be a possibility. However, this is a clinic decision and apparently FCHVs hold onto their posts and it is not easy to replace them.

Expectations from communities

At the onset of the programme the demands were different from what the team had expected. Health for community members implied medicines and not the nutritional approach that was planned from the RNP. The initial concept of gathering mothers together in clusters, with a focus on weighing, was unsuccessful for varying reasons: poor motivation from mothers to stay for discussions, the inexperience of the RICOD team and a lack of understanding about GM from SHP staff. Resolution was through the present system of mother's training, which is inclusive of recently married women, mothers of children <3 years of age and also mothers-in-law. Also the introduction of a participatory mode of training, which is flexible and uses good listening skills, has assisted both the team and beneficiaries.

Comment

This is a lesson learnt, as real expectations from the community could have been explored during the early planning stage, thereby potentially avoiding some of the problems experienced by the team.

Documentation

There appears to be a considerable amount of data and record keeping, although less than the UNP, as the population coverage is considerably smaller. Documentation is frequently managed in the team's free time, but this situation is almost inevitable given that the RNP team live together, with work probably a dominant feature of their lives. The opportunity is given within the second phase to refine targets and indicators and suggestions are given later.

Home Visiting

The time involved for home visiting to 'hard to help' families with malnourished children is limited by the distance to destinations. As stated earlier, it is only the really malnourished children and sick children who are visited. Often there is insufficient time to give explanations to mothers at GM sessions.

Comment
In time it may be possible to enlist the support of well- trained and motivated women to provide very local follow-up visits to families with malnourished children, but not those with complex problems.

Conflict

The conflict situation has impinged on the RNP team in different ways through restrictions on work activities and personal infringement of freedom and liberty.

- Initially it was difficult to gain trust from the community and for the team to stay overnight in the areas, particularly as the insurgents were already present in the target VDCs. This obstacle also applied to bringing mothers to home-based mothers' training; now it is difficult to bring people into open spaces for discussion.

- The envisaged progress of expansion for the RNP has been hampered by conflict. It has not been possible for the team to enter into a 5th VDC and this factor will have curtailed the increase in potential beneficiaries. Therefore, concentration has been given to the consolidation of the existing 4 VDCs, which ultimately has been a positive step to take. Entry into a 5th VDC is intended for the near future.

- Until now there has been a lack of VDC and Ward Profiles. Data has been provided on HHs and population according to the 2001 National Census, but detailed and important data is missing, especially in relation to numbers/ages of children etc. The team originally planned to gather this data during 2004, but the conflict situation prohibited such action. It is now planned to undertake Ward Profiles a.s.a.p.

- The abduction of 3 RICOD team members and one staff of Tdh compounded the above limitation of work during June 2004. They were held for 6 days, unharmed but frightened. During this period the PC (*also a RICOD Board Member*) talked with the Maoists, in order to secure the teams release.

  It was observed on more than one occasion during the evaluation visit how fear was palpably visible amongst team members, especially the senior CF. The PC confirmed that the team are still scared.

- Due to the conflict situation the team were unable to undertake all their usual activities for 1½ months and outreach work only commenced again just prior to this evaluation. However, this lapse hindered the proposed development of more mothers groups.

- It was noted by the Tdh Programme Manager that there appeared to be less men seen in the villages. This fact was not substantiated from the team, but given the movement out of rural areas into 'safer' environments, it is possible that men are leaving their communities to avoid being recruited by the insurgents. The impact of such movement is likely to compound difficulties for families, plus the general livelihood of communities, as many men work as local farmers.

- The team are very concerned about a lack of financial insurance in the case of their being injured; this relates into concern for their family members[26]. The team has raised this issue with their Board Members, but as yet there is no clear plan to assist them. Board Members (*met at RICOD's office*) are considering additional financial support, such as a provident fund, but according to the RICOD chairperson, there are no funding sources available.

Supervision

Of equal concern, is that the team had expressed a lack of support from Board Members. The two Board members met by the evaluation team have a different perception and state that access is always available to them. Clearly there are differing views here, but in part may be explained by the fact that two of the Board Members are also employed as RNP staff, therefore access to the Board could be perceived as via work activities. The team do not take this point of view.

There are issues about the employment of RICOD Board Members as paid members of staff. Firstly, the current PO, who has a background in teaching, is covering two programmes for RICOD, with approximately just 30% of his time allocated to the RNP. He is placed in a difficult situation of which he is fully aware, but his 'instructions' from the Board are that '*RICOD is independent, so do not be a shepherd.*'

Members of the team expressed a need for more quality supervision time, principally because of the security issues confronting them. Secondly the longer-term input for technical supervision (*funded from Tdh*) has been coming from another Board Member. However, during pregnancy she had to reduce her working hours to 50%, and will be absent from work for at least two months from September onwards. Therefore, the RICOD team are somewhat bereft of adequate support and supervision.

