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.