The evaluation team felt strongly that this present situation should be rectified. One stance taken was that consistent technical input is necessary, whilst another sought objective development support to be in place, as the team work in such a closed working environment. Questions are also raised about Board Members being employed within the RNP; it is possible that the SWC[27] regard this as illegal.

RICOD Board

The meeting with the RICOD Board was not so productive and there was a feeling of distance between them and the reality of the RNP teams' work, as referred to in points 5 and 6. The main concern relates to their ability, or willingness, to support the team, both practically and sensitively on work/living issues in a conflict situation.

However, some action is being taken. The chairperson described how the setting up of an 'Advisory Committee' has been formed in order to monitor local situations in respect of security for the team. At the community level the committee is formed from one RICOD general member who lives in the VDC, a FCHV, a schoolteacher, HP staff and one RICOD team member. The Advisory Committee is also available if a complaint should be made about the team and/or programme > this relates to potential difficulties from the insurgents. No further information or progress on this committee was available during the evaluation.

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[26] Additionally, the evaluation showed that the RICOD teams' salary could be less than trained clinic staff, when taking into account the additional benefits received by government employees. This reality was raised with the Tdh office and will be considered during their annual budgeting.

[27] In February '05 all the SWC staff were changed and their current protocols require clarification.

3.6: Monitoring and Evaluation

Consideration has been given to the findings in this evaluation and it is suggested that the following actions are taking in order to modify data gathering for the RICOD team. Basically the key suggestions are similar to those given for the UNP, apart from ANC/PNC supplementations, as these are being adequately covered.

- Exclusive Breastfeeding up to 6/12 - Continue to use the 24-hour breast-feeding recall questionnaire every six months.

- Appropriate Complementary Feeding: Use a re-call questionnaire regularly for M & E purposes. The KAP 2000+ provides an updated format, which is adaptable to Nepalese foods, based on available and cost-effective ingredients.

  Care of the Sick Child – sufficient food and drink given, plus management of fever. Monitoring can be done simultaneously with the re-call for complementary feeding, but the recall period for care of the sick child will need to be viewed over a two-week timeframe. It is suggested that both be done six monthly.

- The data recording on the 'Road to Health' to remain as before. This has proved useful for the RNP, as collection of appropriate information, in addition to the routine growth recording, remains on one card. It is relatively easy to use and as a 'tool' to work with alongside mothers its value has been proved.

Process documentation is incorporated within the team's work and needs to be maintained. It would be worthwhile to hold periodic meetings (*as suggested by one of the male group trainees*) to compare progress and KAP changes, especially on HOW they are being achieved. Such meetings should include all concerned, including schoolchildren who receive training and those reached through peer coverage.

Finally, the RICOD team would like to carefully document all the project processes that have taken place since the onset of the rural project. Their objectives relate to 3 key points, namely > useful for the community, informative for outside visitors and useful for new staff. (*It could also be helpful for funding purposes!*) Wherever possible, it would be helpful if Tdh could provide support and active encouragement towards this possible initiative.

3.7: Recommendations and Suggestions

- Of key importance is that the RNP team should have more substantial support from their Board Members. If this is not feasible, then Tdh, as funders, need to redress the situation.

- Guidelines are necessary on issues relating to the safety of the team

- Follow-up support for the team is required in relation to stress/fear management.

- Consideration required on HOW additional financial assurances can be made available to the RNP team.

- Questions have been raised about the 'legality' of Board Members being paid members of staff. This requires further investigation.

- Adequate technical and objective supervision and support is necessary. In particular, to acknowledge that the present PO is probably doing the best he can,

but that 70% of his time is given over to another project and in a different location. Also to take into account the feasibility of the present technical supervisor resuming a full-time role following her maternity leave.

- Liasion between RICOD Board and the Tdh Office to be on a more regular basis especially to enable sharing of information on the progress of the newly formed 'Advisory Committee'. (*From Board Members > meetings are not so frequent with a reliance on Board employees to fulfil this role*),

- For the RNP team to continue with the nutrition/health educational sessions with schoolchildren and men, as well as increasing the number of mothers groups for training.

- For the RNP to expand (*if the situation allows*) into a 5th VDC area as quickly as possible. Aim to undertake a ward profile of this area as a priority, along with ward profiles in the existing VDCs.

- Consider the introduction of other topics in the training curriculum, such as Family Planning.

- Continue to advocate and promote pure exclusive breast-feeding up to six months. All government health staff to be included in this approach.

Additionally

It has already been suggested that well trained and motivated women could assist and support low-key home visiting to families of malnourished children (*see point 4 of Obstacles*). It is noted from the Annual Report for 2004 that ' *better sustainability will be achieved through 'project ownership' by enabling target groups to gain more control over their health through the formation of more nutrition groups in the target areas.'*

The meetings with mothers indicate that '**project ownership**' is the way forward, as they too saw the need for more women to be trained, in order to advance nutrition and health practices.

The conflict situation has the potential to disrupt the RNP work at any time. Therefore, it is important that organizational steps are considered to maintain key activities, which are centred on behaviour change. The distances between VDCs and the RICOD base, plus the ambiguity of low-intensity conflict necessitates enhanced community involvement of women, men and schoolchildren if the project is to further its goal of improved nutritional status of women and children. Therefore, it is considered that encouragement be given to motivated and able community members to take on more responsibility within the RNP, with the drive towards ownership. Undoubtedly the support and good practices from HP, SHPs and ORCs are also vital to progress being made and sustained.

All of the above-mentioned is reliant on whether access to food is feasible, not only from food cultivation, but on the ability and access to purchase food. The latter is difficult when communities are confronted with increased economical instability and loss of their autonomy. It is recognized that Tdh Nepal are envisaging food for work initiatives within the targeted areas of Lalitpur.

3.8: RNP in Lalitpur District: General Summary and Conclusion

This evaluation has shown that nutrition and health care practices have improved at the personal and HH level within the VDC Wards of Bhattedanda, Ikudol, Malta and Sanku in

Lalitpur District. Approaches taken by the RNP team have relied on their own personal contact with women, men and schoolchildren, in order to provide them with training sessions, which over time became more participatory and fulfilling. Equally relevant are signs of personal and social empowerment for women, as they gain not only knowledge on nutrition and health care, but also the ability and confidence to make changes within their homes. Likewise, attitude changes are noted amongst men and schoolchildren.

Malnourished children < 3years of age have either gained weight and crossed the 80th Centile line, or shown an upward trend whilst remaining below this cut-off point. However, during this same timeframe the number of children requiring referral to NRC was significant.

Home visiting had to be restricted to children who are more malnourished and sick and this fact has to be accepted as a reality, given the terrain and distances involved to reach more far-flung VDCs and Wards. For similar reasons, the population covered cannot be compared to the number of women and children reached in the urban project. Despite such obvious differences, the impact of the RNP was clearly seen during the course of meeting key stakeholders. If entry into a 5th VDC had taken place as planned it is visualised that the number of beneficiaries would have appreciably increased and contributed towards the overall goal of improving the nutritional status of women and children. The intention to expand the project is, hopefully, to occur soon.

Encouraging changes are noted at government health posts. There was a real sense of the RNP and health staff working together, especially with the opening of additional ORCs and exchange of information at all staff levels. The RNP team have, wherever possible, ensured that their good working practices are used as examples for health staff, especially in the SHPs and ORCs.

At the same time recognition has been given to Obstacles identified during the evaluation; they have been explored and comments provided, as appropriate. In particular, the impact of the conflict situation on the RNP team has been highlighted. Practical steps have been suggested towards streamlining the M & E processes, followed by Recommendations and/or Suggestions on ways forward for the RNP in Lalitpur District. The concept of furthering nutrition and health groups within targeted areas has been raised, plus working towards community ownership of the project, as a means of strengthening the overall goal.

Annex 1

Terms of Reference for the External Evaluation of the Urban and Rural Nutrition Project in Nepal

1: Confirm or invalidate the extent to which the objective of the project, the results & the impact indicators have been met (as reported by the project management)

2: Confirm or invalidate factors (as reported by the project management) contributing to the project's successes or failures in meeting stated performance indicators; make recommendations on ways to increase performance in a follow-on project. Suggest mechanisms and approaches to share lessons learned with a wider audience.

3: Assess the overall impact of the program on improving nutrition of children, including assessing whether the stated performance indicators led (or should have led, if properly implemented) to achieving the overall project goal. Identify any additional activities/alternative implementation strategies that should have been implemented to better achieve the project goal, particularly as they relate to operating in a conflict setting.

4: Assess quality, effectiveness, efficiency, and appropriateness of project management of *Terre des hommes* and SAGUN, particularly M & E, and make concrete recommendations for future improvements.

5: Assess how the programme has addressed sustainability.

6: Assess capacity of Urban Nutrition Project and determine which capacity building activities were most effective. Determine additional capacity building needs.

7: Assess the implications of the civil conflict on the rural nutrition programme in Lalitpur District.

Furthermore, given the intensification of the civil conflict, the team will examine the situation of the internally displaced persons (IDP) to determine the extent to which the project could respond to a growing humanitarian crisis – internally displaced persons – in Kathmandu City and to recommend a response system.

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Methodology

The evaluators studied and analysed statistical data from the urban and rural nutrition/health projects. Findings were compared to the defined overall goal, anticipated results and set indicators, thereby providing a quantitative focus for the evaluation.

Given that impact and improved KAP necessitated behaviour change at the personal and HH level, a triangulation approach was taken in order to determine qualitative findings. Similar questions were posed with key groups of people and, where appropriate, during individual meetings. Flexibility was allowed for people to discuss matters that emerged during discussions and the analysis has taken into account the development of women (also men and schoolchildren in the rural programme), as well as essential nutrition and health issues. Overall the 2 evaluations spanned 13 days, including planning, travel to the rural district and de-briefing at TDh Office.

Annex 2

ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
BMI	Body Mass Index
CDO	Chief District Office
CF	Community Facilitator
FCHV	Female Community Health Volunteer
GM	Growth Monitoring
HH	Household
IDP	Internally Displaced Persons
IMR	Infant Mortality Rate
KAP	Knowledge, Attitude and Practice
KMC	Kathmandu Metropolitan City
LBW	Low Birth Weight
MMR	Maternal Mortality Rate
NRH	Nutrition Rehabilitation Home
ORC	Outreach Clinic
ORS	Oral Rehydration Supplement
PHC	Primary Health Care
PHD	Public Health Department
PNC	Postnatal Care
RNP	Rural Nutrition Project
SHP	Sub Health Post
SP	Sarbottom Pitho
SWC	Social Welfare Council
TBA	Traditional Birth Attendant
TF	Training Facilitator
UNICEF	United Nations Children's Fund
UNP	Urban Nutrition Project
VHW	Village Health Worker
WHO	World Health Organization
WIC	Ward Implementation Committee

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Annex 3

Itinerary from August 14th to 29th August

13th August pm	Depart from UK for Kathmandu
14th August	Arrive Kathmandu
Monday 15th	Discussion and Planning meeting at Tdh Office, Jawlakhel regarding meetings to be held for UNP evaluation
Tuesday16th	Discussion and planning meeting at Tdh Office, Jawlakhel regarding visit to RICOD (RNP) team in Lalitpur District

RNP

Wednesday17th	Depart for RNP in Bhattedanda, Latitpur District Meeting with Community Facilitators and Project Co-ordinator, RICOD Meeting with Adolescent Schoolchildren
Thursday 18th	Meeting with members of Male Training Group Meeting with Senior Facilitator + 2 members of the team (BJ) Meeting with members of Mothers Group (SP) Meeting with members of Mothers Group (BJ) Meeting with Health Post Staff Meeting with Ram Hari Ghimire, Project Co-ordinator
Friday 19th	Discussion regarding data recording and indicators Leave AM from Bhattedanda Travel to Chapagaun Meeting with RICOD Board Members Return to Kathmandu
Saturday 20th	Updating of information from RNP visit (BJ)

UNP

Sunday 21st	Meeting with Chhimeki Board Members Meeting with Community Facilitators & Tdh Technical Team Meeting with Ward & Club Members from Wards 35.18.28.20.19

Monday 22nd	Meeting with Tdh Delegation at Tdh office. Meeting with Dr.Jyoti Raj Shrestha, Chief District Public Health Officer Meeting with Dr.Babu Ram Gautam, Chief Public Health Department, KMC Discussions at Chhimeki Office with Gauri Gari, Tdh team
Tuesday 23rd	Observation of Growth Monitoring Session in Ward 18 Meeting with Volunteers from all Wards 14 (AN & PN) (BJ) Meeting with Mothers from Ward 19.20.28 (SP) Meeting with Volunteers from Ward 14 (BJ) Meetings with Mothers from Ward 18.30 (SP) Visit to Child Care Centre, Ward 20 (BJ) Visit to Adult Literacy Centre, Ward 20. (SP) Meeting with Clinic Staff in Ward 18
Wednesday 24th	Meeting with Tdh Trainers Meeting with Volunteers from Wards 19.20.28 (BJ) Meeting with Mothers (AN) from Wards 19.20.28 (SP) Meeting with Volunteers from Wards 18.30 (BJ) Meeting with Mothers from Ward 14 (SP) Meeting with Clinic Staff at Ward 14 Meeting with Dr.Gramesh Yonzan, Chairman of SAGUN
Thursday 25th	Visit to Child Care Centre at Ward 35 Meeting with mothers from Ward 35 (BJ) Meeting with Volunteers from Ward 35 (SP) Visit to Savings Group in Ward 35 Meeting with Pahupati Mahat, Co-ordinator of Child Mental Health Programme, Centre for Mental Health & Counselling, Nepal Meeting with Clinic Staff at Ward 28
Friday 26th	Follow-on meeting with Community Facilitators and Tdh Trainers Full day discussion regarding UNP data and indicators
Saturday 27th	Full day preparation for evaluation briefing (SP & BJ)
Sunday 28th	Feedback to Tdh Delegate, Programme Manager and Technical Team
Tuesday 30th	Depart early from Kathmandu for UK (BJ)

Annexe 4

People met in Bhattedanda, Lalitpur for RNP Evaluation

RICOD Community Facilitators	**Schoolchildren, recipients of training**
Shanti Timalsina Sr. CF	Susmita Karki (F)
Sushila Timalsina	Aftab Alam (M)
Kamala Sapkota	Gobinda Timalsina (M)
Chubi lal Lama	Min B Bista (M)
Santa Lama	
Ram Hari Ghimire: Project Co-ordinator	

Health Post Staff	**Mothers, recipients of training**
Krishna P.Bajgain VHW	Saraswati Ghimire Maju Banjara
Krishna P. Sharma VHW	Kalpana Banjara + **6 other mothers from**
Rajkumar Sapkota AHW	Galtri Banjara **Bhattedanda VDC**
Navaraj Timalsina AHW	Brimkumari Lama
Tehamath Nasneth Health Committee Member	Ambika Gautam Kalpana Gautam

Men, recipients of training	**RICOD Board Members**
Pumanda Ghimire Farmer	Bed B. Lama, Chairperson
Ram Lal Tamang Farmer	Sesananda Sanjel, Secretary
Ram Chandra' Chaurel Farmer	Sushila Lamichane, Board Member and
Nab raj Karki Farmer	Technical Advisor for RNP
Kana P.Dulal Farmer	Ram Hari Ghimire, Treasurer & Project
Nava Raj Timalsina Labourer	Co-ordinator, RNP
+ one Cattle Raiser from Ikudol	

People met in Kathmandu Metropolitan City for UNP Evaluation

At TDH Office: Tdh Delegate – Reinhard Fichtl and Tdh Programme Manager, Shilpa Dunlepcha

Tdh Technical Staff	**Chhimeki Board**
Gauri Giri (Team Leader)	Bimala Rajopadhyaya Uma Thapa
Sabitri Gurung Sr. T.F	Shree Roka Nuthan Shresha
Devindra Bhattarai TF	Beena Shrestha Anita Shrestha
Sushila Shrestha TF	Ishwori Subedi Santa Tajpuri
Shobra Shrestha Sr. T.F	Anju Ranabhat
	Some board members also work as volunteers

Chhimeki Staff

Community Facilitators	**Community Facilitators**
Rama Shah	Gita Amatya
Dina Nepali	Binita Katwal
Binita Rizal	Samjhana Karki
Anita Shrestha	Pramila Shahi
Kavita Lamichanay	Mishra Bharati
Arijali Maharjan	Bishnu Maya B.K Office Assistant recruited from volunteers
6 Community Facilitators recruited from Volunteers	

Volunteers from Ward 35		Volunteers from Ward 14 (AN & PN)	
Anita K. Chaudhary	Shobha Giri	Lalita Neupane	Kusike Maharjan
Kalpana Silwal	Jamuna Pokherel	Sita Joshi	Runa Sahel
Vidya Bhandari	Manmaya Shrestha	Kalpana Rai	Sarala Chauhen
Samjhana Humagain	Dikumari Rai	Mandira Gortan	Sumila Tamreleer
Menuka Paudel	Lila Dhungana	Sanjeka Shrestha	Baguati K.C
Menuka Khadka	Roopa Chettri	Gyan Larmi Shalk	Lamni Marhajan
Meenu Bhattarai	Radna Shrestha	Gajatin Gautam	Renju Struth
		Namita Mallick	
Volunteers from Wards 19, 20 & 28		**Volunteers from Wards 30, 18 & 11**	
Rama Tanduker	Laxmi Thapaliya	Laxmi Sapkota	Chanda Pradhan
Debi Sharma	Sushmaa K.C	Jyoti Giri	Laxmi Shrestha
Sharada Jaisi	Binita Rangit	Hira Maharjan	Binita Dongal
Gyani Dongol	Laxmi Maharjan	Anjana Shrestha	Sonu Maharjan
Gyani Mahargan	Rati Shrestha	Jamuna Rayamaji	Sharmila Maharjan
Laxmi Shakya	Sherada Pradan	Saraswati Maharjan	Binda Koirala
Purneshwori Shrestha	Sarita Bajracharya	Sunita Chitrakar	
Kanchhi Lama	Durga Rahila	**+ Volunteers from Ward 14 x 17**	

Mothers met from Ward 19, 20 & 28		Mothers met from Ward 14	
Priya Lama	Sanu maya Pandey	Ganga K C	Ambika Adhikari
Gyanu Adhikari	Sunita Lama	Kunti Marattha	Bandana Sharma
Poonam Pandey	Tara Gautam	Sashi Khanal	Kanchhi Sundas
Sanu maya Maharjan	Santa Adhikary	Rita Shrestha	Anu Khadka
Bhagawati Baral	Sajana Maharjan	Ram Maya Tamang	Manju Subedi
Indira Nepal		Saita Shrestha	Santi Lama

Mothers from Ward 35				
Sita Oli	Goma Ghimirey	Shanta Thapa	Rali Lama	Sujana Ghising
Ambika Sherpa	Januki Baidey	Radha Maji	Sukmini Adhikari	Kanchhi Shrestha
+ Mothers from Wards 18 & 30 x 10				

Ward Members and Club Officials from Wards 35, 18,28, 20 and 19
Yubaraj Khanal
Niranjan Bikram Basnet
Rajesh Shrestha
Chaity Narayan Maharjan
Gautam Ratna Sthapit

Sarbattom Pitho Group in Ward 35
Samjhana Shrestha, Manmaya Shrestha and Renu Dahal

Ward Clinic Meetings - Health Assistants i/c of 14, 18 and 28 Clinics

Public Health Officials
Dr.Jyoti Raj Shrestha, District Public Health Officer, Kathmandu
Dr.Babu Ram Gautam, Chief Katmandu Metropolitan City, Public Health Department

External Training Support for Community Facilitators, UNP and RNP.
Pashupati Mahat, Clinical Psychologist, Co-ordinator, Child Mental Health Programme, Centre for Mental Health & Counselling-Nepal

Plus staff at Child Care Centres, Adult Literacy Centre and others met at Growth Monitoring Session in Ward 18

Annexe 5

Details of Training for Volunteers in UNP

- The Development of Training Curriculum for the neighbourhood volunteers was based on His Majesty' Government of Nepal's Nutrition issues.
- The curriculum is built on the life experiences from the training participants.
- Training is adopted (*and adapted*) on emerging needs from communities where the UNP is implemented.
- Based on the Curriculum Outline the Training Facilitators write the steps for each day sessions; they are intricately linked/based on the previous sessions and forthcoming sessions. This enables the trainers to effectively make linkages between the issues being discussed and also helps to make the training interesting and easy for the volunteers to understand.
- Training is on a once weekly basis over a time span of 10 weeks.
- Over a 4-5 hour session volunteers are exposed to situations, which motivates and encourages them to share their own experiences of pregnancy, childbirth, childcare etc. It is from these sharing experiences that the concept of **listening** (*and listening skills*) begins.
- During the above, the training facilitators provide the fundamentals of mother-child health issues, which will complement the life experiences of the trainees.
- Following completion of the course the volunteers are supported (through feedback) with their 'hands on' training in their own neighbourhoods. This aspect takes another 6 weeks of 2 – 3 hours a week. Volunteers are expected to mainly share experiences on how the work in their localities, especially visiting the families, is taking shape.

The main components of the Neighbourhood Volunteer's Training basically: -

- Orientation on project intentions
- Know your own community………involves Social Mapping
- Family Cycle
- Antenatal Care
- Postnatal Care, Iron and Vitamin A
- Breastfeeding
- Food Groups
- Preparing menus……learning about nutritious foods/storage/preparation
- Growth Monitoring…involves learning/plotting of Road to Health Chart
- Disease and Malnutrition
- Psychosocial issues in child care
- Job Description
- Training Evaluation

The number of volunteers per training group generally consists of 9 – 16 women. These women tend to stay together as a kind of team following their initial training. Details of selection have been briefly described within the main report.

The above information has been obtained from UNP documentation relating to Neighbourhood Volunteers Training

Annexe 6

References used as background information for the evaluation

REPORTS

Draft Reports from Mary Lungaho, Consultant Nutritionist (undated, but visit took place in May 2004).

Nepal Micro Nutrient Status Survey 1998

Project Proposal for Kathmandu Metropolitan City and Lalitpur District: September 2001 – December 2004.

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SAGUN Urban Nutrition Project, Kathmandu: Nepal. Semi-Annual Report 2004, dated July 2004

SAGUN Urban Nutrition Project, Kathmandu: Nepal Annual Report 2004, dated February 2005-09-27

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UNDP Nepal Human Development 2004: '*Empowerment and Poverty Reduction'*.

Urban Nutrition Report Kathmandu/Nepal: '*Capitalization Report 2005'* by Barbara Weyermann:

UNICEF Statistics: NEPAL - Basic Indicators – via Internet.

'Unravelling Malnutrition: Challenges of a psychosocial approach.' Report by Barbara Weyermann, based on Action Research by Gauri Giri, staff and volunteers of SAGUN. Kathmandu 2003

WHO unpublished data, '*Health of the Newborn*' from a South-East Asia regional Committee 56th Session 10-13th September 2003.

WHO publication in the Regional Health Forum, '*Making Pregnancy Safer in Southeast Asia*' by Drs.N.Kumara Raid & Sanu Maiyan Dali: Vol 6 No 1.2002

Articles/Press Releases

Global IDP Project (Nepal) via Internet and dated 8th September 2004

Editorial Report from the BBC News (UK edition) dated 26th July 2005. '*Children suffer in Nepal Conflict*'

'*Kathmandu Post*': dated Friday 22nd July 2005.

UNFPA – '*Providing Quality Reproductive Health in Nepal' (*Undated*)*

UNICEF press release, dated 1st April 2005 – '*UNICEF appeals for fear to be banished from Nepal's classroom*'.

Other Background reading

Numerous press releases and reports sent through from Tdh Delegation in Nrpal.

'*Mother Sister Daughter- Nepal's Press on Women'*: B.Rana et al. Printed in Nepal by Jagadamba Press. Supported by United Nations Development Fund for Women.

National Nutrition Policy and Strategy (Draft). Dated 24th December 2004 produced by the Nutrition Section, CHD, DoHS, MOH – Nepal

'*The Movement of Women: Migration, Trafficking and Prostitution in the context of Nepal's Armed Conflict':* Sondra L.Hausner, Save The Children. USA. Kathmandu, June 2005.

EXECUTIVE SUMMARY

The implementation of the Tdh Nepal urban and rural nutrition projects commenced in September 2001, with partnerships formed between Tdh and two local NGOs, SAGUN and RICOD covering the urban and rural areas respectively. Research into KAP were undertaken in May '01 and July '02 and the local findings reflected national concerns on the poor nutritional status of women and children; indicating that ANC and PNC attendance required improvement, along with Iron and Vitamin A Supplementation, Exclusive Breastfeeding, Appropriate Complementary Feeding and Feeding and Care of the Sick Child.

This evaluation took place in August 2005 and sought to validate if the overall goal of improving women and children's nutrition had occurred, along with the key objective of improving KAP on issues relating to nutrition of children <3years of age and pregnant women in defined rural and urban localities. The TORs (see Annexe 1) have guided these two evaluations; the results are given as follows

Urban Nutrition Project in KMC: Main Findings

1: Currently the UNP covers 70% of the seven targeted wards in KMC. This represents population project coverage of 17,209 (based on a 2001 census), but of course is primarily aimed at reaching the above-mentioned key target groups.

2: The active volunteers who cover the project number 385 and they provide the core of the UNP, along with their 11 Community Facilitators, who are paid members of staff. The volunteers' work is focused on their own neighbourhoods and their activities, home visiting, supporting families with malnourished children and attendance at growth monitoring sessions, should not exceed 3 hours per week; it is a cost effective method of heath promotion. Volunteers are also considered to be beneficiaries of the UNP, as they too acquire improved KAP on nutrition and health issues.

3: A key feature of the UNP evolves around a psychosocial approach to malnutrition, whereby the impact of family dynamics and complex family problems may act negatively both on the main carer and subsequently on the growth of the child. Action research on 22 families has been undertaken and significant findings were published in September 2003.

3: A major change took place during 2004 and cumulated at the beginning of January '05 when the volunteers formed their own organization, known as Chhimeki; they are now partners of Tdh and continue the UNP work. The Tdh technical team currently provide intensive support to this fledging organization.

4: Statistical data indicates that some 60% of underweight children gained weight during the period of home visiting. On average 59-60% of children <3 years of age attend for monthly growth monitoring, where appropriate complementary feeding and care of the sick child is promoted. The latter figure is likely to be higher, as these issues are covered whenever contact is made between volunteers and carers. Cheap and available nutritious foods are within access of families.

5: A 24 hour recall indicates that 51% of mothers are exclusively breastfeeding up to 6 months[1].

6: Less easy to establish were accurate figures for iron supplementation to pregnant and post-partum women, due to high mobility of families and cultural reservations. However, an

[1] For both the UNP and RNP the accuracy of exclusive breastfeeding is questioned, as mothers frequently stated that water had been given at some stage to their infants.

uptake of ANC and PNC attendance at Ward Clinics in targeted areas is reported. There appears to be a shortfall in the 100% of women who should have received Vitamin A and in the case of hospital deliveries needs to be explored further.

7: Sustainability of the UNP was envisaged through supporting Ward Clinic Staff by peer sharing and gaining their involvement in volunteer training, volunteer follow-up post-training and in community growth monitoring. This aspect of the project ultimately proved to be less fruitful, but has not deterred the upward strengthening of the UNP team and successes flowing from their management and organization have been explored. Undoubtedly the non-hierarchical project structure, positive support from the Tdh technical team (formerly SAGUN), along with other identified factors have contributed towards the high team motivation, which was observed during the evaluation.

7: Qualitative findings indicate that the IMPACT on volunteers, mothers and children has been significant and it is this personal growth of many individuals that underpins the success of the community work been undertaken. Also highlighted is the reality that health education and health promotion (*if sensitively and properly applied*) can be mechanisms of social development, alongside improved nutrition and health care. Examples are given of HOW and WHY personal, social and economic development has been achieved amongst women –many of whom will not have had the benefit of education, besides being caught up in traditions and cultures which inhibit their status in society.

8: The obstacles encountered have been explored and relate to expectations from the community; shifting families, which also applies to volunteers; failed initiatives; extensive documentation and less activity from some volunteers. The breakdown of effective communication between the UNP and Ward Clinic Staff, particularly since January '05, is a cause for concern. Differences in past and present arrangements regarding payment to clinic staff appear to be causing the difficulty, but other issues could underlie the current problems.

9: Monitoring and evaluation has been modified to cover 3 key factors > client recall of nutrition practices, namely that of breast-feeding, appropriate complementary feeding and feeding and care of the sick child (The latter two points to be combined for monitoring purposes). It is suggested that iron & Vitamin A supplementation could be covered through project activities via the Department Of Health: already a feature in rural areas through FCHVs.

10: A variety of mechanisms and approaches to share lessons learnt from the UNP are highlighted. They are generally practical interventions, which could help promote improved nutritional practices for women and children, as well as giving Chhimeki wider recognition.

11: Recommendations and/or Suggestions are based on 3 key points. Promoting health education to a wider audience, plus creating more innovative methods. Extension of project activities, such as adult literacy classes and day care centres, complete targeted wards coverage; explore reasons for volunteer inactivity and for UNP to extend into the wider remit of Kathmandu District. Lessons learnt to be linked into programme activities and 'closer ties' between project and the government sector to be sought, particularly on the promotion of appropriate complementary feeding.

12: A tentative suggestion has been given on the issue of Internally Displaced Persons in Kathmandu, namely to provide a series of drop-in centres for women and children. Such centres could provide a variety of needs and resources, both human and material, plus providing protective mechanisms, particular for lone women with children.

Rural Nutrition Programme in Lalitpur District: Main Findings
Like the UNP, the focus of the RNP is with antenatal, postnatal women and children <3 years of age and has the same stance of applying a psychosocial approach to work practices. The

RICOD team of five community facilitators have to trek far distances to reach the more outlying wards, therefore expectations of coverage have to be realistic. Statistical data shows that anticipated results have been achieved

1: Currently the RNP covers 77.5% of the wards within the four targeted VDCs of Lalitpur District. This equates with total population coverage of 6,940.

2: Uptake of iron for pregnant women was 79% and for postpartum women there was a 100% uptake in Vitamin A and Iron supplementation.

3: Given the HH coverage it can be assumed that families are gaining access to information on appropriate care of children during sickness and appropriate complementary feeding.

4: A 24-hour recall indicated that 72% of mothers were exclusively breastfeeding up to 6 months. Children diagnosed as being underweight are gaining weight, but a significant 25% of them who are malnourished require referral onwards to the Nutrition Rehabilitation Home.

5: Good relationships were noted between the RNP team and the government health staff. This has enabled protocols to be applied and for the skills of the local staff at SHPs and ORCs to gradually improve, as they learn from the CFs good working practices.

6: Qualitative findings indicated that real IMPACT had been made in respect of improved KAP. This was noted with mothers, men and schoolchildren who revealed how access to quality health promotion and education, along with an increase in ORCs had enabled them to improve HH lifestyles. Similarities are found between the findings in Lalitpur District and that of KMC. Personal growth, development and increasing confidence were evident with people met and there appeared to be a real desire to learn more about nutrition and health.

8: The main obstacles encountered have been explored and relate to expectations from communities; the amount of documentation required; limitations in home visiting to malnourished children due to the distances involved; issues surrounding appropriate supervision for the team and a perceived lack of support from the RICOD Board. However the main obstacle affecting this RNP arose from the ongoing conflict situation.

9: Conflict initially impinged on building up trust with the community (now resolved); entry into a 5th VDC was curtailed, thus inhibiting the growth of the programme and the obtaining of essential ward household profiles; abduction of staff last year has left a 'legacy' of fear and the project has to suspend some of its outreach activities this year because of the situation. It is questioned whether men are leaving the villages in order to avoid subscription by insurgents, but this was not confirmed from the local people met. The loss of male labour would, undoubtedly, impinge negatively on family life and income.

10: Monitoring and evaluation has been modified to cover 3 key factors involving client recall of practices, namely that of breast-feeding, appropriate complementary feeding and feeding and care of the sick child (The latter two points to be combined for monitoring purposes).

11: Recommendations and/or Suggestions have been given in respect of the above-mentioned difficulties in point 9. Increased community involvement is posed, as a way forward for the project, along with intensifying the number of trained women, men and schoolchildren. The issue of project-ownership has been raised, particularly when viewing sustainability in a conflict zone.

In both urban and nutrition projects the overall goal of improving nutrition for women and children has taken place, coupled with the key objective of improving KAP on nutritional issues for children <3years of age and pregnant women within the current targeted areas.